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WHEN A PATIENT'S FAMILY MEMBER IS A NURSE: A PORTFOLIO OF RESEARCH

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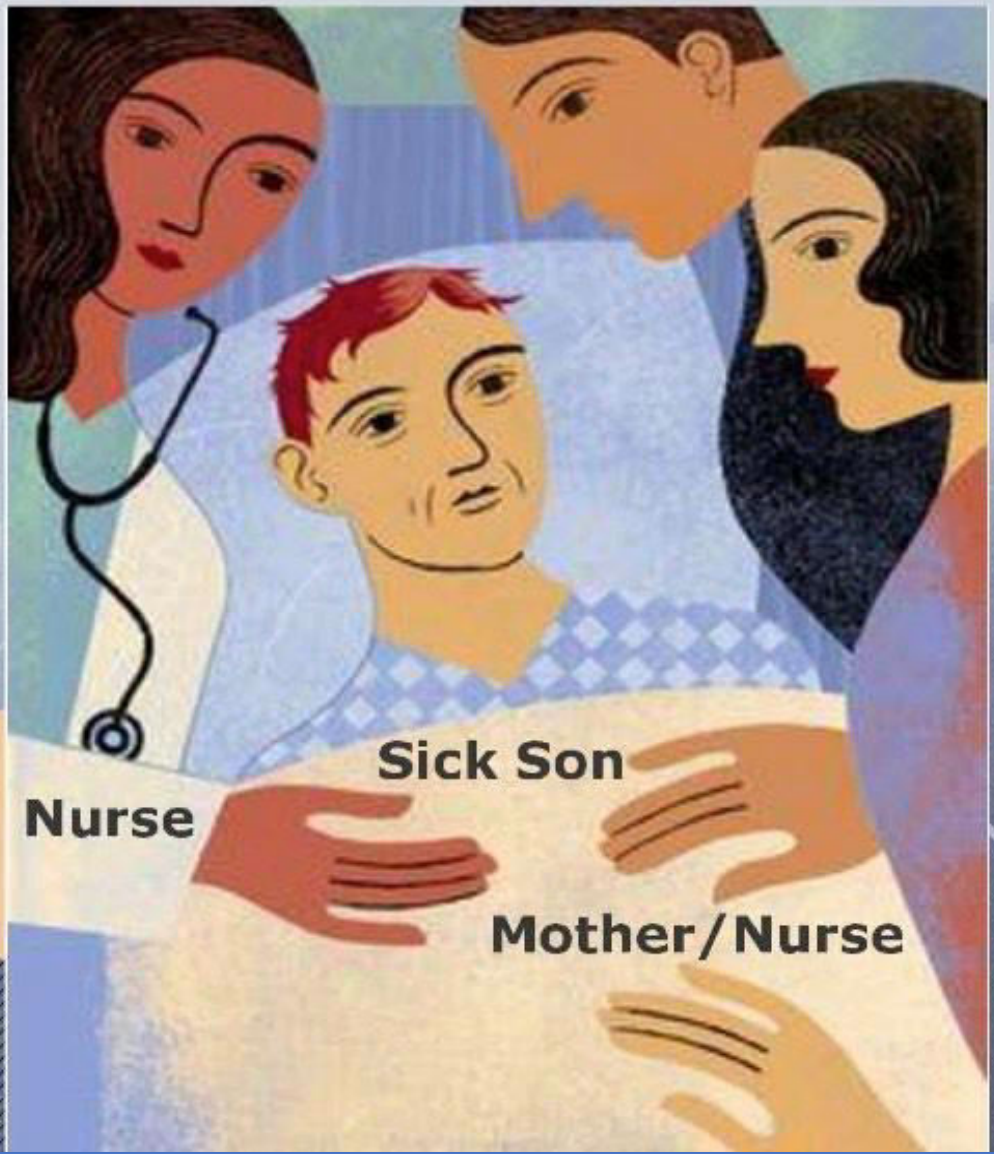

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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PORTFOLIO OF CONTENT

AWARDS, PUBLICATIONS AND PRESENTATIONS

Awards

Adelaide Graduate Award, Division of Academic and Student Engagement, 1st Award Celebration and Ambassador recognition ceremony 2018, National Wine Centre, at the University of Adelaide, Adelaide, South Australia, 23th November 2018. (Portfolio appendix I).

Publications

The published manuscript for study 1 is shown in portfolio appendix II:

Sabyani H, Wiechula R, Magarey J, Donnelly F. How healthcare professionals' experiences of having a significant other admitted into an acute care facility: a qualitative systematic review protocol. JBI Database System Rev Implement Rep. 2016;14(5):103-109.

Sabyani, H, Wiechula, R, Magarey, J & Donnelly, F 2017, 'Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review', JBI Database of Systematic Reviews and Implementation Reports, vol. 15, no. 5, pp. 1409-1439.

Presentations

2018	A survey of how nurses respond when their loved ones admitted to an acute care hospital. Poster presented at the University of Adelaide, Faculty of Health Sciences, 12th Annual Florey Postgraduate Research Conference 2018, National Wine Centre, Adelaide, South Australia, 25 September 2018.
	'Oh, that's fine. I'm a nurse too': The experiences of nursing staff when caring for patients whose family members are nurses. Poster presentation presented at the University of Adelaide, Faculty of Health Sciences, School of Nursing Research Conversazione 2018, Adelaide, South Australia, 19-21 September 2018.
	Who am I? Nurse or brother. Oral presentation presented at South Australian Health and Medical Research Institute, 2018 South Australian Nurses and Midwives Research Symposium, Adelaide, South Australia, 17 May 2018.
2017	Who am I? Brother or Nurse. Oral Three Minute Thesis presentation presented at Faculty of Health & Medical Sciences, 2017 Faculty of Health & Medical Sciences Heat, Adelaide, South Australia, 24 Aug 2017.
	Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review. Oral presentation presented at South Australian Health and Medical Research Institute, 2017 South Australian Nurses and Midwives Research Symposium, Adelaide, South Australia, 17 May 2017.
2016	How healthcare professionals experience having a 'significant other' admitted to an acute care facility: A qualitative systematic review. Poster presented at the University of Adelaide, Faculty of Health Sciences, the JBI 20th Anniversary Conference 2016, National Wine Centre, Adelaide, South Australia, 9-11 November 2016.
	How healthcare professionals experience having a 'significant other' admitted to an acute care facility: A qualitative systematic review. Poster presented at the University of Adelaide, Faculty of Health Sciences, 10th Annual Florey Postgraduate Research Conference 2016, National Wine Centre, Adelaide, South Australia, 29 September 2016.
	Healthcare professionals' experiences of having a significant other admitted into an acute care facility: A qualitative systematic review. Oral presentation presented at the University of Adelaide, Faculty of Health Sciences, School of Nursing Research Conversazione 2016, Adelaide, South Australia, 6-7 October 2016.
2015	Research Proposal: When a healthcare professional has a 'significant other' admitted to an acute care hospital: a qualitative systematic review protocol. Oral presentation presented at the University of Adelaide, Faculty of Health Sciences, School of Nursing Research Conversazione 2015, Adelaide, South Australia, 7-9 October 2015.

SECTION 1: INTRODUCTION

RESEARCH PORTFOLIO INTRODUCTION

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GLOSSARY OF TERMS

For the purpose of this portfolio, the following terms were defined:

- Family member is a person who belongs to a (particular) family; a (close) relative.
- Hospital is an institution providing medical and surgical treatment and nursing care for sick or injured people.
- Nurse is a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country. In Australia, nurses are also designated as registered nurse, enrolled nurse, and nurse practitioner.
- Nurse-family member is a member of the family of the ill patient who is a nurse.
- Significant other is an individual who is important in someone's life.

LIST OF ACRONYMS

- Comprehensive Systematic Review Training (CRT)
- Critical Care Family Needs Inventory (CCFNI)
- Cumulative Index Of Nursing And Allied Health Literature (CINAHL)
- Enrolled Nurse (EN)
- Family Member (FM)
- Feasibility, Appropriateness, Meaningfulness And Effectiveness (FAME)
- Human Research Ethics Committee (HREC)
- Intensive Care Unit (ICU)
- International English Language Testing System (IELTS)
- Joanna Briggs Institute (JBI)
- Joanna Briggs Institute Qualitative Assessment And Review Instrument (JBI-QARI)
- National Ethics Application Form (NEAF)
- Participants, Interventions, Comparisons And Outcomes (PICO)
- Population Or Problem, Interest And Context (PICo)
- Registered Nurse (RN)
- Research Governance Officer (RGO)
- Site Specific Assessment (SSA)
- Standard deviation (SD)

FOREWORD

I am a registered nurse with 19 years working experience in acute and critical care in a public tertiary hospital in the Kingdom of Saudi Arabia. I have included the following description of my personal background as a nurse within the acute care hospital setting which details my interest in the topic.

In 2009, I joined a newly established public academic association and became actively involved in health care education. My involvement in development of nursing courses and promotion of nursing as a competitive academic field prompted me to enrol in the Master of Intensive Care Nursing program in 2010, at Sydney Nursing School, Sydney, Australia. The focus of my Master postgraduate program was intensive care nursing related topics, specifically family members caring for an ill loved one in a hospital setting. This contributed to development of an extensive experiential and theoretical knowledge base in all aspects of care, including assessment and management of patients, and family member participation in acute and critical care departments. In 2012, I completed my degree by conducting a capstone thesis titled 'Nurses' perceptions of family member during invasive procedure: an integrative review'. Since then I have had an interest in the concept of family member experience of having a loved one admitted to hospital.

Interest in this topic originates from reflection on my experiences of establishing and developing my knowledge in the family member concept area. At times, this journey has been tough and challenging, yet satisfying, but mostly I have an increased sense of awareness of family members within hospital settings. I have reflected many times on how this concept has evolved and how it could develop further to ensure the best patient outcomes. With this in mind I thought it would be beneficial yet challenging to be able to combine a passion for this topic with further study required to produce a professional doctorate thesis. I contacted international universities with my proposal project. In 2015, I enrolled into a high degree by research of Doctor of Nursing with the University of Adelaide. The professional doctorate degree aims to present a scientific research topic though three study projects which include a systematic review, a quantitative and a qualitative study, presented in a portfolio of research. I was interested in taking a practical approach to investigate the research topic which became the driving force for this portfolio.

This research journey began with regular meetings with senior supervisors and research librarians. The topic of family members being alongside their loved ones during hospital admission was too broad and needed to be modified and refined. This lead to narrowing the topic focus to a particular group of participants which made the topic more interesting. After consulting with my supervisors, we decided to investigate the experiences and needs of the family member who is a nurse. The motivation for this research portfolio was built on my experience being involved in caring for my own ill relatives, including my parents. In addition, I consider that the idea of the research topic is unique as it is related to nursing staff managing the care of a patient who has nurse-family member within their own workplace. Caring for a patient who has family present is a normal practice, but discovering that a family member is a nurse can be a new and different experience. In this research portfolio, I present a case study from my clinical practice a few years ago describing my experiences with a nurse-family member and the ways in which hospital nursing staff dealt with the situation.

A 24-year-old man lost control of his motorbike and crashed into a car. Unfortunately, he was not wearing a helmet. He was brought to the hospital via private car, admitted to the intensive care unit and diagnosed with a closed head injury with rib fracture. The staff provided support to the patient's family during the first visit to see their loved one, who was unconscious, under mechanical ventilation and surrounded by many invasive catheters and equipment. While supporting the family members, the staff noted that one of the family members (brother) was a nurse at the out-patients' department of the same hospital.

