ORIGINAL RESEARCH

Struggling to create new boundaries: a grounded theory study of collaboration between nurses and parents in the care process in Iran

Fereshteh Aein, Fatemeh Alhani, Eesa Mohammadi & Anoshirvan Kazemnejad

Correspondence to F. Alhani:
e-mail: kowssar2002@yahoo.com;
alhani_f@modares.ac.ir

Fereshteh Aein MSc
PhD Student
Nursing Department, Tarbiat Modares
University, Tehran, Iran
Present address: Shahrekord Medical
University, Iran

Fatemeh Alhani MSc PhD
Associate Professor
Nursing Department, Tarbiat Modares
University, Tehran, Iran

Eesa Mohammadi MSc PhD
Associate Professor
Nursing Department, Tarbiat Modares
University, Tehran, Iran

Anoshirvan Kazemnejad MSc PhD
Professor
Biostatistics Department, Tarbiat Modares
University, Tehran, Iran

Abstract

Aim. To develop a substantive grounded theory of nurse–mother interaction in the care of chronically ill children in hospital setting.

Background. Interaction between nurses and parents is critical in paediatric hospital settings. This area of practice in developing countries has been under-researched.

Method. The qualitative research design of grounded theory methodology was used to develop a theory of nurse–parent interaction within the child care. Registered Nurses (*n* = 17) and mothers of chronically ill children (*n* = 14) from two central paediatric hospital in Iran participated in this study. In-depth interviews with nurses and mothers were conducted using theoretical sampling between July 2007 and August 2008. The data were analysed using constant comparative analysis.

Findings. 'Struggling to create new boundaries' as a core variable was a dominant socio-psychological process that was manifesting itself within three stages: facing up to and perceiving the environmental pressures, balancing nurse's duties, and controlling the nurse–parent boundary in the care.

Conclusion. It is concluded that nurses and parents need a care model, which addresses their collaboration and improved interpersonal relationship and clearly defines the boundary of their roles based on the needs of both sides while allowing parents to choose their role in these defined boundaries and providing parent education with aim to empower them for care at home.

Keywords: care model, chronically ill children, grounded theory, nurse–parent boundary, nurse–parent interaction

Introduction

In this era, the number of children suffering from chronic diseases and experiencing repeated hospitalizations is increasing (Hostler 1991, Boyd & Hunsberger 1998, Charron-Prochownic 2002, Nuutila & Salantera 2006). Care-by-parent units, in which the family lives with the sick child, were first introduced in the United States in the 1960s. In this approach, parents stay with the children in hospital and provide care in conjunction with the nurses. Therefore, nurses have constant contact with children and their parents in hospital, and a great deal of influence on the way care is delivered (Alsop-Shields 2002).

Family centred care (FCC) has been promoted as the optimal philosophy for children and families in their interactions with health professionals (Bruce *et al.* 2002). FCC involves developing a unique and dynamic care model that puts the family in close contact with the healthcare team (Hutchfield 1999, Shields *et al.* 2006, Jolley & Shields 2008) and seeks to involve families fully in the care of children through a respectful and supportive approach (Bruce *et al.* 2002).

Recent researches have highlighted that although the interaction between the family and the healthcare providers is the core of family centred care, in practice, the collaborative processes disappear; especially, the parents' role is not defined mutually, but mainly turns into a handing over of the responsibility to parents (Pongjaturawit & Harrigan 2003, MacKean *et al.* 2005, Soderback & Christensson 2007, 2008). Studies illustrated that as the role of families in caring for children has changed, new challenges have appeared in the roles and relationships between families and health professionals (Bruce *et al.* 2002). Swallow and Jacoby (2001) identified the difficulties which mothers of children with chronic conditions could experience in establishing their role alongside the healthcare team. Previous research (Brown & Ritchie 1990, Casey 1995) found that professionals either assume responsibility for the child's care, ignoring the family's expertise (Thomas 1990) or assume that parents wish to carry out all the care (Callery & Smith 1991, Coyne 1995) yet failed to negotiate the extent of that care (Kawik 1996). Nevertheless, a study by Coyne and Cowley (2007) illustrated that it was difficult for parents to find a balance between their role and the nurse's role due to lack of information and ambiguous boundaries. Parent attitudes towards collaboration have been mixed. Some studies have indicated that parents want and need to collaborate in their child's care (Kawik 1996, Balling & McCubbin 2001). However, other studies have identified differing parental participation rates (McKay & Hensey 1990, Oates 1992). Coyne and Cowley (2007) have recommended that the value of parent participation should not be taken for granted and there is a need for further studies focusing on the effects/outcomes of such an ideology on all participants in the health system. They have indicated that research is particularly needed to focus on parents, and children with chronic diseases, as the care processes could be different due to the nature of long-term family/nurse interaction.

A study carried out by Tonks *et al.* (2005) in Hong Kong and Scotland indicated that effective interaction with parents was seen in both countries as key to effective practice. Expectations of health services differed between cultures. The Hong Kong group emphasized self-reliance and voiced little expectation of emotional support for the family while the Scottish group had a greater expectation that family needs would be a legitimate concern for healthcare professionals.

Culture may also affect the use of models of care. A study by Shields and Nixon (2004), conducted in two developed (Australia and Great Britain) and two developing (Indonesia and Thailand) countries, indicated that although the concept of a family centred care has been adopted by the western cultures, it has been less accepted in the developing countries, and culture plays a major role in defining how care is provided by the healthcare team and how it is received by the parents and what should be the nature of the interaction between the two parties (Cited in Corlett & Twycross 2006).

