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Engaging Clinical Nurses in Research: Nurses' Experiences Delivering a Communication Intervention in a Behavioral Oncology Clinical Trial

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Abstract

Despite the recognized need for clinical nurses to engage in the conduct of research, little is known about their research experiences. This article describes the experiences of nurses who delivered the communication intervention in a behavioral oncology clinical trial for parents of adolescents and young adults (AYAs) with cancer. A qualitative thematic analysis was conducted of nurse interveners' (NIs') reflections on their experiences delivering the communication intervention. Ten

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data-generating questions were developed to guide NIs' reflections. Twelve NIs responded via verbal discussions. Six of these also provided written responses. Overall, nurses' experiences as interveners were powerful and positive, and included time and space to be fully present with patients and families. NIs identified barriers to their involvement in research related to time constraints, administrative support, physical space to privately conduct the intervention, and difficulties maintaining expertise with the intervention. The importance of ongoing collaboration between nurses, unit staff, leaders, and study teams was corroborated. An unexpected finding was the importance of Reflective Clinical Research.

Keywords

Nursing administration; Reflective clinical research; Nurse-patient relations; Randomized controlled trials; Pediatric cancer

Interdisciplinary collaboration, professional autonomy, and patient outcomes are enhanced when nurses work in a culture that emphasizes and facilitates involvement in research.[1–3] When nurses are involved in both patient care and nursing research, they are uniquely able to identify relevant research questions and to propose and champion practice changes based on research findings.[4,5] The 2010 Institute of Medicine report on the Future of Nursing included the recommendation to expand opportunities for nurses to lead and be involved with nursing research.[6] Involving nurses whose practice is focused primarily on direct patient care (i.e. clinical nurses) in research is supported by the Magnet® model, which provides a framework for achieving excellence in nursing practice.[7,8] Similarly, Sigma Theta Tau International Nursing Honor Society and the International Council of Nurses recognize that nursing research promotes health, prevents disease, and addresses the needs of vulnerable populations. They advocate for clinical nurses to be involved with, and use, research in their practice.[2,9] Clinical nurses' involvement in interventional research studies is particularly important to assure the applicability and feasibility of intervention implementation in clinical settings.

Despite this recognized need for clinical nurses to engage in the conduct of research, little is known about their research experiences, beyond the factors influencing clinical nurses' decision to become involved with research.[10,11] Understanding clinical nurses' experiences is particularly important to foster their ongoing involvement in research, and to overcome any lack of interest in, or appreciation of, research and prior negative experiences with research.[1,10,12] This article: 1) describes the experiences of nurse interveners (NIs) who delivered the communication intervention in a National Institutes of Health (NIH) funded behavioral oncology clinical trial for parents of Adolescents and Young Adults (AYAs) with high-risk cancer. It also highlights how a Reflective Clinical Research process enhanced NIs' experiences. The term "Reflective Clinical Research" was developed by the authors, and refers to the process of dedicating time to fully share and reflect more broadly on the processes and meaning of the research. The study, "Stories and Music for Adolescent and Young Adult Resilience During Transplant II (SMART II)", was a NIH-funded behavioral oncology clinical trial for parents of AYAs with high-risk cancer, and is described below.

The SMART II Study

The purpose of the SMART II study was to evaluate the efficacy of a nurse-delivered intervention aimed to reduce parent distress, and enhance the family environment, resilience, and well-being of AYAs with high-risk cancer and their parents.[13] SMART II was a two-group, randomized controlled, behavioral oncology clinical trial conducted at six sites across the United States. AYAs in both groups received the therapeutic music video intervention. Their parents were randomized to either an attention control or intervention group.