The next day, I was assigned to look after the patient's complex care. The patient's brother came into the unit for the second visit just as the doctors and I were assessing and discussing the patient's condition. As the patient's brother approached the bedside, the ventilation machine alarmed, indicating respiratory failure due to pneumothorax which required an urgent chest tube insertion. The Team Leader came to the scene to help and pulled the curtains around the bed in an attempt to screen the situation from the view of the patient's brother, as well as from other patients and visitors. At that moment, I took the concerned brother into the waiting room to explain what was happening. The patient's brother looked at me and asked whether he could be with his ill brother during the medical intervention.

Following common practice, I said "No". Since then, I have developed an interest in the concept of family presence, as a nurse, I have found myself dealing with a relative who is actually a colleague.

I later documented the events in my reflection portfolio, which is part of clinical professional development. The feedback from my manager questioned the hospital's policy. He questioned whether nurse-family members' access to loved ones during a procedure should or should not be restricted. The concept of a family member who is a colleague in this situation involved a conflict between the desire of the patient's brother to be present during the procedure and the desire of the staff nurses to keep the family away from the initial scene. While supporting family members who have ill relatives admitted in a hospital was something that I as a nurse do instinctively, finding myself as a family member with an ill loved one was a new and stressful experience.

A few years later, a number of my family members were hospitalised due to elective surgery or needing medical intervention because of chronic disease. This included siblings, parents and grandparents. The most significant of these events was my grandmother's admission, she was diagnosed with end-stage chronic obstructive pulmonary disease. She was not only admitted at my workplace, but to the unit where I work. Like other nurse-family members, I found myself having two roles, a grandson and a nurse. Nursing knowledge and professional identity provided me the ability to manage care from a medical point of view, as well as advocate for my loved one. Although some staff were uncomfortable, others were supportive with my involvement with care. Indeed, being with colleagues while caring for my ill loved one was not an easy situation, but it helped build a therapeutic relationship. In addition, this therapeutic relationship benefited my family members and grandmother, specifically regarding care delivered. For example, my parents were able to visit my grandmother at any time. Knowing my grandmother's prognosis was poor, the process prepared me in accepting the loss when she deteriorated and died. This significant experience opened the door to understanding the experiences of family members in a similar situation and being the nurse caring for them.

As demonstrated above, I have nursing knowledge and experience in caring for patients in acute care settings. Each study process of this research portfolio, from choosing the primary topic through to data collection, analysis, synthesis, and conclusions, has called upon a degree of self-expression and self-analysis of my clinical practice. Having described my current practice as a nurse and outlined my interest in undertaking this research portfolio, I explore the development of the concept of nurse-family member with a relative who is acutely ill in hospital. In undertaking this professional doctorate research portfolio, I wanted to go deeper into nurse's experiences in clinical practice.

RESEARCH PORTFOLIO INTRODUCTION

Family members are likely to be with their ill adult loved one during his or her admission to an acute care hospital. An acute care hospital is a level of in-patient care that has facilities and health care staff that provide a range of treatment, such as acute illness and trauma. Over the last century, it has been recognised that family members play a critical role in the acute care hospital setting. Frequently, this group of people provide care for their ill loved one during the period of hospital admission. Health care professionals, for example nurses, may experience being a family member to a loved one admitted in an acute care hospital. With the meeting of two dynamic responsibilities, family member and nurse professional, the term 'nurse-family member' denotes a double identity. With an interchange in nurse-family members' responsibilities, nurses' participation in their loved ones' care may become inevitable. Indeed, double responsibilities vary and are complex when family members are also nursing staff within an acute care hospital. This intersection of responsibilities in a delicate situation represents the uniqueness of the experience of nurse-family member with a relative who is acutely ill in hospital. The research presented in this portfolio investigates experiences of health care professionals whose family members have been hospitalised and examines the experience of caring for a patient whose family member is a nurse. It also offers an insight to the experiences and needs faced by health care professionals as family members.

RESEARCH PORTFOLIO OVERVIEW

The main objective of the research portfolio is to examine the research question using different methodological approaches. The content of this research portfolio includes:

Section 1: Research Portfolio Introduction

Section 2: Experiences of health care professionals of having their significant other admitted to an acute care facility: a qualitative systematic review

Section 3: The opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital: a quantitative study

Section 4: The experiences of nurses in general wards caring for adult patients who have a family member who is a nurse: a qualitative study

Section 5: Research Portfolio conclusion

This research portfolio is formatted as a 'thesis by Professional Doctorate' under the academic program rules set down by the Adelaide Graduate Centre, The University of Adelaide. This thesis format offers cohesive presentation of the research relevant to the researchers' field of clinical practice.

RESEARCH PORTFOLIO CONCLUSION

The conclusion chapter was designed to summarise results and significance of this research portfolio. How some results may be used in practice was discussed. It also provides implications and recommendations for clinical practice and further research.

SUMMARY

This portfolio of research presents three separate research approaches examining the experiences of health care professionals when their ill loved one has been admitted to an acute care hospital. It provides a brief introduction information on contemporary issues related to experiences and needs of health care professionals as family members.

The structure of the portfolio incorporates three studies: Study 1, a qualitative systematic review: experiences of health care professionals of having their significant other admitted to an acute care facility. Study 2, a quantitative study: opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital. While Studies 1 and 2 are directly linked, Study 3 focuses on the experiences of nursing staff in general wards caring for adult patients whose family members are nurses, using a qualitative study. While the final chapter provides a discussion of the portfolio and contains overall findings and offer recommendations for practice.

SECTION 2: STUDY ONE

Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review

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Chapter One: Introduction

In an acute care hospital, patient care is not only provided by healthcare professionals, but also by patients' significant others. Mills and Aubeeluck (2006) describe significant others assume the role of informal carers. This may involve providing physical and psychological support, such as providing assistance with bathing and feeding, as well as being emotionally supportive. The need for a significant other's presence alongside a loved one is well documented in literature (Eggenberger & Nelms 2007). Therefore, healthcare professionals are responsible for providing patient care and need to understand the emotional state of their significant others.

Researchers have explored experiences of healthcare professionals who are also significant others and determined that these healthcare professionals' experiences are very different from the experiences of significant others who are non-healthcare professionals. For example, Salmond (2011) conducted a grounded theory study of this phenomenon prompted by her own experience as a nurse-family member when her daughter was critically ill. Also, Fulbrook, Allan, et al. (1999); Fulbrook, Buckley, et al. (1999) and Fulbrook, Creasey, et al. (1999) in a series of articles, explored the experience of a nurse whose spouse was hospitalised in the intensive care unit where she practiced. These studies indicate that nurse-family members were treated differently compared to general public family members. In some cases, staff were more communicative and supportive of nurse-family members, in other cases the opposite occurred. These experiences are unique and challenging for both healthcare professionals and nurse-family members.

Aim of thereview

The aim of this systematic review was to synthesise findings of research studies of the experiences of healthcare professionals when their significant others have been admitted to an acute care hospital. The outcome of Study 1 systematic review informed the following two studies of the portfolio.

Review question

The systematic review addresses the following research question: 'What are the experiences of healthcare professionals when their significant others are admitted to an acute care hospital?' Reviewing available qualitative evidence aims to provide a clearer understanding of what it means for healthcare professionals when experiencing this phenomenon.

Significance of the current study

Having a significant other who is a healthcare professional in a relevant clinical area is a special experience for the staff member and family members. However, the healthcare system places its own needs, concerns and expectations on healthcare professionals that may limit their ability to care for their loved ones. Increased awareness of these circumstances may help healthcare professionals make better judgments regarding patient care and support and care for relatives who are health professionals. Although there have been some investigations into this issue, many have primarily been concerned with family members in the critical care setting (Fromme et al. 2008; Maxwell, Stuenkel & Saylor 2007; Vandall-Walker, Jensen & Oberle 2007; Verhaeghe et al. 2005). One qualitative systematic review identified addressed this issue;

however, most studies were restricted to nurse-family members whose relatives were critically ill (Giles & Hall 2014). While the Giles and Hall review only included studies published up until April 2013, this review included studies until 2016. In addition, the protocol for the systematic review (Sabyani et al. 2016) and the review itself (Sabyani et al. 2017), were externally peer reviewed and published. Furthermore, this systematic review has a broader focus: the experience of healthcare professionals as significant others and factors influencing unique experiences in any acute care setting. Synthesis of qualitative studies regarding life experiences of healthcare professionals whose significant others have been hospitalised in the acute care sector will increase our understanding of this issue. This review informs healthcare professionals, administrators and policy makers about dealing with health professionals as significant others to patients within the acute care sector.

Definitions of keywords

For the purpose of this study, the following terms were defined by Oxford Dictionaries (2018):

- Family member is a person who belongs to a (particular) family; a (close) relative.
- Lay-person is a person without professional or specialised knowledge in a particular subject. It is also known as layman or laywoman.
- Hospital is an institution providing medical and surgical treatment and nursing care for sick or injured people.

Structure of study

Study 1 provides insight to lived experiences of healthcare professionals when significant others are hospitalised in an acute care setting. The study presents a qualitative systematic review which comprises six chapters. Chapters 1 – 2 introduce the systematic review topic and provide background of important issues that are the foundation for this review. Chapter 3 addresses methodology of systematic reviews, in particular qualitative systematic reviews. Chapter 4 describes methods used to conduct the review. Methods used in this review are based on recommendations of the Briggs Institute and include use of an a priori protocol which guided conduct of the review (Sabyani et al. 2016). Chapter 5 presents results of qualitative systematic review. Chapter 6, as the final chapter, discusses significance of review findings and implications for practice and future research. Each chapter is summarised in the following overview.

Chapter 1: Introduction

The introduction to the study addresses the focus of the systematic review to provide an understanding of experiences of healthcare professionals when their significant others are hospitalised. The review question, aims and significance for practice and policy are provided.

Chapter 2: Background

This chapter focuses on background to the experience under investigation. Knowledge regarding lived experiences of healthcare professionals as significant others has not been synthesised. In acute care settings, patients' significant others often accompany them at the time of admission, it may be an

uncomfortable experience but also may offer a support and comfort to their ill loved one. When a healthcare professional's significant other is hospitalised, the context is different. Details of the difference and factors that influence this experience are explored. Expectations, conflicting roles and communication are important factors stated in the literature.

Chapter 3: Methodology

In this chapter, the underlying systematic review methodologies are described. The purpose of this chapter is to provide a discussion of the use of systematic review, the difference between systematic review and literature review, and the rationale of choosing a qualitative systematic review of the current literature. Details related to develop a qualitative systematic review using established review protocol are provided.

Chapter 4: Method

This chapter provides detailed description of systematic review methods used. This includes the review question, objective, inclusion/exclusion criteria for studies, search strategy, assessment of methodological quality, data collection and data synthesis.

Chapter 5: Result

Chapter 5 reports on results of the qualitative systematic review, including detailed summary of search results as well as a description of included and excluded studies. A total of seven studies were included that addressed aims of this review. The chapter articulates results of the meta-aggregative process and confidence in the meta-aggregative qualitative synthesised findings. Synthesised findings are summarised using narrative and tabular presentation which include the categories, findings and illustrations.

Chapter 6: Discussion

The discussion chapter highlights significance of the qualitative systematic review undertaken, using a diagram of synthesised findings that describe the experience of healthcare professionals with a loved one admitted in an acute care setting. Issues relating to limitations, implications for both practice and research are provided.

Summary

This chapter introduces the focus of the systematic review report within this thesis. It addressed introduction of the topic, provides clear aim of the review, followed by the review question and presented significance of the current study. The chapter concluded with a structure of Study 1.