Generally, studies have not facilitated the recognition of the integrated perspective of the whole parent–nurse relationship across different cultures (Coyne 1995).

Healthcare system in Iran consists of private and governmental healthcare systems. Governmental healthcare systems are divided into University and Community sections. In university hospitals, mothers have been taking part in the hospital care of their children for over a decade. Today, university hospitals included in their policies that mothers should stay with the child during hospitalization to support him/her psychologically and protect the child's safety, with some accommodation facilities provided for them. Nursing staff in those hospitals consist of Registered Nurses and Nurse Assistants. Registered Nurses have Bachelor degree and Nurse Assistants have diploma in nursing. Registered nurses have the role and responsibility for nursing care delivery to children. The registered nurses (RNs) usually care for eight or nine patients, with the nurse assistants functioning under the supervision of the RNs. Despite those hospitals providing specialized care to children, they inevitably function with limited resources and most children admitted in those hospitals are from low-to-moderate economic class because of low treatment cost and the insurance coverage. Most wealthy families prefer private and well-resourced hospitals. There is no qualitative research on nurse–parent interaction in hospital in Iran that gives data and analysis on this subject. The only quantitative study of parent's viewpoints regarding family centred care published in Iran highlighted that most parents viewed support, respect and collaboration as the most important elements of family centred care (Bagonjani 2006). Published literature highlights the effects of the prevailing social characteristics and those of healthcare system upon the nature of interaction between families and nurses (Shields & Nixon 2004, Shields & King 2001a,b, Alsop-Shields 2002). Strong family bonds and parental responsibility for the care children is a significant cultural construct in Iran. However, studies have not examined the existing process of interaction between families and

nurses in the context of hospitalized children in Iran. Studies are needed in Iran on nurse–parent collaboration in university hospitals. It provides nurses with the opportunity to reflect on and address parental themes, so that there will be a further understanding of nurse–parent collaboration. The current study aimed to develop a substantive grounded theory of nurse–parent interaction in the care of chronically ill children in hospital setting.

Method

Aim

The purpose of the study was to generate a theory of nurse–parent interaction process in the care of hospitalized children.

Design

Classical GT was chosen as the method (Glaser 1998). GT is well suited for studying complex and hidden processes (Morse 2001). It provides guidelines for discovery and formulation of theory and is particularly useful for understanding fundamental social-psychological patterns (Glaser 1998).

Participants

Participants were nurses, and mothers recruited from different wards of two university paediatric hospitals in the capital city in Iran. Those hospitals take referrals mainly from across the country. Those wards included children with blood, renal, endocrine, metabolic, rheumatologic and gastrointestinal diseases. We used purposeful sampling with a maximum variance approach according to Glaser (1998) by recruiting both key informants including mothers and nurses from different wards to acquire rich data about the care process in paediatric units. Convenience sampling was used initially, because there were no data from participants to guide what information was sought. Participants who met eligibility criteria were interviewed. Mothers who had a child with a diagnosed chronic condition (e.g. endocrine, blood, metabolic, gastrointestinal or renal disorders), ability to speak Persian and not cognitively impaired were recruited and interviewed individually at least 3 days after child's admission to hospital. By a primary investigation of patient's records in the ward, author has identified that the mean of children's hospitalization length was 7 days. The time of interview (at least 3 days after hospitalization) was chosen because there was enough time for mothers to interact with nurses from admission and also for the author to have follow-up interviews with mothers before discharge. The registered

nurses who care for these children and have at least 3 months of work experience in the paediatric wards were recruited in the study. Recruitment and analysis were carried out concurrently to allow theoretical sampling, based on emergent findings. After interviewing four nurses and coding the transcripts, a great deal of data related to managerial and organizational variables were observed and therefore it was decided to interview the key informants in these areas.

Data collection

Participants were given information about the study and informed consent was obtained from all the participants. Data collection was performed by means of unstructured formal and informal interviews.

First, several observations were conducted before data collection to establish familiarity with the ward layout and daily routine, the staff and the families. This information proved to be very useful in determining 'good times' of the day in which to approach parents and nurses. The interviews with nurses carried out in the wards and started with a general question, "please tell me about your experience in interaction with parents in the care of chronically ill children during hospitalisation" and gradually evolved, further exploring emerging topics of interest to the study.

The parents were interviewed in a quiet room nearby. We started interviews with mothers by asking more detailed questions including 'please tell me the reason for your child's hospitalisation' as an opening question. A few mothers described in full what had happened to them during hospitalisation but most mothers needed more detailed questions such as 'tell me about the first moments you arrived in the ward and what happened during the first hours in hospital, tell me about your feelings at that time, tell me about whatever you do for the child during hospitalisation, tell me about when and why you interact with nurses'.