The SMART II intervention involved three tailored, private 60-minute sessions delivered to the parent by a trained NI. The sessions focused on: 1) *Managing the Chaos: Self Care as the First Step to Supporting Your Teen/Young Adult,* 2) *How to Listen to and Encourage Your Teen/Young Adult to Talk,* and 3) *Strategies for Teen/Young Adult Autonomy Support: Understanding Teen/Young Adult's Ways of Coping.* Each session included a review of session goals; skills training tailored to parent needs in the content area; skills practice through role-play exercises; reflection on and reinforcement of learning; and take-home tip sheets and a prescribed practice plan. Nurses were educated to deliver the intervention during a two-day in-person training, with ongoing follow-up provided bi-weekly to monthly during conference calls. Emphasis during training was on teaching particularly challenging skills (e.g. conducting role-play exercises). Intervention fidelity was fostered through initial training; quality assurance monitoring using audio-recordings of each session; and discussions during team meetings.[14] Results and further details of the methods of SMART II will be reported in a separate article.

Methods

Institutional Research Board approval was obtained for SMART II at the coordinating center and all sub-sites. A thematic analysis of NIs' personal reflections on their experiences of delivering the SMART II communication intervention was completed and is reported in this article. This analysis was not conducted as a formal research study.

Twelve nurses were serving in the NI role when it was decided to conduct a formal Reflective Clinical Research process. All NIs had at least a bachelor's degree or higher; 58% had more than ten years of oncology nursing experience; 50% spent at least one quarter of their time in direct patient care; and 33% spent almost all their time in direct care. Most NIs were primarily employed in areas other than research (66.6%). SMART II was the first experience conducting nursing research for 58% of NIs. See Table 1 for detailed demographics.

Data Collection

As part of SMART II, routine monthly NI conference calls were conducted. The primary purpose of these conference calls was to discuss study protocol implementation, and to learn from other NIs' experiences delivering the intervention. What (unexpectedly) emerged during these calls was reflection on how the NIs' nursing practice was being impacted by their role as SMART II interveners. When the study team recognized the importance of thoroughly describing NIs' experiences of being involved in SMART II and delivering the

communication intervention, a core group of NIs volunteered to conduct a more systematic analysis of NIs' experiences. This was done under the guidance of the SMART II study Principal Investigator, an experienced qualitative researcher. This process required having dedicated time and support during meetings to fully share and reflect on the meaning of the research.

To provide a framework to guide reflections, the core group developed ten data-generating questions that explored NIs' experiences when delivering the SMART II intervention (Table 2). These data-generating questions were developed based on the rich discussions that occurred during each NI call led by the principle investigator. On subsequent routine NI calls, these questions were discussed among the whole group as a regular agenda item, with the discussion captured in the meeting minutes. To more systematically obtain the NIs' full perspective and provide an opportunity for anonymous feedback, the same ten data-generating questions were emailed to all NIs. Their written responses were sent to the study project manager, who removed all identifying information from the completed written responses before sending the data to the NI core group for analysis. All data were analyzed using the Microsoft Word outline feature and stored on a secure web-based server. All 12 NIs participated in the conference call discussions. Six of the 12 NIs also submitted written responses.

Data Analysis

The NIs' written responses were de-identified and accessed only by study team members. The NI core group analyzed the data using a qualitative thematic analysis in two phases.[15] The first phase involved analysis of the conference call meeting minutes. In the second phase, the data from the written responses to each question were merged with the data captured in the first phase.

Using an interpretive phenomenological perspective, the analysis of the merged data involved revealing commonalities of meaning. Data analysis steps included identifying the meanings of significant statements, and then organizing the meanings into themes. clusters, and categories. The principal investigator guided the data analysis.

Findings

Five major themed categories emerged regarding how involvement in SMART II impacted the NIs. These were reflections on the nature of nursing practice; acquisition of new knowledge and skills; sacred space to interact with parents; challenges being involved in research; and reconsideration of professional boundaries.

Theme Category 1 - Reflections on the Nature of Nursing Practice: "The unique opportunities I have as a nurse"

NIs described how study involvement helped them refocus on what it means to be a nurse. An example of this is staying in the moment with a family rather than going through a checklist of what needs to be done. NIs were also reminded of the essence of what they learned in nursing school, the importance of caring for the whole patient and family. This

was expressed by one NI: “Connecting with parents reminds me of the unique opportunities I have as a nurse.”