Chapter Two: Background

Introduction

Being in hospital can be an unpleasant experience for patients and their families. Families, who may be classified as 'significant others', traditionally provide care and support for loved ones for the duration of their illness. A family member might include a wife, husband and/or children; each of these individuals could potentially be a 'significant other'. Gavaghan and Carroll (2002) and Sneeuw et al. (1997) identified 'significant others' as individuals important in someone's life. These are often individuals who have participated the most in the development of their loved one's treatment plan (Band, Barrowclough & Wearden 2014). The terms friend, spouse, partner, relative and significant other are used interchangeably in existing literature.

When a significant other is admitted to an unfamiliar environment, like a hospital, it can be an overwhelming and stressful experience for everyone involved. From the perspective of staff caring for the patient, Engstrom and Soderberg (2007); Fulbrook, Buckley, et al. (1999) and Medina (2005) claim that presence of family members is a valuable resource as they can speak on behalf of patients. Having patient relatives at bedsides may allow healthcare professionals to better meet patient needs, such as through improved communication (Engstrom & Soderberg 2007; Fulbrook, Allan, et al. 1999; Fulbrook, Creasey, et al. 1999; Salmond 2011). From the family's perspective, being present may result in positive outcomes, like reduced anger, distress and anxiety in their loved ones. Generally, family may take the responsibility of offering support and comfort to their loved one during a stressful event (Vandall-Walker, Jensen & Oberle 2007). For some significant others it is common to be present during information dissemination from healthcare professionals about the patient's condition, either good or bad. However, a family member's need for appropriate information may increase their emotional reactions, such as stress and anxiety levels (Verhaeghe et al. 2005). While healthcare professionals provide support for physiological and psychological needs of patients, they also consider the needs of significant others throughout the duration of their loved ones' stay in the acute care hospital.

When a healthcare professional's significant other is admitted to an acute care hospital, the context is somewhat different. Having a healthcare professional as a family member can impact on delivery of care to an ill loved one (Fulbrook, Creasey, et al. 1999; Olivet & Harris 1991; Salmond 2011). Salmond (2011) used a qualitative approach with open-ended, focused exploratory interviews to bring to light what a nurse-family member of an ill loved one experienced. Another study by Chen et al. (2001), using in-depth, semi structured telephone interviews, clarified the challenge physician-family members face when a relative becomes ill. They explained that when a patient has a physician-family member, patient care becomes unique (Chen et al. 2001). Fromme et al. (2008) supported that having a physician-family member is a 'good thing', due to the physician's greater familiarity with the current healthcare system as compared to other family members. What is more, the physician may be an expert in a relevant area of practice or hold strong views about what care should be provided. Commonly, most physicians are involved in their ill family member's care personally, and sometimes professionally (Scarff & Lippmann 2012).

Schofield (2013) explained that being a nurse and family member to a loved one admitted to hospital offers a special form of assistance within the hospital environment. For instance, the nurse may personally know

staff members they are dealing with. Scarff and Lippmann (2012) highlighted that healthcare professionals often feel the need to influence their relative's care because they believe they are more concerned with patient wellbeing than healthcare staff in charge. Other researchers propose that a nurse-family member does not experience the same emotional distress as other relatives due to their increased awareness of hospital environments (Olivet & Harris 1991). Although nurses' familiarity within the clinical setting may be helpful, their professional knowledge may also increase their stress, and they may fear that the worst situation will happen (Fulbrook, Allan, et al. 1999; McNamara 2007; Mills & Aubeeluck 2006).

Often a healthcare professional who is a significant other is more familiar and knowledgeable about their loved one's health conditions as compared to others. For example, they may have increased information about their loved one's medications, medical history and desired form of care. As healthcare professionals, nurses understand the importance of how those details can impact on the quality of patient care and influence decision making (Mills & Aubeeluck 2006; Olivet & Harris 1991). Fromme et al. (2008) emphasised that having a physician-family member may provide relief to other family members, provided they are knowledgeable and truthful. Clearly, some researchers have focused on healthcare professionals as significant others who are knowledgeable about their loved ones' medical area of concern. Alternately, healthcare professionals may not be versed in relevant medical areas. This situation may significantly heighten anxiety because healthcare professionals' families or colleagues may have unrealistic expectations. Olivet and Harris (1991) stressed that healthcare professionals and other family members place expectations on nurses who have ill loved ones. A healthcare professional who is a significant other may experience pressure concerning their roles and responsibilities, including being an expert in the field, being a significant other, and being part of the decision making process. These roles and responsibilities may trap a healthcare professional into having unbalanced identities: a professional identity and personal identity.

It is likely that multiple factors affect healthcare professionals as significant others when caring for loved ones. In almost every study, expectations, conflicting roles and communication are important factors highlighted in the current literature (Fulbrook, Allan, et al. 1999; Fulbrook, Creasey, et al. 1999; Giles & Hall 2014; Olivet & Harris 1991; Salmond 2011). The next section further explores these issues.

Influencing factors

Expectations

Expectations are a central element in relationships between healthcare professionals and significant others. When a significant other is a healthcare professional their colleagues and family members have specific expectations of them. However, these expectations have been described as either unclear or incomplete (Olivet & Harris 1991). This may put pressure on healthcare professionals as a significant others concerning their personal and professional experiences (Mills & Aubeeluck 2006). The following sections highlight expectations of other healthcare professionals, ill loved ones and family members towards healthcare professionals who are significant others.

In responding to healthcare professionals' expectations, healthcare professionals as significant others may sometimes be expected by colleagues to be involved in their loved ones' care. Chen et al. (2001) mentioned

that in a healthcare setting, some physicians were expected to participate in treatment of their loved ones due to their specialised knowledge. Also, Fulbrook, Creasey, et al. (1999) indicated that nursing staff expected nurse-family members to contribute to their loved ones' nursing interventions, for example by making their bed. Frequently, healthcare professionals support and welcome colleagues who are relatives of ill patients to be part of treatment plans (McNamara 2007; Salmond 2011). However, Fulbrook, Creasey, et al. (1999) reported that some healthcare professionals only allowed other healthcare professionals who were significant others to remain beside their loved ones if they agreed not to ask questions.

When healthcare professionals are significant others, the healthcare team may have expectations about their familiarity with technology, workplace environments and their loved ones' conditions. Because of this specialised knowledge, healthcare staff members may expect a healthcare professional who is a significant other to be an expert in the specific field of interest, but this is not always the case because they may have different areas of specialisation. Olivet and Harris (1991) stated that colleagues expect a nurse-family member to have specialist knowledge and understanding in the care provided, even though they may have a different specialty. As a result, the care provided to their loved ones may be difficult for them to comprehend due to a lack of specialised experience.

In responding to family expectations, families may expect healthcare professionals who are significant others to be knowledgeable about the healthcare system, to ensure that adequate care is being delivered and to advocate for their loved ones' plans and treatments. Also, they can help convey their loved ones' conditions to family using easy, simple language, such as by interpreting the meaning of medical terminology or by explaining a specific intervention. Mills and Aubeeluck (2006) indicated that families of nurse-family members expected them to describe ongoing care, offer emotional support and satisfy needs for information. In addition, Chen et al. (2001) stressed that these family member physicians expected them to not only advocate clinically, but also be emotionally involved with the family. Fromme et al. (2008) argued that family members do not have to be physicians to efficiently advocate for loved ones or to effectively communicate with healthcare staff. In reality, non-healthcare professionals as significant others may stand and advocate for their ill loved ones through proper communication with healthcare teams.

Conflicting roles

Being a healthcare professional and significant other at the same time can create role conflict. McNamara (2007) described conflicting roles that these individuals experience and explained that it creates challenges and imbalances in personal and professional responsibilities. Personal and professional boundaries must be respected to maintain patient confidentiality and professional ethics (Chen et al. 2001; Fromme et al. 2008; Hill & Hill 2011). This has been supported by a perception of ethical boundaries that sparked a controversy in the medical field, because of physicians' potential lack of objectivity. Also, this advice is endorsed by the Medical Board of Australia which emphasised that 'whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship'(Medical Board of Australia 2014, p. 11). For example, a physician who is a family member may avoid treating their loved ones to avoid conflict of interest. Healthcare professionals should carefully consider whether or not to intervene in their loved one's medical care. Trueland (2013) indicated that no policies currently exist concerning nurses providing care to their loved ones; therefore, there is no reason why nurses should not provide that care.

Although it is clear that professional roles between physicians and nurses are different, both are directed towards patient care. The rationale behind the difference lies in medical knowledge and the power of ultimate authority that physicians' have over patient care (May 1993). In the hospital setting, Issa (2002) stressed there was a very high probability that physicians who engage in double roles could unintentionally experience a role conflict between being a professional and a family member. Studies by McNamara (2007) and Mills and Aubeeluck (2006) suggested that due to these two responsibilities, nurse-family members could experience conflict when the patients' needs are not being met. Researchers admit that having two identities, one as a healthcare professional and the other as significant other, makes it more difficult to set boundaries (McNamara 2007; Olivet & Harris 1991).

Being a healthcare professional and a significant other to a loved family member naturally means wanting to be there for them; however, Salmond (2011) suggests that this may only be realised once their role as a healthcare professional has been satisfied. In the Salmond (2011) study, participants confirmed they prioritised being nurses first and family members second. When healthcare professional identity comes first, it helps ensure that quality care is delivered. Then, family member identity can follow so support may be offered to loved ones. Salmond (2011) pointed out that nurses' professional and personal roles cannot be entirely separated from one another. In addition, healthcare professionals have acknowledged that significant others who are healthcare professionals have special needs and unique circumstances (Chen et al. 2001; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999; Giles & Hall 2014).

Communication

Good communication is central in achieving the best patient outcomes. 'Good patient care is enhanced when there is mutual respect and clear communication between all healthcare professionals involved in the care of the patient' (Medical Board of Australia 2014, p. 13). Family members require precise and consistent information (Verhaeghe et al. 2005). When loved ones are ill it is crucial to provide information to family members (Fulbrook, Creasey, et al. 1999). In a crisis event, communication between a healthcare professional and their significant other can become difficult. It seems that healthcare professionals are primarily focused on intervention and often leave significant others to cope emotionally on their own (Schofield 2013). Researchers have claimed that because of their unique knowledge nurse-family members require different approaches to satisfy their information needs as compared to the general public (McNamara 2007; Salmond 2011).

When a healthcare professional is involved as a significant other they may have knowledgeable expertise about the care provided, unlike a member of the general public. However, this depends on their professional experience and areas of expertise. Indeed, healthcare professionals' work environments, knowledge of medical terminology and use of medical equipment make it much easier to convey specific medical details, especially within their own workplace. However, Olivet and Harris (1991) explained that there were instances where nurse-family members did not receive adequate information due to assumptions that they already knew about interventions that had been provided. In reality, if healthcare professional practice is within a different area of expertise, their skills and knowledge may not be aligned with the healthcare being provided to their ill loved one (Fulbrook, Allan, et al. 1999). This may lead to

misunderstandings about information and raise questions that require clarification to ensure that adequate care is provided in a shared workplace.

When a healthcare professional's loved one is admitted to a different hospital, their need for information would logically be the same or greater as compared to other significant others. They may have relevant professional knowledge, but not local knowledge about the specific organisation. Fulbrook, Allan, et al. (1999) and Fulbrook, Creasey, et al. (1999) explained that healthcare professionals who are relatives may find it difficult to develop new relationships with other healthcare professionals in a different workplace due to poor communication. Gaining adequate information and access may lead to decreased fears and anxiety for healthcare professionals who are also family members (Salmond 2011). Although there have been some investigations into this issue (Fromme et al. 2008; Maxwell, Stuenkel & Saylor 2007; Vandall-Walker, Jensen & Oberle 2007; Verhaeghe et al. 2005), they have primarily been concerned with family members in the critical care setting. This review synthesises experiences of healthcare professionals whose significant others have been admitted to an acute care hospital. This provides greater understanding of the current experience of healthcare professionals as significant others including factors influencing these unique experiences.