The first author (AF) conducted all the interviews from July 2007 to August 2008. The interviews lasted 30–100 min for parents and nurses. A few occasional observations were also carried out during data collection at the bedside of the child or in nursing station by the first author (AF) with a focus on the issues raised during formal interviews with parents and nurses, which needed more justification. Relevant observations were made on the nurses' interactions with children and their parents and on the parents' care of children, and sometimes were supplemented by brief, informal questions about what they were doing and why. The type of observation was 'observer as participant' in that the predominant activity was to observe and potentially to interview (Streubert and Carpenter, 2007). Notes taken at the time of observation

were written in detail on the same day. For ethical consideration, the head nurses gave permission for observation to begin at the start of each shift so that nurses' actions could be monitored and they were also assured that the observer would leave the room during embarrassing and private conversations. To obtain informed consent, nurses were informed about the purpose of the study and that their interaction with mothers and children would be observed. To eliminate their sophisticated behaviour, their interaction was observed for at least three times. The interviews and observation data were analysed concurrently using the constant comparative method. The interview data, observation data and the field note data were used to support and validate the emerging grounded theory of nurse–parent collaboration in child care.

Analysis

In view of the fact that the purpose of the study was to generate a theory of nurse–parent interaction process in the care of hospitalized children, grounded theory was applied (Glaser 1992, 1998). In using grounded theory, we used the concepts of emergence, fit, work, relevance and modifiability (Glaser 1992). In accordance with Glaser (1992), three questions have guided us in the process of analysis, namely (1) What are the data a study of? (2) What category does this line or incident indicate? and (3) What is actually happening in the data? Initially, each interview was audiotaped, transcribed verbatim and analysed before the next interview took place to provide direction for the next. Observational and interview data were coded. To analyse the data, the text was read several times and meaning units were identified, and subsequently labelled using an open code. The codes were then grouped thematically into categories and comparisons were made within and between the categories. Several strategies as recommended by Glaser (2004) were used to assist the process, which were constant comparison and reduction; theoretical sampling; theoretical coding; writing memos and drawing diagrams. The rigorous steps of the data analysis process (as described by Glaser 1992) were adhered to and this process contributed to the reliability of the findings. As we proceeded to compare incident-to-incident in the data, then incidents to categories, a core category began to emerge. The core variable, which appeared to account for most of the variation around the participant's concern or problem that was the focus of the study, became the focus of further selective data collection and coding efforts. This selective data collection and analysis continued until we had sufficiently elaborated and integrated the core variable, its properties and its theoretical connections with other relevant categories. By finally reaching theoretical saturation with 31 participants, we ceased data gathering from participants.

The literature review was performed parallel to the elaboration of the categories and development of the theory.

Ethical issues

Ethical approval was obtained from the ethics committee of Tarbiat Modares University. Voluntary informed and written consent was obtained from parents and nurses. Participants were given numbers to ensure privacy when reporting the data.

Findings

In total, 14 mothers and 17 nurses participated in the study. Characteristics of nurses and mothers are summarized in Tables 1 and 2 respectively. We included mothers only because fathers were not allowed to stay with the child in hospital due to cultural and organizational limitations. Nurses were aged, 24–50 years with between 5 months and 30 years work experience in paediatric wards, 12 were ward nurses, two head nurses, one nurse assistant in the role of 'welcome nurse', and three supervisors. All of them had bachelor's degree in nursing except one who was a nurse assistant. Mothers were aged between 25 years and 42 years with a chronically ill child and had different educational coming from around of Iran.

The findings of the study cover the discovery of the main concerns of nurses and parents in the care of children and the strategies adopted by nurses and parents to resolve their main concerns.

Table 1 Characteristics of sample: nurses

Sample	n	Age (years)	Marital status	Work experience (years)	Position	No. of own child
Nurses	17	Min = 24 Max = 52 Mean = 32	Married (n = 12) Single (n = 5)	Min = 2 Max = 30 Mean = 5	Nurse Assistant (n = 1) Ward nurse (n = 10) Head nurse (n = 2) Supervisor (n = 3)	Min = 0 Max = 3 Mean = 1

Table 2 Characteristics of sample: mothers

Sample	n	Age (years)	Gender of child	Age of child	No. of child's hospitalization	Length of child's hospitalization (days)	Job status	Education	Child's medical diagnosis
Mother	14	Min = 25 Max = 42 Mean = 32	M = 7 F = 7	Min = 4 months Max = 10 years Mean = 5 years	Min = 1 Max = 6 Mean = 2	Min = 5 Max = 22 Mean = 7	Housewife (n = 11) Teacher (n = 2) University student (n = 1)	Illiterate (n = 2) High school (n = 3) Diploma (n = 6) Higher education (n = 3)	Blood disease (n = 2) Renal disease (n = 3) GI disease (n = 3) Metabolic disease (n = 2) Rheumatoid disease (n = 2) Endocrine disease (n = 2)

Struggling to create new boundaries: core variable

'Struggling to create new boundaries', was a basic psycho-social process which conceptualized the nature of the strategies adopted by nurses and parents to resolve their main concerns. This core variable was processed through three stages (Figure 1):

Stage one: facing up to and perceiving environmental pressures

Stage two: balancing nurses' duties

Stage three: controlling the nurse–parent boundary within the care

Stage one: Facing up to and perceiving environmental pressures

Analysis of the data illustrated that nurses' main concern was providing care under pressures prevailing in the work environment. These included pressures resulting from the demanding structure of the work in paediatric wards, and those due to inappropriate human resources management.

1-1: Demanding structure of the work in paediatric wards

This category referred to time constraints, vulnerability of children, constant presence of mothers by child's bedside with their needs and expectations, difficult and time consuming nature of paediatric nursing procedures, and the unpredictable nature of the work in the ward.