The impact of the study went beyond the influence NIs had with study participants. NIs experienced increased awareness of, and empathy for, families. As one nurse stated, “We often forget families have other things going on in their lives. The parents are just human beings trying to get by.” NIs also described an increased appreciation of families’ issues and concerns, realizing there is much more going on in the family than just the ill AYA. As shared by an intervener: “I have a better understanding of just how many stressors families [are] already dealing with, and how cancer isn’t the only thing in their lives. They were already really busy and then this [cancer] happened. They have a lot of things to juggle, and so do we, but taking the time to stop and listen and build that trust… is so important to both them and special to us…it forges a bond.”

Another NI said, “It [being an NI] made me take a step back and look at what the parent is going through… family members are at the hospital for long periods of time, dealing with high stress circumstances. There is no break for them.” NIs also gained increased understanding that not everyone copes well and indicated by this quote: “If a family lacks coping skills, it is likely the reason for their behavior – it’s not necessarily a reaction to what the providers are doing and saying.”

NIs gained an increased awareness regarding the importance of reacting with empathy rather than frustration during difficult situations. Reflecting on a difficult family situation related to the number of visitors allowed, one NI commented that, instead of reacting with frustration (as she previously did), “this time I was able to be much more empathetic.” This NI also described being more sensitive to how a hospital policy can result in significant added stress for a parent.

NIs felt their involvement in SMART II allowed them to reclaim valued aspects of nursing practice that had been neglected or relinquished to other professionals due to the increased demands on hospital- based nurses. They described their study involvement as a unique opportunity to impact the unit culture due to the dedicated time allowed to listen and to provide care that was focused on the family as one nurse reflected: “I realize that we often just let the social workers deal with anything that isn’t directly related to giving the medical care to the patient.”

Being involved in SMART II also fostered NIs’ awareness of the meaningful link between their practice and research. The research experience enriched NIs’ practice, especially through an increased awareness about the need for research focusing on family caregivers. Comments documented during their group calls endorsed this realization: “Nurses can enrich their practice by participating in research that helps develop and deliver needed services to family caregivers,” and “Nurses want to deliver the best care possible, so this is one opportunity to deliver better care.”

Theme Category 2 - Acquisition of New Knowledge and Skills for Practice and for Life: "Skills that people need all the time"

The NIs' involvement in SMART II provided opportunities to learn and use new knowledge and skills that were applicable beyond the study. NIs received training to deliver the intervention regarding: active listening and open-ended communication to convey empathy and foster dialogue; strategies to open and sustain dialogue; and differences in the nature and amount of dialogue when communicating through active listening, in comparison to teaching or comforting communication. NIs not only learned these skills in order to effectively deliver the intervention, but found the skills were transferable to other situations. As one NI shared, "I use the skills I learned in the study with other families and with my own (family), and with other staff members."

NIs described the value of using active listening techniques. They reported increased confidence in their ability to use those techniques. One NI stated, "Practicing 'so you're saying…' sounds so artificial when you are role-playing for this study, but when you listen to yourself doing it…it is amazing how natural it sounds in the flow of conversation and [how it] really does help clarify what the person was saying." Another NI shared that she gained "an awareness of using more open-ended questions… typically, … our approach is …to use closed questions in order to seek the information we need." NIs felt the active listening skills are universally important. One shared that, "I think the skills we are teaching the parents are so vital during this time of turmoil. In fact, I think these are skills that people need all the time, not just when they get a cancer diagnosis."

NIs also felt empowered with the new skills to address parents' needs and concerns and to connect with families in new ways: "I feel much more able to connect with families in ways I didn't before." As listening skills increased, so did NIs' insight into families' daily lives. This included a better understanding of parents' stressors, in addition to the stressors of having an AYA with cancer: "You have a greater appreciation for all these families struggle with, day in and day out."

NIs also noted they were more likely to be proactively engaged with families on their units outside of the study: "Being a NI has made me more in tune with the needs of the parents I care for in my 'regular' job too. I am much more likely to offer my full attention to families when I encounter them now because I realize how important it is to listen to what they are going through and help them deal with all the aspects of their situation, not just their child's medical care." Another NI commented, "We are helping parents open up and deal with what is going on in their lives."