Summary

The purpose of Chapter two was to provide background related to experiences of healthcare professionals when their significant others are admitted to an acute care hospital. It highlighted common factors affecting healthcare professionals as significant others when caring for loved ones. While the literature consistently indicates this experience is different to non-healthcare professionals, it does vary and is complex. The next chapter presents the methodology was used to undertake this study.

Chapter Three: Methodology

Introduction

This chapter also details methodological issues on the steps when conducting systematic reviews, including the systematic review protocol, review question objective, background, inclusion criteria for studies, search strategy, assessment of methodological quality, data collection and data synthesis. The methodology for the qualitative systematic review is based on elements and tools suggested by the Joanna Briggs Institute (JBI). This chapter also highlights an overview of the systematic review protocol, including the review question objective, background, inclusion criteria for studies, search strategy, assessment of methodological quality, data collection and data synthesis.

Systematic review

Summarising previous and current research findings in a given area of research using specific tools, such as systematic review, is not a new research approach. As early as the 1960s, systematic reviews were used in psychology and other healthcare disciplines. During the 1980s systematic reviews became more commonplace (Chalmers, Hedges & Cooper 2002). Today, many professional groups, including researchers, policy makers and healthcare clinicians, routinely conduct systematic reviews. According to Bettany-Saltikov (2012), systematic reviews are essential for making evidence-based decisions in healthcare. Briefly explained, the systematic review method is 'a review of research literature using systematic and explicit, accountable methods' (Gough, Oliver & Thomas (eds) 2012, p. 2). In other words, a systematic review is a form of research that reviews evidence and synthesises findings using a systematic strategy. Aromataris and Pearson (2014, p. 54) indicated that it aims to systematically search, progressively gather, critically review and generally summarise knowledge from studies that answer a specific question adhering to eligibility criteria. They listed seven characteristics that define systematic reviews:

1. Clearly articulated objectives and questions to be addressed.
2. Inclusion and exclusion criteria, that determine the eligibility of studies.
3. A comprehensive search to identify all studies, both published and unpublished.
4. Appraisal of the quality of included studies, assessment of the validity of their results, and reporting of any exclusions based on quality.
5. Analysis of data extracted from the included research.
6. Presentation and synthesis of the findings extracted.
7. Transparent reporting of the methodology and methods used to conduct the review.

Systematic reviews aim to summarise the best available evidence using a standardised approach to minimise bias and aid transparency. In addition, it is an excellent method for gaining knowledge and sharing information among health professionals.

Systematic review vs literature review

Systematic review is not just a research based literature review. However, systematic reviews are commonly confused with traditional literature reviews because both are used to summarise specific topics

using existing literature, but they are significantly different (Bettany-Saltikov 2012). Health professionals must recognise and understand the difference between these two review methods in order to find the best available research evidence. Bettany-Saltikov (2012) summarised the two types of reviews based on ten elements: research question, protocol, background, objectives, inclusive and exclusive criteria, search strategy, selection process, evaluating articles, extraction process, results, and discussion. Table 1, below, highlights differences and similarities between systematic and literature reviews.

In developing scientific research, researchers often look for general information to gain knowledge on the topic by conducting a literature review. Traditionally, a literature review is the most common approach used for finding research evidence (Gough, Oliver & Thomas 2012). This type of review is suitable for summarising published information relating to a specific topic. According to Bettany-Saltikov (2012), a literature review or narrative review provides an overview of a topic of interest by an expert reviewer in the field, without using a systematic strategy (Bettany-Saltikov 2012; Gough, Oliver & Thomas 2012). In addition, the search strategy is not provided, there is no justification for inclusion and exclusion criteria and critical appraisal and methods for data synthesis are not clearly stated. Therefore, there is no transparency in the literature review which leads to more bias, because a scientific methodology approach is not followed.

Table 1: Differences and similarities between systematic and literature review.

	Systematic Review	Literature Review
Question	Focused on a single question	Not necessarily focused on a single question but may describe an overview of a topic
Protocol	A peer review protocol (or plan) is included	No protocol
Background/literature review	Both provide summaries of the available literature on a topic	
Objectives	Has clear objectives stated	Objectives may or may not be identified
Inclusion/exclusion criteria	Criteria stated before the review is conducted	Criteria not usually specified
Search strategy	Comprehensive search conducted in a systematic way	Strategy not explicitly stated
Process of selecting papers	Selection process usually clear and explicit	Selection process not described
Process of evaluating papers	Comprehensive evaluation of study quality	Evaluation of study quality may or may not be included
Process of extracting relevant information	Process is usually clear and specific	Process of extracting relevant information is not explicit and clear
Results/data synthesis	Clear summaries of studies based on high-quality evidence	Summary based on studies where the quality of included papers may not be specified, and can be influenced by reviewers' pet theories, needs and beliefs
Discussion	Written by an expert or group of experts with a detailed and well-grounded knowledge of the issues	

In healthcare practice, systematic reviews are the stepping stone for evidence-based practice and often provide a summary of recommendations for clinical decision-making. Systematic reviews are described by Higgins and Green (2011, p. 5) as 'attempts to collate all empirical evidence that fits pre-specified eligibility criteria in order to answer a specific research question'. In any systematic review there is a clear objective and an explicit scientific research methodology with a clear set of inclusive and exclusive criteria. In addition, systematic review processes allow research results to be more widely 'disseminated' and 'utilised' (Jones 2004, p. 272). Prior to conducting the review, a comprehensive search strategy is stated and clearly summarised in order to identify all studies that meet the eligibility criteria using critical appraisal tools, extracted data, and synthesis. Consequently, a systematic review offers a highly transparent review paper that minimises bias for accurate results.

The term systematic review is used frequently and interchangeably with 'meta-analysis' in the literature (Gerrish, Lathlean & Cormack 2015, p. 336). Briefly, meta-analysis is a method of analysis used with statistical data from findings of more than one study to produce a snapshot of statistical data. This type of review follows a standard format of scientific research processes using a protocol or plan. However, a systematic review may also analyse data obtained using non-statistical techniques, i.e. from findings of qualitative inquiries, which is known as a qualitative systematic review or meta-synthesis. There are different types of systematic reviews that can address different types of evidence. Within this research portfolio, a qualitative systematic review methodology was chosen to gain a deeper understanding of the lived experiences of healthcare professionals as significant others to hospitalised loved ones in acute care settings. The next section briefly focuses on qualitative systematic reviews.

Systematic reviews of qualitative studies

Qualitative inquiries have been of growing interest as a rich resource of information for evidence-based practice. Dixon-Woods and Fitzpatrick (2001) support the claim that qualitative research has rapidly increased in the healthcare field and offers an important source of knowledge about healthcare. It also provides an understanding of how healthcare professionals perform clinical practice. A research based systematic review of qualitative studies, also labelled a 'meta-synthesis', puts forward the concept of synthesising qualitative-evidence findings, which is different to a meta-analysis review (Polit & Beck 2016, p. 27). Meta-synthesis is qualitative synthesis of primary non-statistical data from different studies to generate a summary of evidence investigated. Gough, Oliver and Thomas (2012) explained that qualitative systematic reviews use inductive methods for collecting qualitative data that may be used to interpret and address specific questions about an experience and the meaning of phenomena.

A qualitative systematic review explores an in-depth understanding of experiences and restricts the focus to qualitative research studies. The studies include, but are not limited to, designs such as ethnography, phenomenology, grounded theory, action research and feminist research. Results from qualitative systematic review processes may be used to improve current practice in the topic of interest or the phenomena being studied. In this study, the outcome from this qualitative review increased understanding of the experiences of healthcare professionals when significant others are hospitalised in the acute care setting. The information gained may also contribute to enhancing clinical practice and improving quality of

patient care. Health professionals are expected to deliver high quality care and sound clinical decision making based on a scrupulous review of the best available evidence.

Systematic reviews may be created using search strategies based on systematic steps, which in turn may be developed using established review protocols. Prior to developing a protocol, it is recommended that researchers register their review title with the JBI to minimise duplications, and to provide transparency and avoid bias (Joanna Briggs Institute 2014). In conducting a qualitative systematic review, the JBI recommends having two reviewers who have attended the comprehensive systematic review training (CRT) course. CRT allows health professionals to learn how to conduct systematic reviews of different evidence types to provide the best available evidence for evidence-based practice. The author, as the primary reviewer, has undergone the CRT prior to conducting the review. In addition, the author had three supervisors with CRT certificates.

Systematic review protocol

The first step in a systematic review is to establish a formal protocol or proposal. Bettany-Saltikov (2012) mentioned that when conducting a rigorous systematic review, having a protocol is essential for creating a proposal plan. A protocol is defined as 'a statement of the approach and methods to be used in a review made prior to the review being undertaken' (Gough, Oliver & Thomas (eds) 2012, p. 9). Specifically, a systematic review plan (protocol) should contain comprehensive details of each step of the review process. Protocols also describe methods used to conduct the review and explain how review findings might be utilised. Therefore, writing a clear structured protocol may minimise error and limit bias when conducting research reviews (Cook, Mulrow & Haynes 1997). The structured plan used in this study is based on the recommendations of the JBI and is comprised of standardised headings (Joanna Briggs Institute 2014).

Review Question/Objective

In a systematic review, regardless of the method used, establishing the questions and objectives are an important first step. Review questions should align precisely with objectives. Cooke, Smith and Booth (2012) stress that developing a review question is an essential stage to ensure effective searching for research evidence. In order to write clear and focused review questions, the following components are to be included: participants, interventions, comparisons and outcomes (PICO) (Higgins & Green 2011; Cooke, Smith and Booth 2012).

However, while PICO is used to ask quantitative review questions, there is an alternative for qualitative review questions, such as the population or problem, interest and context (PICo) format (Joanna Briggs Institute 2014). PICo is a frequently used tool in qualitative reviews and focuses on clinical questions that seek to analyse phenomenon of interest and human experience. The qualitative systematic review question may contain the following features (Gough, Oliver & Thomas 2012):

- The study population: peoples' subjective experience or the meaning that a disease.
- The phenomenon of interest: experience, event, or process under-investigation.
- The context: geographic location, interests based on race or gender, and setting.

Although a qualitative systematic review may designate an intervention, its questions are centred on the perception of people's experiences. The questions direct development of the review protocol, including inclusion criteria, search strategy, and data collection methods (Higgins & Green 2011).

Background

The review background is an important part of the protocol. It aims to provide in-depth information to the reader concerning what the review is about, and it describes the setting and context of the area of interest. Bettany-Saltikov (2012) highlighted that background content may vary depending on the specific topic. The content may include, but is not limited, to any of the following:

- Definitions of the key concepts.
- A list of the current research to be undertaken, such as statistics documents.
- A description of the type of target population, the interventions or phenomenon to be reviewed, and the outcomes to be used.
- An explanation of why a systematic review is needed and the contributions it may make to existing knowledge.

Criteria for inclusion of studies

Establishing criteria for the inclusion of studies plays a substantial role in selecting articles to review. Inclusion criteria must be sufficiently detailed including types of participants, phenomena of interest, context and types of studies, so that objectives of the review can be achieved (Higgins & Green 2011). Conversely, exclusion criteria are intended to exclude studies that are not eligible. Having inclusion and exclusion criteria are essential to produce high quality systematic reviews (Bettany-Saltikov 2012).