Children's vulnerability, dependency and anxiety in the absence of mother, in practice resulted in mothers' constant presence by children's bedside the whole time.

It is the child's needs that parents' presence was necessary. (Supervisor 2)

Parents need care themselves due to being there all days and nights that has made nurses having to face mother's needs and expectations, which puts them under extra pressure.

... you in fact are working with two clients: the patient and his/her mother with her own needs and expectations.... (Supervisor 1)

In addition, nurses require more time, and skills in working with children, which put them under extra pressure and make time management more demanding.

Nursing procedures for children are more challenging. Paediatric nurses should be more skilful and patient.... (Supervisor 3)

1–2: Inappropriate human resource management

This is another source of stress for nurses. Nurses are faced with low staffing level and a shortage of non-professional staff, which led to heavy workload and compulsory working hour schedule, time constraint, excessive fatigue, and ultimately
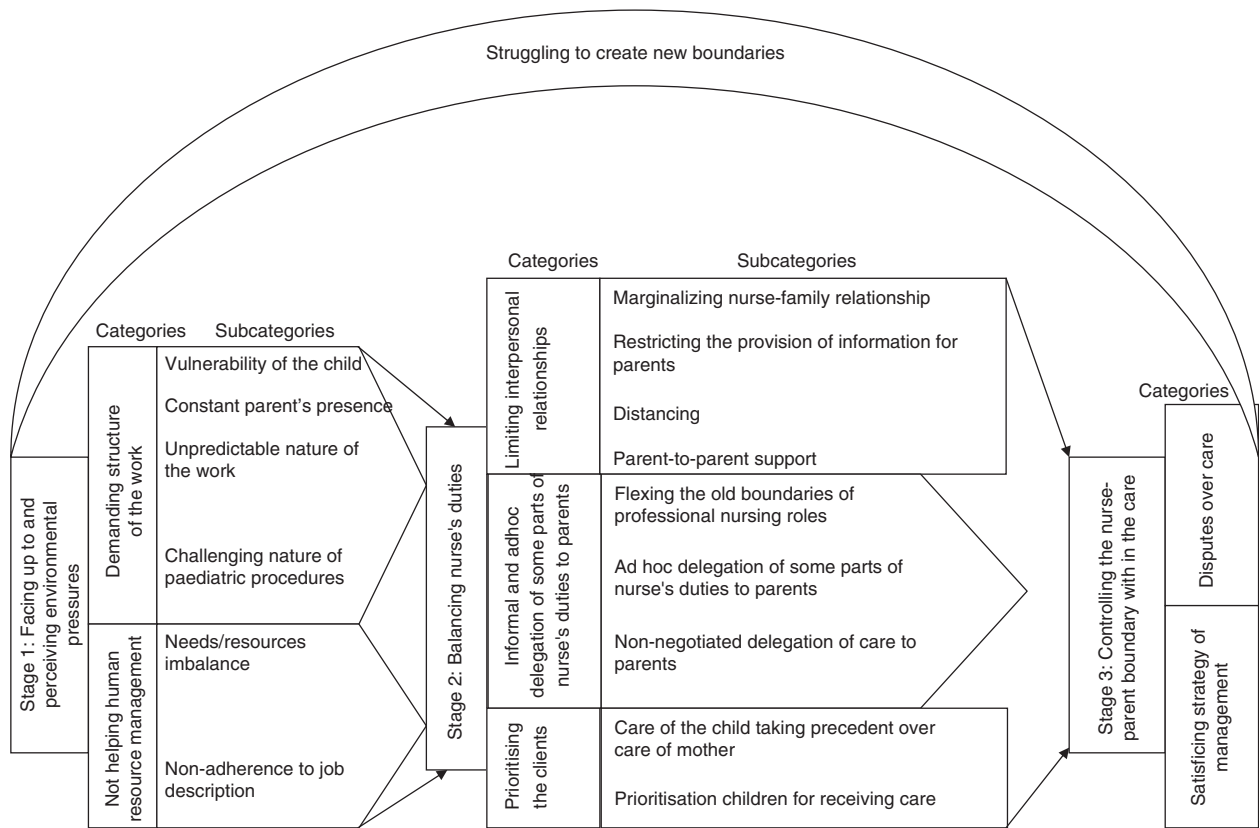
Figure 1 Basic psychosocial process of 'struggling to create new boundaries'.

resulted in their not being available to meet children's needs for appropriate nursing care, and came in the way of their effective interaction with children and their parents.

We never have sufficient number of nurses per shift. We have 40 patients, and only have two nurses.... (Nurse 10)

Furthermore, hospital managers do not adhere to job description of nurses and therefore nurses have to undertake tasks that should not be carried out by them which could increase their work pressures.

Job description?... A lot of tasks are not part of our role but we perform them that put much pressure on us.... (Nurse 6)

Overall, the environmental pressures due to demanding structure of the work and inappropriate human resource management led to nurses' concern about handling the care in the ward. For parents, a child suffering from a chronic illness and facing uncertainty is a cause of concern for their children. Nurses not being constantly and promptly available adds to parents' concern for the child causing them to lose their confidence in their child receiving appropriate care.

... Nurses are not available by child bedside....One can't be certain if the child would be looked after well.... (Mother 13)

Such feelings made both parents and nurses adopt strategies to resolve their concerns which also had an impact upon their interaction. These strategies formed the second stage of 'struggling to create new boundaries' process.