Reflecting on the knowledge and skills learned and being used, NIs noted that "[nurses] are very task oriented" …"We often say one thing, but parents may be hearing a very different message. Dialogue helps us identify the disconnect." NIs gained an appreciation of the need for these kinds of interactions with families: "I need to spend more time just listening… not just about the tasks I need to complete for our shift, but really being a person that can just listen … as RNs we are very task driven and … [we need to] take that extra time to offer and hear what other concerns they [parents] may have." Having the opportunity to improve their

interactions with families was highly significant to many NIs because it transcends and enriches the task-oriented nature of nursing practice.

Theme Category 3 - Sacred Space to Interact with Parents: "Time to really be a person that can just listen"

NIs highly valued the opportunity to take time to be truly present and listen well to their patients and their families. Reflecting on the value of the experience, they used words such as "luxury", "privileged", and "precious" to describe their time with the study parents. One NI stated, "[It is] honoring that [the parent] was able to share emotions with a 'complete stranger'." The parent-NI interactions during SMART II are uncommon in busy clinics and inpatient settings. A NI reported, "I literally never get uninterrupted time with parents." Another said, "Unfortunately, because of the work flow at the clinic it is not always possible to have this kind of interaction."

NIs felt that the value of the unique parent-NI encounters during SMART II also extended to parents. One NI stated, "It is obvious they are grateful for the chance to talk about what is going on." A different NI said, "The SMART study has shown me that some parents definitely do need that sacred space. Some just need to talk. I'm glad that for those parents we've been able to provide that." Some NIs were already aware of the need for sacred space: "Prior to SMART II, I felt that every nurse should be truly present [during patient and family interactions]."

Families received more nursing attention because of the SMART II intervention, and NIs identified benefits to families through the resulting connectedness. NIs got to know the families better and were able to identify and address families' problems more expediently. Because the NIs felt more in tune with the needs of families, they felt better able to help families effectively care for their AYA with cancer: "Listening is cost effective." The NIs also felt more able to help families acknowledge their feelings about their AYA's cancer. Specifically, NIs discussed the importance of skillful communication for difficult conversations: "What[ever] is said needs to be done well or it can make the situation worse. SMART interventions strategies help make it go well."

Theme Category 4 - Challenges of Being Involved in Research: "Grateful for this opportunity, but…."

Challenges identified by NIs were related to: the amount and flexibility of time they had available for study-related activities, the logistics of delivering the intervention, the impact on colleagues' workloads, a desire to achieve excellence when delivering the complex communication intervention, and the visibility of SMART II on the nursing unit.

NIs expressed the need for more time to prepare for and perform the SMART II interventions. One NI explained, "Finding two straight hours in a day is difficult --finding a room, setting up, seeing if the parents are ready - sometimes I have to check in several times - and doing the actual intervention." NIs also needed flexible time that could accommodate the inevitable last-minute scheduling changes (e.g. due to AYA feeling unwell or AYA's plan of care changing), as well as time to prepare for the session, upload recordings, and

complete evaluations after the session. As one nurse explained, it is “Very tricky… It is time consuming and doesn’t always mesh with my available time”.

NIs reported varying degrees of difficulty managing logistics of the intervention. For example, finding an available room, where interruptions could be avoided, was particularly challenging for NIs: “Finding a room away from the patient room… for uninterrupted time is like finding a gold mine!”. The varying levels of difficulty that NIs had incorporating the intervention into their work flow depended on the NIs’ nursing role. One NI came in on days when she was not working to deliver the intervention. This required juggling personal obligations, and impacted her family. In contrast, another NI described having no problem delivering the intervention, explaining her “working schedule is rather flexible.”

NIs perceived that their roles in SMART II had a broader impact on the nursing team as a whole. For example, one NI reported feeling responsible for her colleagues “drowning” when she did an intervention during work hours. NIs acknowledged the need for unit support when delivering the intervention: “Although I haven’t faced constraints, I can see how intervention delivery can be challenging for nurses who have a full [patient] load and need to be alert to any situation that may emerge on the floor”.