Search strategy

Joanna Briggs Institute (2014) emphasises that in a systematic review documentation of search strategies is a key element of achieving scientific validity. A search strategy is a set of logical steps taken by the researcher to gather literature related to the research issue, and is supported by detailed tables and diagrams. One of the major steps is to identify appropriate keywords by breaking down the review question. These keywords might be used in electronic databases as index terms. For example, the PubMed database uses medical subject headings. Evans (2002) states that index terms are indicative of both the review topic and types of study designs. Subsequently, these selected index terms, keywords and phrases can then be used to search databases, with the Boolean terms 'and' and 'or' used to combine terms. Consulting with a librarian or information specialist will facilitate development of keywords and allow individuals to become familiar with the database system (Bettany-Saltikov 2012; Higgins & Green 2011).

The next step is to search through a variety of electronic databases. Gough, Oliver and Thomas (2012, p. 90) defined a database as 'one of the most important electronic tools a reviewer will use'. There are significant numbers of search engines that include general databases, like the journal database PubMed, Google Scholar internet searches and professional journals, such as the Journal of the Medical Library Association. There are a large number of databases that may be general or specific. The selection of

databases is guided by the review question and inclusion criteria. PubMed and Cumulative Index of Nursing and Allied Health Literature CINAHL are generalist databases and commonly searched. CINAHL is particularly appropriate for searching for qualitative research. Specialist databases, such as PsycINFO, would be selected if the topic of interest had a mental health focus. A comprehensive search dictates multiple databases. Grey literature which encompasses unpublished papers should also be considered. The search for unpublished material is however much less precise, but still important to avoid publication bias. For example, grey literature searches yielded a great deal of irrelevant material, but some did provide background information for the review. Undertaking a comprehensive systematic search will provide a full list of primary articles either published or unpublished that aligns with the research question. Finally, it is also necessary to include details of the search outcome in the appendix of the review for future duplication (Higgins & Green 2011). In the appendix, it is useful to highlight any excluded articles and to provide the rationale for their exclusion from the final dataset.

Assessment of methodological quality

To assess the rigour of a systematic review it is important to consider different approaches to assessing quality of the research. A critical appraisal is defined as 'the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context' (Burls 2009, p. 1). In any systematic review, establishing good critical appraisal processes for retrieving quality primary studies will produce more valuable research reviews. Gough, Oliver and Thomas (2012) stressed that the quality of primary studies is connected to the research question mentioned in the review. There are a large number of critical appraisal instruments available and accessible via the internet for both quantitative and qualitative studies (Bettany-Saltikov 2012). However, as mentioned in the previous section, having more than one independent reviewer to appraise the study helps avoid bias and maintains the quality of critical appraisal (Higgins & Green 2011). In cases where there are disagreements between the reviewers' judgment, an internal discussion or discussions with a third-party reviewer may resolve the disagreements. Specifically, for qualitative studies the JBI qualitative assessment and review tool is utilised. The critical appraisal tools described are a checklist of items that reviewers need to provide an evaluation for each primary study using a scoring system. For any systematic review protocol, it is useful to include critical appraisal tools in the appendix to ensure that readers are well-informed of the link between the instruments and systematic review methodologies.

During an assessment of methodological quality of the studies included in the qualitative review, it is important to grade papers in terms of study approach used and level of evidence. The JBI is one professional group that has developed levels of evidence that are structured according to the feasibility, appropriateness, meaningfulness and effectiveness (FAME) scale (Joanna Briggs Institute 2014). The FAME scale may assist in identifying the strength of a recommendation when undertaking systematic reviews. The JBI has developed qualitative assessment and review instruments to facilitate the methods for qualitative research, these new levels of evidence and grades of recommendation are being used for all JBI documents as of 1 March 2014 (Joanna Briggs Institute 2014).

Data collection

When conducting a systematic review using a qualitative approach, collection of data is considered important in demonstrating the degree of systematic synthesis. It is the stage where the reviewer demonstrates an understanding of how to find robust evidence and how to capture information from qualitative data to support recommendations of the review. Qualitative data findings were collected from included studies using a data collection form. Magarey (2001, p. 379) stated that the data collection form is 'used to document this process.' In general, the data collection stage involves gathering and summarising relevant information from primary research articles to answer the research question (Bettany-Saltikov 2012). In this review, the tools used in data collection are described in the appendix section to allow other reviewers to follow the process and replicate any steps if required.

Data synthesis

The final component of this protocol is data synthesis, which describes the process of systematically and appropriately combining results. Data synthesis provides information that answers the review question and also summarises narrative synthesis of the study result (Bettany-Saltikov 2012). The most common method used to present findings of qualitative research in systematic reviews has been through a narrative summary. Narrative summary offers an overview of study results, emerged themes and issues of importance. When summarising and synthesising results it is necessary to use appropriate tools, which may also minimise data-entry errors. Many tools may be used to combine results of articles into a synthesis, in ways that are appropriate for different methods and events (Bettany-Saltikov 2012; Gough, Oliver & Thomas 2012). In general, research findings were graded according to their quality and categorised based on similarities of meaning. These categories were then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings. These tools are available from the JBI and should be selected based on the type of study design employed (Higgins & Green 2011).

Summary

The aim of chapter three was to discuss in detail the methodology of the systematic review used in Study 1. Information related to developing a systematic review protocol was provided. The structured plan used in the review was based on the recommendations of the JBI. This protocol discussed the following key components: the objective, background, inclusion criteria for studies, search strategy, assessment of methodological quality, data collection, and data synthesis. The next chapter provides details about the methods used to conduct the systematic review.

Chapter Four: Method

Introduction

This chapter reports on methods used to identify and synthesise the qualitative evidence of lived experiences of healthcare professionals as significant others to hospitalised loved ones in acute care settings. Methods in review are tools that reviewers use to assist the review process. This review was conducted according to a priori published protocol (Sabyani et al. 2016). In the chapter the following will be addressed in details which include: Review question / objectives, Inclusion and exclusion criteria, Types of participants, Phenomena of interest, Context, Types of studies, Search strategy, Critical appraisal, Data collection and Data synthesis.

Review question /objectives

As mentioned above, the question to be answered by this review is:

What are the lived experiences of healthcare professionals as significant others to hospitalised loved ones in acute care hospitals? The following are the objectives of this qualitative systematic review:

- To review studies of the experiences of healthcare professionals when their significant others have been admitted to an acute care hospital.
- To gain insight into healthcare professionals' lived experiences when their significant others are in acute care hospital.
- To identify factors that impact on the experiences of healthcare professionals who are significant others when their loved ones are admitted to an acute care hospital.
- To identify the needs and perceptions of healthcare professionals when their significant others are admitted to an acute care hospital.

Findings from the systematic review were used to inform Study 2 of this research portfolio.

Inclusion and exclusion criteria

The following criteria were used to focus the systematic review and ensure appropriate studies were identified in regard to the review question and objectives.

Types of participants

The review considered studies that include only registered nurses (RNs) and physicians who reported their experience as a significant other when a relative had been admitted to an acute care hospital. Other healthcare professionals were excluded due to the different characteristics in terms of patient care and responsibilities of clinical practice.

Phenomena of interest

The review considered studies that explored the experience of RNs and physicians when a significant other had been admitted to an acute care hospital.

Context

The review studied research conducted in any acute care hospital, i.e. a hospital that offers treatment care for acute disease or trauma services, such as acute care, critical care, intensive care and emergency departments.

Types of studies

The review considered primary qualitative studies including, but not limited to, research designs such as phenomenology, grounded theory, ethnography, and action research.

Search strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was utilised in this review. An initial search of PubMed and CINAHL was undertaken followed by analysis of text contained in title and abstract, and of index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Thirdly, reference lists of all identified reports and articles were searched for additional studies. Only studies published in English were considered for inclusion in this review. There was no date restriction. Databases searched were: PubMed, CINAHL, PsycINFO, and Embase. The search strategy for each database is shown in Appendix I. The search for unpublished studies included: Google Scholar, ProQuest Dissertations and Theses. The keywords utilised to generate the database search strategies were:

- Healthcare professional, Health Personnel, Professional-Family Relations, Nurse, Nurse-Family member, Physician, Doctors.
- Significant other, Family, Spouses, Partner, Loved one, Family Relations, Extended Family, Immediate Family, Close relative, Family member, Family presence, Wife, Husband, Mother, Father.
- Life Experiences, Experience, Personal experience, Role expectation, Dual role.
- Acute care, Critical care, Intensive care.

Critical appraisal

Papers selected for retrieval were assessed independently by two reviewers for methodological validity prior to inclusion in the review using a standardised critical appraisal instrument from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix II). Any disagreements that arose between reviewers was resolved through discussion.

Data collection

Findings from included studies were extracted using the standardised data extraction tool from JBI-QARI (Appendix III). The data extracted included specific details about the phenomena of interest, participants, study methodology and methods that described the experiences pertinent to the review question and specific objectives. The data were extracted by the principal author to an electronic document and checked by a second author prior to entering into JBI-QARI as a single entry.

Data synthesis

Qualitative research findings were pooled using JBI-QARI software and methods. This involved aggregation or synthesis of findings to generate a set of statements that represent that aggregation through assembling findings rated according to their quality, and categorising these findings on the basis of similarity in meaning. These categories were then subjected to a meta-synthesis to produce a single comprehensive set of synthesised findings that can be used as a basis for evidence-based practice. To ensure confidence in meta-aggregated findings the ConQual approach was used. ConQual is acknowledged as the confidence of synthesised qualitative findings (Munn et al. 2014). In the next chapter, the ConQual summary of findings is explored in detail regarding level of dependability and credibility to influence confidence of findings using the ConQual assessment approach (Munn et al. 2014).

Summary

Chapter four detailed methods of conducting this qualitative systematic review. The methods used in the review were based on those recommended by the JBI. The following key components were described: the review question, objective, inclusion/exclusion criteria for studies, search strategy, assessment of methodological quality, data collection and data synthesis. The next chapter provides the findings of the systematic review in detail and a summary of the ConQual approach undertaken.

Chapter Five: Results

Introduction

This chapter describes results of the systematic review. Initially, a full summary of the findings, including search results using search terms, details of all included studies using appropriate frameworks and the critical appraisal process are offered. Finally, a summary of the data extracted, including a synthesis of overall results, is presented. All results presented in this chapter are discussed comprehensively in Chapter six.

Summary of searchresults

The systematic search produced 5600 titles from all databases. Duplicate studies, numbering 826 in total, were removed. The remaining 4774 studies had titles and abstracts screened on the basis of inclusion criteria. During this process, a total of 4759 studies were excluded, and 15 articles were selected based on their relevance to the review topic. After a full text review, a further five articles were excluded. Ten articles moved forward for quality assessment using the JBI critical appraisal tool. Subsequent to critical appraisal, three additional articles that reported on one study were excluded. The list of articles excluded and the rationales for exclusion are provided in Appendix IV.

A total of seven studies reviewed met inclusion criteria and were deemed of sufficient quality. Figure 1 (PRISMA flow diagram, http://www.prisma-statement.org/) presents details of the search strategy stages.