Stage two: Balancing nurse's duties

The concept of balancing nurse's duties encompasses strategies nurses adopt to manage own workload, and enables them to reach a balance in their duties and be able to handle more pertinent aspects for which they are accountable. The concept includes following three strategies:

2-1: Limiting interpersonal relationships
To reduce the time spent on educational and interpersonal aspects of their role, nurses were observed to be unconsciously limiting their interpersonal relationship with the parents involved. This approach consisted of marginalizing interpersonal relationship with parents, restricting the provision of information for parents, and distancing. Shortage of staff leading to an imbalance between the available human resources and patients' needs resulted in nurses spending a great deal of their time on paperwork, managerial and

technical tasks. Consequently, supportive, inter-personal and educational aspects of the nurses' roles have been marginalized. Observation data also showed nurse's busywork and limited nurse–parent relationships.

…When the child arrives and we are rushing to get a blood sample from another patient, we don't even say hello or see her… (Nurse 1)

The quality of the interpersonal relationship between nurses and parents was also influenced by nurses' ability to communicate effectively with parents and patients. A lack of interpersonal skill, could lead to nurses' incompetence in providing psychological support.

… We did not receive training for how to communicate to patients… I don't know how to support them psychologically. (Nurse 4)

Inadequate relationship between nurses and parents, and a lack of psychological support led to mothers seeking each other's support.

The roommates offered me emotional support… I felt calmer… (Mother 8)

Shortages in human resources resulting in a lack of time have also led to the children being psychologically not prepared for the procedures by nurses.

I don't really talk to the child. We do not have time… (Nurse 6)

Parents had concern for their children were actively seeking information. A part of nurses' role is to provide information. Nurses were always busy with paperwork and practical aspects of their work and parents were not able to reach them easily to speak to them or ask questions about the care process. Encountering nurse's unpleasant reactions when attempting to cross boundaries to seek information led to a majority of parents resigning themselves to status quo; accepting the existing boundaries, refraining from attempting to form an effective relationship or asking questions.

I'd like to know but… I am afraid to ask and they get angry again… (Mother 4)

2-2: Informal and ad hoc delegation of some parts of nurse's duties to parents

This concept was the second strategy adopted by nurses to balance their tasks. By gradually flexing the old boundaries of professional nursing roles and brining in parents into the nursing domain, nurses were delegating some parts of their duties to mothers to reduce their own workload under environmental pressures. In practice, this involved delegating some aspects of care, which they are legally accountable for, to parents without providing sufficient training or supervision and without any negotiation with them.

Gradually, nurses learnt that once the mother was there and could take the temperature or report I&O so let her do them …Because nurses have not had enough time…. (Head nurse 2)

Observation data showed that mothers have not had enough skills to do nursing care. Nurses' attitude that children are more conveniently cared for by their mothers acts as a facilitating factor in delegating some aspects of care to parents.

Children are more convenient being cared by their mother than a nurse. This is why we want mothers do some nursing care. (Nurse 10)

However, parents' willingness varied across a continuum ranging from accepting all the duties delegated to them to a total non-compliance in this respect. The latter stance was due to a sense of lacking the necessary expertise, their being not willing to devote time, and a feeling that nurses have imposed the tasks on them.

I'd like to be by his bedside so that he doesn't feel left alone…but not to be given tasks all the time. (Mother 3)

Since a mother is more compassionate than a nurse, she does a better job and that's why I love to do all the tasks. (Mother 2)

I prefer the nurse to take the temperature as she does it better…. it is their duty. (Mother 13)

The degree to which nurses trusted mothers' ability to carry out specialized aspects of care depended upon nurses' experience. Senior nurses were less willing to delegate more technical tasks to parents unless they were able to closely supervise the latter.

When the mother says 'I have learned NG Tube feeding', some of junior nurses believed mother's claim, but I say 'I come and watch you do it'. (Nurse 3)

Although the norm was parent's being there and being involved in care, it takes place in an ad hoc manner. New nurses also follow more experienced nurses as 'role models' during socialisation, learning the norms of the ward.

Nothing has been defined for us…What we saw on the first day of the more senior staff, has become routine. (Nurse 7)

2-3: Prioritizing the clients

Prioritizing the clients is another dimension of balancing tasks in circumstances where time pressure and imbalance of resources and needs hinder nurse's ability to accomplish all their duties promptly, which involved (i) care of the child taking precedence over concern for the mother and (ii) prioritization of care of the children according to how acute their case is.

We don't have time....We'd care of parents as far as it doesn't cause any problems. (Nurse 6)

Also, work pressure, lack of resources and the unpredictable nature of nursing in children wards force the treatment team to consider how care for certain patients takes precedence over others.

A patient is in critical condition while another mother asks for help but nurse give the priority to the critical-ill child. (Nurse 3)

Stage three: Controlling the nurse–parent boundary within the care

This concept constitutes the third stage of the basic psychological process of 'struggling to create new boundaries' and is an outcome of the previous notion, achieving a balance of duties. It had two dimensions: (i) dispute over care and (ii) satisfying strategy of management.

3-1: Dispute over care

At this stage, both nurses and parents felt that the other party was encroaching upon their domain, which caused friction and added to the sense of pressure for both. Each party has own domain in mind that was different from traditional domains of nursing and parenting when the child was admitted to hospital.