NIs felt challenged by the complexity of the SMART II intervention and their desire to deliver the intervention well: “It has been a struggle to balance the need to provide adequate time to listen to parents and allow them to talk with the need to end the session in a timely manner.” NIs also described the challenges of delivering the intervention on an intermittent basis, particularly when enrollment at their site was low: “I did not have my first participant for a year, and that was where my struggle was. It had been a long amount of time [since being trained].” Role-playing was used in the intervention to practice communication skills. Role-play exercises with parents were particularly challenging for the NIs: “It is difficult to take on the role of the patient who I tend to know very little about, and it is also difficult for the parents to understand the take home point of the role-playing.”

Visibility of the study varied on the nursing units at different sites, and NIs received varied feedback from colleagues regarding their role as NIs for SMART II. NIs felt that peers’ responses were that interventional nursing research was unfamiliar in the inpatient setting. One NI described the perception that, “Research nurses do not work near the inpatient unit.” Overall, NIs’ colleagues had ambivalent responses to the study: “Many peers like the idea of the SMART study, but I have to say, I can’t remember going into a lot of depth about it or anyone’s reactions.”

Theme Category 5 - Reconsideration of Professional Boundaries: “The bond and relationship has been formed”

Based on the NIs’ experiences of delivering the interventions, the concept of professional boundaries was refined and expanded. One NI stated, “Rather than trying to confine the relation[ship] to a ‘professional bond’ … opening of spaces for self-reflection and expanding the boundaries of nurse-patient-families enriches the quality of healthcare.” NIs recognized that beyond necessary professional boundaries, personal boundaries are often set for self-protection. The intervention enhanced the nurse-parent relationship by providing NIs with

new perspectives of what parents were dealing with. “Since I’ve talked with this mom extensively for sessions, …I have an understanding of how she is probably dealing with this bad news and what we might be able to do to help.” NIs reported feeling closer to the parent than they had in their previous parent relationships, and identified a greater understanding of the family’s strengths and struggles. However, this increased understanding can result in feelings of greater grief for a family at the death of their AYA: “I felt even more grief than usual when I found out that one of our SMART II AYAs had relapsed. It wasn’t just about him; now I was thinking about his sweet mother, his brothers, his dad and all their hopes and dreams for him.”

A unique issue experienced by NIs was boundary conflicts related to simultaneously having both research and clinical nursing roles. As part of the SMART II intervention, special bonds were formed, and parents shared information that the NIs would not have known in their clinical roles. Conversely, NIs learned of changes in an AYA’s status in their clinical roles that they would not have known as an NI with SMART II. This resulted in situations where NIs were uncertain of how to respond to parents or the broader healthcare team after learning particularly compelling information: “Health information is on a need to know basis. I am not caring for this patient… therefore I don’t need to know right now. However, the bond and relationship has been formed, and part of me wants to reach out to this mom, to offer her support.” Similarly, NIs spoke about their responsibility to protect information shared as part of SMART II, while recognizing the need to report safety concerns and to share information with the clinical team that might impact patient care: “I struggled with how to handle some incredibly sensitive information that came out during an interview. I had to weigh the choices of potentially jeopardizing a patient’s safety with … breaking confidentiality with a parent”.

Discussion

Overall, nurses’ experiences as NIs were powerful and positive. An unexpected and significant benefit of SMART II was the positive effects that delivering the intervention had on NIs’ communication with other patients and families in their day-to-day nursing practice. Their increased ability to foster a connection with other patients and families outside of the study resulted in a greater appreciation for nurses’ role in enhancing advocacy for patients and families. In addition, NIs unexpectedly found their new communication skills useful in their everyday personal interactions outside of the work setting. The benefits NIs experienced support previous literature findings regarding the need for time and space to focus on forming therapeutic nursing relationships with patients and families.[10,11]

Despite the overall positive experiences, NIs also experienced barriers to their involvement in research, including time constraints; insufficient support from colleagues and managers; lack of a physical space to privately conduct the intervention; last minute scheduling changes; and difficulties maintaining expertise with the intervention due to unpredictable recruitment. These findings are also reflected in the literature.[1,10–12,16–20] Burns [21] advocates that studies completed within three to six months are the most feasible in clinical settings. SMART II was open to recruitment for almost four years (June 2012 through

March 2016), which may have contributed to challenges retaining its visibility and support on the units.