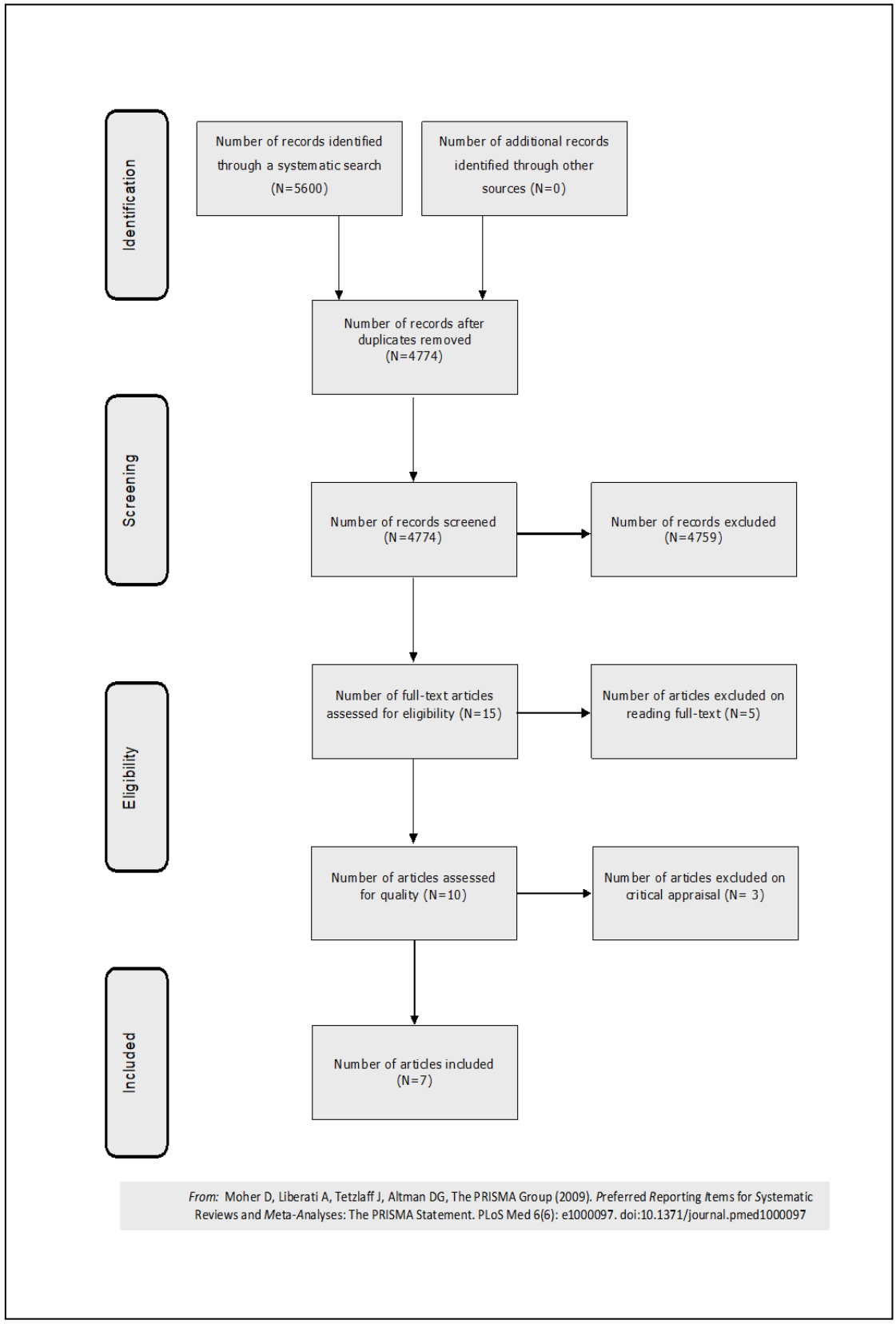

Figure 1: Flowchart of the study selection process.

Description of included studies

The included studies were conducted over a ten-year period in five countries: three in Australia (Giles & Williamson 2015; Ledwidge 2010; Lines, Mannix & Giles 2015), and one each in Sweden (Carlsson et al. 2016), New Zealand (McNamara 2007), the United Kingdom (Mills & Aubeeluck 2006) and the United States of America (Salmond 2011). The earliest included studies were published in 2006, and the most recent in 2016. The studies used a variety of methodologies. Three contain phenomenographic and hermeneutic phenomenology approaches using semi-structured interviews (Carlsson et al. 2016; McNamara 2007; Mills & Aubeeluck 2006). However, the other four studies use descriptive (Giles & Williamson 2015; Ledwidge 2010), exploratory (Lines, Mannix & Giles 2015) and grounded theory (Salmond 2011) approaches.

In six of the seven studies, participants were registered nurses (Giles & Williamson 2015; Ledwidge 2010; Lines, Mannix & Giles 2015; McNamara 2007; Mills & Aubeeluck 2006; Salmond 2011), and one study by Carlsson et al. (2016) examined a variety of healthcare professionals (registered nurses, physicians, assistant nurses, midwives, social officers, occupational therapists, radiographers and biomedical technicians). This study was included as the majority of participants were RNs and all but one of the illustrations provided were specifically attributed to RNs. Two of the studies were theses (Ledwidge 2010; McNamara 2007) and five studies were published articles (Carlsson et al. 2016; Giles & Williamson 2015; Lines, Mannix & Giles 2015; Mills & Aubeeluck 2006; Salmond 2011). The studies were conducted in acute care facilities; three examined a single hospital (Ledwidge 2010; Lines, Mannix & Giles 2015; McNamara 2007), two were multi-hospital studies (Carlsson et al. 2016; Salmond 2011) and two did not report the details of their settings (Giles & Williamson 2015; Mills & Aubeeluck 2006). The details of included studies are presented in Appendix V.

Methodological quality

As previously mentioned, the studies' methodological quality was assessed using the JBI critical appraisal tool. Results of the appraisal are presented in Table 2. The included studies scored a minimum of 7/10. Two studies achieved a methodological quality of 10/10 (Ledwidge 2010; McNamara 2007), two studies were scored as 9/10 (Carlsson et al. 2016; Salmond 2011), two studies were scored as 8/10 (Giles & Williamson 2015; Lines, Mannix & Giles 2015), one study was scored 7/10 (Mills & Aubeeluck 2006). One study (embodied in three articles) was excluded after critical appraisal with a quality score of 2/10 (Fulbrook, Allan, et al. 1999; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999).

All included studies were strong in the critical appraisal questions related to congruity between research methodology and the research question, research methodology and methods used to collect data, representation and analysis of data and the interpretation of results. In addition, the questions addressing adequate representation of participants' voices, evidence of ethical approval and the conclusion are drawn from analyses were strongly represented. Half of the included studies stated their philosophical framework and situated the research culturally or theoretically. The weakest reporting among all studies was related to question seven, which was of concern; this addressed the influence of the researcher on the research and vice-versa. Only two studies clearly stated this influence (Ledwidge 2010; McNamara 2007).

Table 2: Methodological quality of included studies.

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	10/10 Y response
Carlsson et al. (2016).	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	09/10
Giles and Williamson (2015).	Y	Y	Y	Y	Y	N	UC	Y	Y	Y	08/10
Ledwidge (2010).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10
Lines, Mannix and Giles (2015).	Y	Y	Y	Y	Y	UC	UC	Y	Y	Y	08/10
McNamara (2007).	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10
Mills and Aubeeluck (2006).	UC	Y	Y	Y	Y	N	N	Y	Y	Y	07/10
Salmond (2011).	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	09/10

Y= Yes; N= No; UC= Unclear.

Results of meta-synthesis of qualitative research findings

Forty findings were extracted and aggregated to create ten categories, and five synthesised findings were derived from these categories. Of 40 total findings, 18 unequivocal and 22 credible findings were extracted from included studies. Then, findings were grouped into categories based on similarities of meaning. The following is a detailed description of meta-synthesis including synthesised findings with their related categories, findings and illustrations. Levels of credibility are also included for each finding, i.e. Unequivocal (U) and Credible (C). The meta-synthesis is also provided in tabular form in Appendix VI.

Synthesised finding 1: Privileged knowledge

The first synthesised finding relates to privileged knowledge that healthcare professionals have as a result of their practice. Healthcare professionals recognise this knowledge of healthcare practices and more broadly the healthcare system as being fundamental to the experience of having a family member (FM) admitted to an acute care facility. Findings indicate that this knowledge brings some benefits in better understanding of what is happening to their relative and also a need to have this acknowledged by staff. In addition, knowledge from being a health professional results in a heightened sense of judgment about the care being provided to their relative. Two categories were generated from eight findings (three U and five C), which contributed to this synthesised finding.

Category 1: Having expert knowledge is central to the experience when a loved one is ill.

Five findings were grouped into this category. Healthcare professionals acknowledged the importance of knowledge they bring from their practice. They recognised the importance themselves, but also wanted staff to acknowledge this. Importantly, they also recognised that their knowledge might not be complete,

particularly in settings in which they had no experience as a clinician. These findings were extracted from four studies.

Finding 1: The informed bystander: benefits perceived to be related to their professional experience were knowing the healthcare system and how to navigate the system, possessing knowledge that facilitated their understanding of the patient's illness and communication with staff about the patient's test results and medical state as well as about what plans were made for the patient (C).

Illustration: 'What I appreciated very much – I asked lots of questions, it's important to me to know how it looks, how is the ECG? Is it an MI or only angina, or what is happening?... So, I phoned the Emergency Department direct and could talk to a nurse, and I said, 'It's me, Anna – we know one another, we work together every day – my Dad has just arrived in the ED, how is he?' It was really fine to get an immediate response. And she told me, 'The ECG looks like this and the test results are like that,' and I don't think she would have told that to a general relative. But, she chose this track immediately, she chose to tell me about those very important medical findings, and then she asked, 'Do you want to talk to the doctor in charge?'(Carlsson et al. 2016, p. 54).

Finding 2: Wanting acknowledgment of specialised knowledge: nurse-FMs believed that their specialised knowledge made them different to general public-FMs and wanted their knowledge acknowledged and respected by staff (U).

Illustration: 'We like more information and want to be included when possible. Respecting the increased amount of knowledge that we have vs. the general public is important.' (Giles & Williamson 2015, p. 7).

Finding 3: Wanting specialised communication: nurse-FMs highlighted the need for specialised communication that took into consideration previous knowledge and skills (U).

Illustration: 'We should be given more time for explanation because we need more depth and have more questions than most other people who would simply accept what was going on and the treatment offered.' (Giles & Williamson 2015, p. 8).

Finding 4: Specialised knowledge: nurse-parents found themselves in a unique position where they possessed not only an intimate knowledge of their child's personality, idiosyncrasies and medical history, but also considerable nursing knowledge and expertise. However, they were quick to acknowledge the limits of their knowledge, which was generally linked to their clinical specialty (C).

Illustration: 'I certainly felt comfortable saying... you don't need to speak that basic, or that's a little bit too complex.' (Lines, Mannix & Giles 2015, p. 13).

Finding 5: Knowing and not knowing: alongside knowing, not knowing also caused feelings of anxiety and stress. Not knowing what was happening while sitting in the waiting room and not having answers for relatives created feelings of frustration and powerlessness (C).

Illustration: 'I was scared… it was just that there was that nurse part of me that maybe added to that personal role that actually kept me from panic…I'd be panicking about something and thinking… Don't be ridiculous this is how it would normally go...' (McNamara 2007, p. 29).

Category 2: Healthcare professionals as relatives use their specialist knowledge to judge the care provided.

This category represents some aspects of healthcare professionals as relatives who used their special knowledge to evaluate the care provided in terms of observing, detecting and protecting. In addition, they experienced frustration with the quality of care delivered. This category contains three findings extracted from three studies.

Finding 6: Evaluating care: nurse-parents were aware of general standards of care expected in the hospital setting and often compared their child's care to the nursing care they would ordinarily provide (U).

Illustration: 'I had requested about three times for... a medical review and... they [nursing staff] would come back and say 'well we've spoken to him [the doctor] on the phone and... he said she's okay and... we'll give her a bit more pain relief.' (Lines, Mannix & Giles 2015, p. 15).

Finding 7: Expertly observing, detecting and protecting: being vigilant served a number of purposes (C).

Illustration: 'Dad was hospitalised in the hospital where I trained, so the environment was very familiar to me. I think the experience is much less foreign if you are an RN. You understand what the bedside charts mean ... You also become quite critical of the deficiencies of the public hospital system.' (Ledwidge 2010, p. 145).

Finding 8: Disempowerment: all had experienced some dissatisfaction in the delivery of care and of responses to their own needs (C).