Nurses' strategy of limiting interaction with parents led to a dearth of knowledge; parents remained unaware of the reason for diagnostic procedures and adjustments in the care plan, which led to a lack of trust towards nurses. Therefore, to protect their children's rights, mothers interfered with the care, which in turn was viewed by nurses as breaking their boundaries and led to further dispute over care of the children.

There has been times when I have objected to unnecessary procedures. They (nurses) didn't explain why it was necessary... They frowned at me 'why are you asking at all?....' (Mother 9)

Mothers are present at the children's bedside all the time, and are informally observing nurses practice. Their comments to nurses about how care should be done are considered as 'interference' and challenged nurse's authority leading to nurses clashing with mothers to defend the boundaries of their work.

The nurse came to set up the drip; she just attached it and left... I told her' look it isn't flowing, they usually do something to his/her vein for the fluid to get through'. She said 'who are you to comment?... I said I am going to tell the supervisor. (Mother 13)

At times, nurses are needed but are not available, because of attending to higher priority cases. In such cases, some mothers with frequent experience of hospitalizations under-

take certain nursing tasks, without consultation with nurses because they think it is a simple task and does not need much expertise. It jeopardizes quality of care and because nurses would be accountable for the consequences of such actions, it leads to dispute between nurses and mothers.

... I adjusted the serum to continue for six hours but mother increased the flow 2 or 3 times faster. .... The mother sees herself entitled to do this.....I become very angry because I'm accountable.... (Nurse 10)

In cases where mothers were frequently interfering with the treatment plan and quarrelling with the nurses, more experienced nurses made effective use of the authority of the father or other influential members of the family to force the mother to observe the boundaries as the staff had intended.

When I am not able to resolve the issue with the mother, I talk to the father or who in the family is she close to. It is very effective. (Nurse 10)

Mothers were concerned about their children and insisted on being present at painful procedures to provide emotional support. Nurses did not allow mothers, whose presence caused increased anxiety in children and made them less cooperative or were interfering with the nurses' jobs, to be present. This was one way nurses controlled the parent–nurse boundary.

...As a rule, no, they interfere, not only the mother is agitated but it has an effect on us too. We say if you want to act like this back off. (Nurse 3)

Moreover, some mothers, who have had previous unsuccessful conflicts with nurses, have come to the realization that as the child needs frequent hospitalization, it is best to stop their struggle, keep quiet and cooperate with the nurses. As a result, they have turned into calm but unsatisfied parents who do not communicate their needs, and respect nurses' preferred boundaries. This indicated that nurses have the authority and set the agenda in the wards, but mothers who are naturally concerned about their children would like to change the situation.

....One of the mothers who has been coming here for a long time, says to me: 'always try to cooperate with them, can't you see that because of your child's illness you have to be coming here all the time? Whatever you say in the end you'll be beaten... (Mother 9)

Delegating aspects of care to mothers without negotiating with them caused their wishes not being taken on board. Some nurses reported that some mothers looked down upon nurses' duties. Consequently, they resisted fulfilling the tasks assigned to them or at time complained to the managers and therefore nurses called them 'uncooperative' parents.

... A lot of parents view it in a negative light. Some are insulting;....it is your duty'. (Nurse 8)

Mothers who had had to perform the same procedures at home collaborate better with respect to the tasks that nurses had delegated to them.

... when they realise that they had to do Nebulizer at home, they no longer say 'it is your job'. (Nurse 10)

Parents were not included in the decision-making in relation to the treatment and the care processes. They made certain comments about the treatment decisions, which were considered interference by the care team. This resulted in confrontations to exert control over the boundary between the staff and the parents. The evidence indicates a lack of real partnership between parents and nurses, whereas some parents were asking that their views are taken on board.

Well, they should pay full attention to what I say... what was the reason for urinary catheterization. They said 'why are repeating this so many times? (Mother 9)

3-2: Satisfying strategy of management
Managers conveyed to nurses that delegating nursing duties to parents is not acceptable legally. Nevertheless, they have not been able to insist upon the legally defined boundaries of nurses' roles due to the pressures experienced by nurses, caused by a disparity between the demands and the available resources. They were also overlooking the practice unless they were faced with complaints by parents or if the care provided by the mother could have resulted in harm to the child.

We have told our colleagues that mothers are only here to be with their children. But unfortunately what we say is not possible; because there is no parity between the number of nurses and patients.... (Supervisor 3)

At times of conflict between nurses and parents, if they sought assistance from the nursing office, managers attempted to calm the situation and explain the position of each party to the other to create mutual cooperation.

We have to calm both sides, explain to both parties; to nurse so that she appreciates patients' situation, and to parents so that they understand that a given procedure is not as simple us they think. (Supervisor 2)

Parents' frequent grievances against nurses led hospital managers to create a new role of 'welcome nurse' to lessen parents' discontent. Her role is to mediate, talk to the protesting parent and the nurses involved and attempt to explain the new boundaries to be accepted.

...Nursing Office management decided to appoint someone called 'Welcome Nurse' to calm the parents... (Supervisor 1)

Nature of the strategies adopted by the nurses and parents alike indicates that both sides are struggling to find solutions to their concerns and form new boundaries.

Discussion

Findings allow for the nurse–mother interaction in the care to be explained through the psychosocial process of 'struggling to create new boundaries'.