NIs experienced significant challenges incorporating the intervention sessions into their work flow. This was especially difficult for the NIs involved in direct patient care, and may have influenced retention of NIs. The issue of overtime was especially contentious, due to a perception by some leaders that the study was causing overtime, rather than there not being enough staff to support nurses' involvement in previously agreed upon research. The literature describes similar challenges of juggling research responsibilities in a clinical setting, and the need for collaboration between unit s16taff, leadership, and the study team. These challenges continue to persist.[10,11,16,18,22,23] Identifying research participation as an opportunity for the hospital and unit to receive recognition and facilitate Magnet® certification may increase administrator and manager buy-in. When nurses have a positive research experience, they may be more likely to continue to participate in research, and their enthusiasm may foster other nurses' involvement in research and professional development. Following their SMART II involvement, several NIs went on to obtain advanced degrees and / or participate in other research studies.

Despite study start-up and ongoing strategies to publicize SMART II within each site (i.e. discussions with nursing administrators, presentations at change of shifts on all units, information fliers at the unit desks, and lapel pins about the study), NIs described low and varying levels of visibility for SMART II on their units. Unit visibility was increased when AYAs premiered a music video and when there was publicity around publication of a manuscript. Unit visibility is described in the literature as crucial to enhancing communication with the study team as well as integrating research into the daily flow of clinical patient care.[10,11,18]

The process used in this study included dedicating time during NI meetings to fully share and reflect on the meaning of the research. It was subsequently termed "Reflective Clinical Research". Reflective Clinical Research emerged when NI conference calls grew from only discussion of logistics and protocol-related items to include discussions of what the NI experience was like, personally and professionally. Reflection was particularly meaningful as NIs became comfortable discussing their experiences with their SMART II colleagues. Reflection on experiences of conducting research, especially regarding behavioral interventions, fosters communication and meaning-making and is essential to understand the full impact and benefit of clinical nurses' involvement in research.

Limitations

A limitation of this analysis is that data obtained on conference calls evolved over time and, as such, the beginning processes of Reflective Clinical Research were not captured. Audio-recording the calls may have influenced the depth of the discussion for some nurses, and hence impacted reflective processes. However, the level of participation of the NIs did not appear to change when audio-recording began.

Implications for Nursing

To engage clinical nurses in research that addresses the needs of hospitalized patients and families, it is necessary for nurses to have opportunities to be involved in research in the clinical setting; tangible and consistent support from the administration and the unit; sufficient time and flexibility to accomplish study-related work; meaningful recognition from leadership (including at performance reviews); logistical support for conducting the study; and, opportunities to experience Reflective Clinical Research.

Support from leaders is a persistent concern related to nurses' involvement in research. Leadership support needs to be tangible, visible and ongoing for clinical nurses' involvement in research to be successful (e.g. funding, approved time away from other work responsibilities, and recognition for advancement). Support cannot simply be for the intervention delivery but rather, needs to include time and resources for training, pre-intervention preparation, and post-intervention documentation. When research is supported by grant funding, leaders may need to consider how to effectively use that funding to ensure sufficient staff are dedicated to research activities. Sites involved in SMART II did not typically hire additional staff to manage study-related activities. Instead, existing staff took on SMART II in addition to their other work activities. While the use of existing staff can be effective, it is important to the success of studies that staff are not over-burdened, and that nurses have sufficient support to be able to take time from their other responsibilities to complete study activities.