Illustration: 'I couldn't possibly have gone off sick, I couldn't, I just couldn't have possibly done it. I would have felt that I was cheating the system, you know, I didn't want to let anyone else down.' (Mills & Aubeeluck 2006, p. 162).

Synthesised finding 2: Unavoidable dilemmas as a consequence of dual identity

Healthcare professionals experience the feeling of being trapped between their personal and professional identities when a FM is hospitalised. The second synthesis contains 14 findings (seven U and seven C), and three categories fall under this synthesised finding. Healthcare professionals in the role of significant others experience the dilemma of dual identity (being a healthcare professional and a significant other). They are acutely aware of their two roles and are often conflicted in terms of which role they or others feel they should be undertaking. The decision of when or if to disclose their professional status to staff is also a significant concern. Finally, they are confronted with personal and professional boundaries that bring pressure from within themselves and from others.

Category 3: Healthcare professionals as family members experience role conflict moving between two identities.

Five findings were grouped into this category, which represented healthcare professionals as FMs recognising the reality of having dual identities (professional versus personal roles). As a result, they experienced tension and conflict as they tried to reconcile their roles. These findings were extracted from five studies.

Finding 9: Rather be treated as a lay son/daughter: staff would treat them differently and that they would be disadvantaged by disclosing their RN status so they preferred to be treated as a lay son or daughter rather than as an RN (U).

Illustration: '… because I think it does make the other registered nurses uncomfortable. Sometimes you could tell that they looked at you and you thought ohhh. I think that registered nurses are a bit sort of hesitant. It's like when you go in as a registered nurse [as a patient] and people know you're a registered nurse I think you either get under-cared for or you get over-cared for big time. I don't think there's a happy medium.' (Ledwidge 2010, p. 100).

Finding 10: Feeling torn: the nurse as relative cannot simply switch off the nurse in her being. Inextricable connections mean that she cannot act as a detached FM (C).

Illustration: '…I wanted to be watching his monitor because we can watch the monitors from theatre, and then part of me said: 'Look, I might even go and sit in the gallery'…I mean totally illogical sort of things you wouldn't allow family members to do normally. Part of me wanted to do that but the family side of me said I had to go home and be with my family…' (McNamara 2007, p. 30).

Finding 11: Personal and professional boundaries: as a consequence of being a nurse and FM, they had to deal with the difficult issue of boundaries (C).

Illustration: 'It [confidentiality] was an issue for me throughout. The confidentiality had been broken initially, so until she gave me permission to talk to her doctors about her, I didn't. I had ample opportunities to break her confidentiality. I could have looked on the Trust's computer system, I could have spoken to the doctors specifically about her and I chose not to and I was very strong about that.' (Mills & Aubeeluck 2006, p. 162).

Finding 12: Emotion versus intellect: they stressed the importance of staff recognising both the FMs-self and the nurse-self to provide effective care and support (U).

Illustration: 'It is the opinion of everyone else that nurses who are family members should know all about what is going on. Yet people forget that we are human too and when it is your family it is different, often you can't shut off as easily from the emotions as you do when you are at work. We also need that medical jargon conversation as that satisfies the working nurse in us and the knowledge side. Once that side is sorted we can then... be the support for the family member who is sick.' (Giles & Williamson 2015, p. 9).

Finding 13: Resuming family roles: development of trust was pivotal to managing the challenge of resuming family roles (C).

Illustration: 'By staying with her I witnessed the competence of the nursing staff. They communicated what they were doing, what they were finding, what they would do. They were there when I interacted with the physician requesting that care be changed. It made me feel safe. I could act like her mother for a while instead of the nurse in charge. Then I would come back to being the nurse in control.' (Salmond 2011, p. 16).

Category 4: Healthcare professionals must consider whether or not to disclose their professional identity.

This category represents healthcare professionals as FMs considering whether or not to disclose their professional identity. Healthcare professionals recognised that disclosing their professional status could provide advantages for their loved ones, but might also change expectations about their role as a relative. This category contains four findings that were extracted from two studies.

Finding 14: Dual role conflicts: nurse-FMs experienced a conflict between wanting to conceal and wanting to reveal their RN status (C).

Illustration: 'I didn't mind they knew I was a registered nurse but during a family meeting I was asked if I was and of course I said I was, and after that the staff would always say 'oh are you the nurse?'. [It] made me feel that I was often the topic of conversation at hand-over when I was actually there as a sister and medical and legal guardian.' (Giles & Williamson 2015, p. 7).

Finding 15: Disclosure unnecessary: participants did not generally want or expect to take over the nursing of their parent as they expected the hospital staff to nurse their parent (U).

Illustration: 'People know their job. What are you hoping to achieve by telling staff you're an RN? That they're going to look after your father better? Aren't they already doing the best job they can? The implication in telling people you're an RN is that they'd better watch out because you're watching them. It's just not necessary.' (Ledwidge 2010, p. 96).

Finding 16: Disclosing to be treated as a peer/colleague: advised staff of RN status to be recognised as a peer/colleague (C).

Illustration: 'So many of the registered nurses knew me so we got treated differently: more intimately, we got more information, we got involved in different ways... I remember when I worked with them – when they were students because I had a rapport with them – so this rapport just bubbled in.' (Ledwidge 2010, p. 110).

Finding 17: Disclosing to get action: a need to advise staff of their RN status to gain added power to intervene in a way that was as influential as possible and resulted in getting their parent the care and attention they needed (C).

Illustration: 'As Mum was dying from cancer it was horrible. She went in for a palliative ileostomy and I wanted her home as soon as possible. After surgery care was ordinary and staff at one stage even taped the bag on with Elastoplast. Every lunch time and tea-time I would arrive and her legs would be dangling

in a recliner and her bag would have leaked all over her. I would change her and clean her up and elevate her legs that were very swollen. After 2 days of this it was time to let staff know. They even referred Mum to the stoma therapist. She ordered appropriate bags that didn't leak and Mum's legs were always elevated. Until they found out that I was an RN the staff had told my aunty that it was normal for stoma bags to leak.' (Ledwidge 2010, p. 116).

Category 5: Healthcare professionals are confronted by personal/professional boundaries.

Five findings were grouped into this category, which represents healthcare professionals as FMs' experiences of pressure in relation to their personal and professional boundaries. Findings indicated that healthcare professionals were confronted by the boundaries between two roles of relative and healthcare professional. They identified that pressure to overstep this boundary could come from themselves or the expectation of others. These findings were extracted from three studies.

Finding 18: The carer: the informants' descriptions focused on how they not only monitored the medical status of their loved ones and took over communication with ward staff as well as the coordination of care, but also that they were forced to take over much of the care, both in hospital and at home (C).

Illustration: 'I am trained to observe and monitor patients' vital signs, that's what I'm there for [at work]; observe and tell nurses or doctors when there is a change... I could see her puff and I thought, 'She will develop pulmonary oedema.' So I said, 'You would need one of those pipes'... Well, I went to my ward for a pipe so that she could do her breathing exercises. On Monday, the resident in charge praised me for having started the exercise. She asked if the physiotherapist had prescribed the pipe. 'No, it was Mum,' my daughter said! And I felt a bit embarrassed.' (Carlsson et al. 2016, p. 56).

Finding 19: Stepping in on numerous occasions to ensure that their FMs received adequate nursing care, believing that their specialised knowledge and skills prevented significant deterioration in the patient's condition (U).

Illustration: 'Many times I had to be there to request basic care, notice when he was deteriorating and feed and keep him clean... Thankfully my own abilities possibly saved him from deteriorating further... I was not prepared to sit back and watch the appalling care my husband received... [he] would not have made the progress he has without the input my knowledge added... He had to have someone to keep him safe.' (Giles & Williamson 2015, p. 8).

Finding 20: Expectations placed on self: nurse-FMs actively nursed both their own FM and other patients in the vicinity (U).

Illustration: 'The obligation they felt to provide this care, and the added pressure they felt to maintain control, lest everything 'fall apart'.' (Giles & Williamson 2015, p. 9).

Finding 21: Staff expectations: nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general public-FM (U).

Illustration: 'When I visited they hardly came near my father and I felt they were leaving me to attend to the care. In the end I was distant to [my father] as I felt all care was being left to me... I wanted to be me and not a nurse... It was difficult to see what was happening with my knowledge and wanting to 'hide' as my [father] was dying, but having to keep him in bed, make sure the IV wasn't pulled out etc. Not my job!!! The topic of me doing the care should have been discussed. Some people may want to do it, others not.' (Giles & Williamson 2015, p. 9).

Finding 22: Filling in gaps: over-stepping boundaries and gender differences: overstepped the usual child-parent boundaries and this intruded on the parent's privacy and led to feeling uncomfortable (U).

Illustration: 'When [the nurse] arrived I assisted her to change my father because he had been slightly incontinent when she was putting the syringe driver in and I regret that I had done that because Dad was a very, very private person and he would have hated me doing that... and it's just something that I think about now and again and I just wished I hadn't done it because he wouldn't have liked me doing it. I think she should have asked for one of the other nurses to come and help her not me. It was her request and it was a spontaneous thing and I just did it without thinking - and I can remember thinking - we were finishing the task and I was thinking - oh I wished I hadn't done that - I just thought it was invading his privacy in a way that I don't think he would have liked.' (Ledwidge 2010, p. 156).

Synthesised finding 3: Being a protector is imperative

The professional identity of healthcare professionals and their specialist knowledge makes it imperative that they take on the role of protector of their loved one. This third synthesis contains six findings (two U and four C), and two categories fall under this synthesised finding. Healthcare professionals as significant others recognise that observing their ill loved one's condition and being a spokesperson for him or her to ensure that adequate care is delivered is unavoidable. They feel the need to query the in-depth details of care provided and contribute to the provision of care, when appropriate.

Category 6: The need to watch over their ill loved one is inescapable for healthcare professionals.

This category represented healthcare professionals as FMs' experiences being compelled to watch over the care provided to their ill loved one. They feel pressured or even distressed when keeping watch and monitoring their loved one's illness, but recognised there was no choice and this had to be done. Three findings extracted from three studies were aggregated from this category.

Finding 23: The supervisor: this way of understanding was focused on monitoring the patient's medical status, test results and nursing care while staying in the background (C).

Illustration: 'I talked to him [the fiancé] and said, 'You really have to tell them, or I'll do it!' And then he did, and they [the staff] became more active about his diabetes, his blood sugar tests and so. Without me nagging about that, I think they were a bit off-handed, but I watched over them and made things happen... Well, I told him over and over again 'If you don't talk to them, I will!' It was obvious that when I pushed and he asked the right questions – then, things happened.' (Carlsson et al. 2016, p. 55).

Finding 24: Keeping watch and advocating: nurse- FMs felt compelled to watch over and advocate for their FMs, fearful that care would deteriorate in their absence (U).

Illustration: 'The weeks during his stay when his care was appalling were very difficult as I did not want to be 'over reacting' but could not tolerate what was happening. When expressing my concern to people I was labelled as 'anxious' and 'stressed' — both true and real but hardly the reason for expecting my husband to be kept clean, dry and warm, let alone covered and dignified in front of strangers.'(Giles & Williamson 2015, p.8).

Finding 25: Surveillance and protection: vigilant observation was the key to surveillance and protection (U).

Illustration: 'They were phenomenal. They never questioned any-thing about whether I should be there beside him. I was part of the team. They shared details, gave me real information. It allowed me to be in control.'(Salmond 2011, p.15).

Category 7: Healthcare professionals are compelled to be an advocate for their ill loved one.

Category 7 focuses on healthcare professionals' experiences of being an advocate for their ill loved one's care. They stressed that advocating for the patient was their role because of their clinical experience and family relationship. This category contains three findings extracted from three studies.