When the results were compared with other grounded theory studies from Western cultures, there were both similarities and differences. A grounded theory study by Coyne and Cowley (2007) in United Kingdom (UK) highlighted the concept of 'concern for the child's welfare' which is similar to the concept of 'concern for the child' in the current study, although in our study the chronic nature of the illnesses had heightened parents' concern for the future prospect of the children's illness; in both studies, parent's presence at the hospital was not only considered a moral obligation but also it was necessary to deal with child's needs where nurses were not able to be constantly available. The importance of parent's presence to the child, nurses and parents is universal across different cultures as it has been reported by Rowe (1996) in Australia; Chapados *et al.* (2002) in Canada and Lam *et al.* (2006) in Hong Kong.

The concept of 'delegating parts of nurse's duties to parents' in our study is somewhat similar to the concept of 'relying on parents' as reported in the grounded theory study carried out by Coyne and Cowley (2007) in UK, and to that of 'nurses' expectations' as reported by O'Haire and Blackford (2005) in Australia. In all three studies, faced with the inadequate nurse to patient ratios, nurses expected parents to provide psychological care, basic care and some aspects of nursing care. As this was the norm, nurses did not see themselves to be responsible for these aspects of care. However, their attitude was different in these studies. Nurses in Coyne and Cowley's (2007) study believed that parent's role changes when they are in the hospital and involving them in the care process restore parents' confidence, self-esteem and re-establish their role as parents, whereas in our sample, nurses considered that the children would be more comfortable if cared for by their mothers, a notion that facilitated the handover of duties to them.

In addition, nurses in the study by Coyne and Cowley (2007) in UK allowed the parents to determine their participation level and nurses played a role of 'observer' and 'supporter' helping parents gain a state of equilibrium. Other qualitative research studies showed that Western parents (Power & Franck 2008, Coyne & Cowley 2007, Kawik 1996) and some Asian people such as Hong Kong parents (Lam *et al.* 2006) also participated

in nursing tasks by choice, while in the current study, prevailing pressures led to nurses handing over some duties to parents with no negotiation about the participation levels. Factors such as low staff ratios that exacerbate this problem are supported by recent research studies (Balling & McCubbin 2001, Roden, 2005, Coyne & Cowley 2007). To ensure parent confidence, hospitals need to maintain an acceptable nursing staffing ratio, which takes account of upset children.

In contrast to the current study in which some parents impinged upon nurses' domain, Coyne and Cowley's (2007) grounded theory study reported that parents were anxious in case they neglected to do something that the nurses expected them to do or exceeded their role remit and encroached on professional territory. Either action could incur nurses' displeasure. Difficulty for parents in reaching a balance between their own role and that of the nurses due to dearth of information was the core variable of the aforementioned study. Similar findings had been reported by other studies (Callery & Smith 1991, Coyne 1995). In contrast, some of our parents wanted to determine their roles in the care. While some willing to handover all nursing care to nurses, others desire to participate in both performing nursing care and decision-making about care. Some negative parental attitude included feeling incompetent or overwhelmed due to lack of knowledge or skills to participate in child care. Similarly, Power and Franck's (2008) systematic review has also concluded that parents generally desire and expect to be involved in caring for hospitalized children, but the ways in which they want to be involved may differ and a need for information, communication and negotiation were recurrent to enable parent participation in several studies. Finally, our study suggests that clear guidelines about parents' expectations of their participation in care would help nurses' understanding of parents' needs and would assist parents in their care role.

The concept of 'dispute over care' has been also reported in grounded theory study by O'Haire and Blackford (2005) in Australia, which referred to the disagreements between the nurses and the parents about what is best for the child. In fact, a majority of our nurses were arguing with parents to defend their own domain. Needing to be in control and/or oversee the child's care has also been expressed by Swedish parents (Kristensson-Hallstrom & Elander 1997).

In studies by Coyne (1995), Galvin *et al.* (2000), Coyne and Cowley (2007) in UK, and MacKean *et al.* (2005) in Canada, parents stated that they expected nurses to spend time to form a relationship with them and their child. A need of parents for emotional support has been also reported in systematic literature review of previous studies (Power & Franck 2008). Nevertheless, Coyne and Cowley (2007)

reported that nurses made a conscious effort to gain the trust of the children and their parents. However, in our study, facing pressures at the workplace resulted in nurses not having sufficient time and energy to devote to this aspect of care despite their willingness to provide support to the child and parents emotionally, which meant that parents' expectations of the nurses revolved around the child's physical needs. Information, communication and negotiation were universally the most important parts to ensure successful collaboration with the parents so that all parties are satisfied (Espezel & Canam 2003, O'Haire & Blackford 2005, Ygge *et al.* 2006, Power & Franck 2008).

In addition to environmental pressures, in the current study, nurses lacked interpersonal skills, which limited their ability to build an effective relationship with the parents. All nurses in this study believed that they need more knowledge to be able to undertake interpersonal roles. It has also been reported in previous literature that interpersonal relationship between nurses and patients leads to satisfaction, but achieving it requires skill and hard work (Chant *et al.* 2002, Millar 2002, Welsh 2004, MacKean *et al.* 2005, Power & Franck 2008).