It is important to establish a culture of appreciation for research, as well as an understanding of the research study at the unit level, in order to increase buy-in from colleagues and effectively manage day-to-day challenges that arise. Periodic re-education of unit staff can help raise visibility of the study. In addition, the study team must carefully plan activities (emails, conference calls, intervention appointments, etc.) in consideration of clinical nurses' other work commitments, to minimize the burden of the study on the unit. Careful collaboration will yield a win-win partnership that will build a research-friendly culture.

Reflective Clinical Research, involves having opportunities to discuss not only how the intervention sessions are delivered, but also the impact of research on patients, families and nurses. It is a promising strategy that may help clinical nurses become more engaged in research. It reminds nurses of the essence of their nursing practice, as learned in nursing school. It highlights the importance of integrating research into practice. Reflective Clinical Research extends beyond delivering the intervention because research by clinical nurses needs to include time and space for personal and group reflection in order to actualize the benefits of research involvement. A leader skilled in qualitative research interviewing and group processes is necessary to effectively conduct Reflective Clinical Research. Such a leader facilitates meaningful communication among team members and ensures group relationships and group work are attended to in equal proportions. Other important aspects of Reflective Clinical Research include initial development of guiding questions or a framework for reflection, the use of open-ended question to foster rich verbal discussions, and opportunities for both oral and written reflections.

Conclusions

Logistical barriers to clinical nurses' involvement in research can be overcome when study-related activities are directly meaningful and relevant to nursing practice and the patient population. Although these challenges existed in SMART II, they were outweighed by the benefits that unexpectedly extended from clinical practice into personal relationships, through increased empathy and improved communication skills. The Reflective Clinical Research process was key to unlocking these benefits for SMART II NIs and has the potential to help close the practice / research gap for clinical nurses. The authors recommend that nurse administrators and managers facilitate Reflective Clinical Research processes, to maximize the benefits of clinical nurse participation in research.

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Table 1.

Characteristics of Nurse Interveners (n=12)

Characteristics	n (%)
Highest Degree	
Bachelors	7 (58.3%)
Masters	4 (33.3%)
PhD/DNP	1 (8.3%)
Years in Oncology Nursing	
< 10 years	4 (33.3%)
> 10 years	7 (58.3%)
Not answered	1 (8.3%)
Primary Role	
Outpatient Registered Nurse	3 (25%)
Researcher	4 (33%)
Inpatient Registered Nurse	1 (8%)
Nurse Educator	2 (17%)
Nurse Practitioner	2 (17%)
Time in Direct Patient Care	
None	3 (25%)
1-25%	3 (25%)
26-50%	2 (17%)
51-75%	0
76-100%	4 (33%)
Previous Involvement in Nursing Research	
Yes	5 (42%)
No	7 (58%)

Table 2.

Data Generating Questions

1. In what ways, if any, has involvement in SMART II changed you as a nurse? We are especially interested in how it changes your practice and the way you practice. Please give examples of situations, if possible.
2. In what ways, if any, has involvement in SMART II influenced how you interact with patients and families. Specifically, please tell us about influences on the following:
a) ways you interact with patients/families in short term situations (e.g. moments of crisis),
b) ways SMART II has influenced your long-term patient/family relationships (e.g. connectedness) with patients in general.
c) ways your relationship with the families you worked with in the study?
3. What are the challenges/struggles you have dealt with to:
a) deliver the intervention?
b) incorporate/balance the SMART II intervention into your workload?
c) Any other challenges/struggles.
4. How has involvement in SMART II influenced your perspectives of nurse - patient / family boundaries?
5. What are your experiences in talking with peers about SMART II and what are their reactions?
6. Please tell us your thoughts on the potential, if any, of the SMART II parent intervention to change nursing practice.
7. How has your experience with SMART II influenced how you think about families in general, including your own?
8. How has your experience with SMART II influenced your experiences of establishing “sacred space”—taking time to be truly present to be able to hear patient/families?
9. How has involvement influenced your own resilience—your confidence/mastery in your roles, pride in what we are doing as a nurse, wanting to reach out to others?
10. What recommendations do you have to improve the parent intervention? The study procedures?