The concept of a 'Welcome Nurse', which was discovered in one of hospitals in our study, has only been reported by Roden (2005). Although O'Haire and Blackford (2005) reported that nurses had suggested getting experienced people or social workers involved in the process, no official or administrative approach was reported as regards how to resolve conflicts with parents. That the nurse unit manager welcomed the idea of trying to assign a liaison officer to assist in communication problems between staff and parents was a greatly positive move. However, while this may be of some assistance, of greater assistance in the long-term would be staff members who communicate better and negotiate with parents, value the role parents play, and anticipate parental concerns and need for information (Roden, 2005).

The core concept of 'struggling to create new boundaries in care' illustrates that nurses are searching for new boundaries to maintain nurses' professional territory. The notion of partnership denotes an equal relationship between parents and nurses, together with sharing information and responsibilities, and negotiating roles (Coyne & Cowley 2007). Whereas in the current study, parents' roles were mostly assigned to them, rather than being jointly decided, interpersonal relationships were inadequate and it was the nurses who wish to dictate the final course of interactions. Getting on most parents with the staff did not address negotiation but rather 'merging into the background' and doing what one has to do. This made it difficult for most parents to talk on equal terms with the nursing staff, confirming the findings of Kawik (1996) and Roden (2005). Most argumentative parents also realized that

What is already known about this topic

- Family centred care philosophy involves developing a unique and dynamic care model that puts the family in close contact with the healthcare team.
- Mothers of children with chronic conditions could experience difficulties in establishing their role alongside the healthcare team.
- Generally, studies have not facilitated the recognition of the integrated perspective of the whole parent–nurse relationship across different cultures.

What this paper adds

- Essential requirements such as higher staffing level, nurses' improved communication skills and changed attitude towards effective and purposeful nurse–parent collaboration is needed to facilitate empowering relationships with parents.
- Mothers of chronically ill children and nurses working with them need a different form of care delivery that changes traditional nursing boundaries and defines new boundaries in the care to improve nurse–parent collaboration and allows parents choose their role in these defined boundaries as long as it empowers them for child care at home.
- Redefining professional boundaries as they define who is to take part in the relationship and what should be the nature of the communication is suggested to maintain the integrity of both parents and nurses.

Implications for practice and/or policy

- It is vital to establish and respect clear boundaries in the care based on the needs of both parents and nurses and it is managers' duty to make transparent what is expected of each role, parents and staff alike.
- The model of care delivery should foster nurse–parent collaboration and improve interpersonal relationship while allowing parents to choose their level of participation and providing educational support to empower them for care at home.
- Parents' willingness and ability to participate in the care of child in hospital should be continually assessed and their participation needs to be supported.
- Staffing levels and communication skills of nurses should be considered as necessary infrastructure for implementing parent participation.

their struggles were futile and reluctantly decided to cooperate with the nurses. This may be due to the fact that most parents of our sample were from a low-to-moderate socio-economic class and had no economic ability to choose well-resourced private hospitals. Therefore, to hospitalize their children in hospitals of our study was the only option they had.

Studies of care-by-parent units have demonstrated parents' enhanced learning, reduced anxiety and acquired functional skills (Ecenroad & Zwelling 2000, Galvin *et al.* 2000, Van Riper 2001). However, the implementation of care-by-parent units necessitates a new approach to the delivery of healthcare services to children and families (Bruce *et al.* 2002). To establish a good working relationship with parents, it is vital that paediatric nurses demonstrate that they value the role of parents and that they can anticipate their concerns and questions (Roden 2005).

Conclusion

Findings of this study suggested that nurse workload on the unit, time constraints and non-negotiation with parents will hinder effective nurse–mother interaction in the care process. Getting on most parents with the staff did not address negotiation but rather 'merging into the background' and doing what one has to do. This made it difficult for most parents to talk on equal terms with the nursing staff. Therefore, it is unreal to expect a truly shared care under these circumstances.

Implication for practice

In this era of changing in the care paradigm from limiting visiting hours for parents to constantly being present on the ward, consideration should be given to the essential requirements such as higher staffing level, nurses' improved communication skills and changed attitude towards effective and purposeful nurse–parent collaboration to facilitate empowering relationships by engaging in collaborative discussions about care with parents.

Findings of this study have suggested that in this era of more chronically ill children needing care by parents at home, mothers of these children and nurses working with them need a different form of care delivery that not only changes traditional nursing boundaries and defines new boundaries in the care to foster nurse–parent collaboration and improved interpersonal relationship but also clearly defines the boundary of their roles based on the needs of both sides while allowing parents to choose their role in these defined boundaries and providing educational support to empower them for care at home. Moreover, it has been shown that

respect the boundary of professional nursing is a moral and legal issue. Redefining professional boundaries is essential as the boundaries define who is to take part in the relationship, what should the nature of the communication be, and in the relationship what is expected of each side. Hence, the integrity of both parties is maintained. To that end, information, communication and negotiation are the most important parts to ensure successful partnerships with the parents so that all parties are satisfied.

Limitations

Although the data provided a rich exploration of nurse–mother collaboration in care, from the nurse and parent participants' viewpoint, generalization of research findings to the larger population of nurses is limited. Results were, however, checked with nurses who did not participate in the research and they confirmed the fitness of the results.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

AF, AlF, ME and KA were responsible for the study conception and design, performed data analysis and provided administrative, technical or material support. AF, AlF and ME performed data collection, were responsible for drafting the manuscript, and made critical revisions to the paper for important intellectual content. AF provided statistical expertise and supervised the study.

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