Finding 26: The advocate: informants who understood being an FM of a hospitalised patient as being an advocate of the patient (C).

Illustration: 'So, he was placed in this room, he had to stay in the ward where he didn't want to be – his lungs were the problem and they belonged to that ward. And he couldn't go home... and it was hard to say, 'You should terminate the cancer treatment,' like that. They [healthcare staff] were so careful and, like respectful, you know. But he got just worse and worse and he had no energy, so I thought, I'll have to ask for a talk with the resident, and ask him, 'Since he [the father] can't go home, and since he's not going to have any more treatment – well, this is a ward for cancer treatment, there must be somewhere else for him to be, a hospice ward or something.' (Carlsson et al. 2016, p. 56).

Finding 27: Being the fixer and fixing: intervene in management of care (C). **Illustration:** 'I wrote an official complaint but nothing ... they phoned and said 'we're sorry about the loss of your mother but we felt we did everything we possibly could and perhaps you might have been affected because you were too close to you mother' ... I thought oh no.' (Ledwidge 2010, p. 157)

Finding 28: Advocating for: advocacy occurred with or without collaboration; however, patient and family needs were best served when collaboration existed (C).

Illustration: 'I came in in the morning. They told me he was unstable. I started asking questions, his blood gas, his pH was like 7.0. I was like 'what', he's going to code. You need to do this, you need to do that... I

wasn't trying to manage the situation but I knew what needed to be done and I had to be sure everything was being done.'(Salmond 2011, p. 16).

Synthesised finding 4: Family expectations are inevitable

Healthcare professionals struggle to meet the unavoidable high expectations of their FMs. The fourth synthesis contains six findings (four U and two C), and one category makes up the synthesised finding. Healthcare professionals as significant others are under pressure to take the lead for the family when a loved one is acutely ill. They are required to know what is going on, be the support for the rest of the family, even when this means not showing their true feelings.

Category 8: There is considerable pressure to be present for family when one is a healthcare professional.

This category shows how healthcare professionals, as FMs, perceived the role of being an FM of an ill loved one. They experienced pressure from FMs' expectations, including ill loved ones, and took a leadership role in overseeing the quality of care. As a consequence, the healthcare professional FM was responsible for dealing with two relationships, their relationship with family and their relationship with staff, in order to facilitate and gain information. Six findings, which were extracted from three studies, were grouped in this category.

Finding 29: FM expectations: nurse-FMs felt under considerable pressure from the patient and other FMs to play a particular role (U).

Illustration: 'I was more anxious and worried than other family members and this was reinforced when they tended to rely on me to make decisions for them all... Other family members relied on me but I did not want to be in control or responsible for decisions.' (Giles & Williamson 2015, p. 9).

Finding 30: Leading and staying strong at any cost: being the eldest child was an important factor in relation to taking a leading role (C).

Illustration: 'Fundamentally that comes about because I'm the eldest of six. I'm the only nurse. There is a medical doctor but he was not in the state at the time when things first happened. I'm also very close to both my father and my mother and because this was an experience for my father, my mother needed a lot of support so for those reasons I got pulled in and was the main support for both of them.'(Ledwidge 2010, p. 132).

Finding 31: Being adept at hospital language: the RN-on-standby understood 'hospital talk' and could interpret it for the family (C).

Illustration: 'The rest of the family needed me to interpret the language that the doctors and nurses were using – the staff could not seem to explain anything easily in layman's terms – thank god I could or confusion would have been greater. [My brother] was listening and being very polite to the doctors and nurses and then as they'd walk out the room sometimes he'd cross his eyes and say 'what the heck was that?' (Ledwidge 2010, p. 151).

Finding 32: Keeping it real: providing reality grounding: at times, participants spoke up to correct the family's misguided ideas about the parent's prognosis or expectations of improvement, and this sometimes challenged FMs who were in denial or dramatically altered or shattered the family's hopes of the parent's recovery, and at times resulted in conflict between the participant and FMs (C).

Illustration: 'I just very quietly would say don't get your hopes up too high just expect that things aren't going to be good. But just very quietly and comfortingly really... because... I knew that if I were to say yes she'd be ok then they'd literally take my word for it and it would have been devastating for them to have discovered that she wasn't going to be ok. And because they trust my word so much I couldn't pretend that things would be ok but at the same time I had to be very gentle and not direct and really well I'm sorry this is it sort of thing. So just tried to soften it by saying look don't get your hopes up too much just try to think the worst because then that way if something else happens well it's a bonus.' (Ledwidge 2010, p. 153).

Finding 33: Gaining information and seeking meaning: nurse-FMs intentionally built relationships to facilitate acquisition of detailed information and explanation of the meaning of this information (U).

Illustration: 'I was insisting on seeing every blood test, to know every vital sign. The nurses were wonderful. They gave me a short course on all the new technology in the ICU. They interacted with me knowing I was a nurse and not an average daughter sitting at the bedside.' (Salmond 2011, p. 15).

Finding 34: Required to be 'in-charge': outwardly, they wore a mask so that they appeared in control (U).

Illustration: 'Oh my God, it was the scariest time of my life. But I couldn't, I wouldn't let them [family members] know how concerned I was. They looked to me for their hope and I did not want to diminish that.' (Salmond 2011, p. 14).

Synthesised finding 5: Intense impact on experience

The experience influences the healthcare professional's personal state and their clinical practice. The fifth synthesis contains six findings (two U and four C), and two categories fall under this synthesised finding. Healthcare professionals, as significant others, feel an additional impact on them personally because of their professional knowledge and understanding and this is mainly negative. Conversely, there are some who feel that the experience of having a love one admitted to an acute care facility has a positive impact on their own practice.

Category 9: The impact on their personal wellbeing is amplified because of their professional identity. This category provides evidence from healthcare professionals as FMs who experienced a negative impact and emotional imbalance in their personal life when an ill loved one was admitted in an acute care hospital. Many felt that this impact was greater due to being a healthcare professional. The five findings allocated to this category were extracted from five studies.

Finding 35: Personal impact of child's hospitalisation: describing overall unpleasant experiences (C).

Illustration: 'he [son] couldn't cry because... of the tube in his throat... it was heart-breaking, and... I was in tears, it was horrible.' (Lines, Mannix & Giles 2015, p. 15).

Finding 36: Specialised knowledge amplifying emotions: the impact of nurse-FMs specialised knowledge on their emotional state (C).

Illustration: 'Just that situation of being emotionally involved, and trying to make decisions on behalf of the family. [It was] very difficult to be professional and play RN professional role... The knowledge and experience is still there — but the emotion is stronger I think — that's what I found difficult. Regardless of my knowledge it was very hard to be on the other side of the care... I was not scared by the ventilators, could help with suction etc. but it was my dad on that bed and it scared the hell out of me.' (Giles & Williamson 2015, p.9).

Finding 37: A nurse's nightmare describes unexpected intense emotions experienced by Intensive Care Unit (ICU) nurses when an FM is admitted, critically ill, to an ICU (C).

Illustration: '…I know that feeling of utter helplessness, it's that fear, it's that fear that is so persuasive... I think you underestimate the absolute fear that you're actually related to everything…' (McNamara 2007, p. 26).

Finding 38: Heightened emotional turmoil: they pictured different scenarios of what might happen and what might go wrong as they dealt with the present and projected ahead to 'what ifs' (C).

Illustration: 'At times it was like no matter what they said to me, I could not feel comfortable and confident that everything was going to work out. I kept thinking of the 'what ifs...' and kept wishing I did not know anything so I could just go in there and sit by the bedside and just be supportive. Knowing made it much harder.' (Salmond 2011, p. 14).

Finding 39: Quality of life: as a consequence of caring for their FM, they had experienced a negative impact on their quality of life (U).

Illustration: 'He never made me feel bad for it, but you're trying to please everyone, you're trying to give everyone a bit of you and you can't. Our own needs got really pushed down to the bottom of the needs of others.' (Mills & Aubeeluck 2006, p. 161).

Category 10: The experiences of having an ill loved one can have a positive impact on their professional practice.

This category demonstrates the positive impact that healthcare professionals as FMs felt when they gained better insight through their experiences when an FM was admitted to the hospital. One finding, extracted from one study, was in this category.

Finding 40: Gaining deeper insight and new meaning: the insights have also provided their practice with new meaning (U).

Illustration: '… I would regard it as probably quite a pivotal turning point for me. I have started to maybe question things a lot more … I do a far better family handover … I have a deeper understanding of relatives and it has changed my reaction to them quite a bit. It was a huge eye opener to me just… seeing the way things happened and seeing it from the other side…' (McNamara 2007, p. 35).

Confidence in meta-aggregated findings

To develop confidence in meta-aggregative qualitative synthesised findings, a ConQual approach was undertaken in line with methodology of Munn et al. (2014). The ConQual approach calls for a special methodological group assessment to generate a qualitative summary of findings table and to grade findings using specific criteria related to the type of data, level of dependability and credibility. Recently, the JBI has adopted the ConQual summary findings approach as a part of the qualitative systematic review for establishing confidence in synthesised findings. The five synthesised findings of the ConQual summary findings were graded as 'moderate' (Table 3).

Table 3: ConQual summary findings

Systematic review title: Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review **Population: Registered nurses and physicians who reported their experience as a significant other when a relative was admitted to an acute care facility** **Phenomena of interest: The experience of healthcare professionals when a significant other is admitted to an acute care facility** **Context: Research conducted in any acute care setting**					
Synthesised Finding	Type of research	Dependability	Credibility	ConQual Score	Comments
Privileged knowledge	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Exploratory approach • Hermeneutic phenomenology	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Unavoidable dilemma as a consequence of dual identity	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Hermeneutic phenomenology • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Being a protector is imperative	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Family expectations are inevitable	• Descriptive approach • Descriptive interpretive approach • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Intense impact from the experience	• Exploratory approach • Hermeneutic phenomenology • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings

Conclusion

This chapter presents results of a qualitative systematic review that identified seven studies that addressed the aim of this review: the experiences of healthcare professionals when their significant others have been admitted to an acute care hospital. After using the systematic search strategy and meeting the inclusion criteria following critical appraisal assessment, these studies were included. Among the seven studies, 40 findings were extracted and then grouped to create ten categories; furthermore, five synthesised findings were derived, representing a variety of healthcare professionals' experiences. In addition, these studies were assessed using the ConQual approach to provide confidence in the qualitative synthesised findings, which were graded at the 'moderate' level in terms of dependability and credibility. The following chapters discuss the meta-synthesis findings in detail.

Chapter Six: Discussion

Introduction

The question for this review is 'What are the lived experiences of healthcare professionals as significant others to hospitalised loved ones in an acute care hospital?' This chapter provides comprehensive discussion of synthesised findings identified in the review and considers how these findings align with related literature. In addition, the following discussions outline limitations of the review, implications for practice and the need for further research. Finally, this chapter summarises conclusions drawn from this study.

Synthesis of mainfindings

The seven studies included in the meta-synthesis resulted in 40 findings which were grouped into 10 categories and five synthesised findings. The findings were categorised under the following headings: privileged knowledge, unavoidable dilemmas as a consequence of dual identity, the need to act as a protector, inevitable family expectations, and the intense impact of the experience. These findings greatly aided the understanding of experiences of healthcare professionals when their ill or injured loved ones are hospitalised in acute care settings. For any individual, the experience of having a significant other with an acute illness can be an anxious or even a distressing experience. When that individual is a health professional, there is added complexity to the experience. This complexity arises from medical knowledge health professionals possess. This privileged knowledge is fundamental to the experience and gives the healthcare professional a different perspective of themselves and the part they play in care being provided to their significant other. As a consequence, the health professional is drawn to consider that the dual identity of being a relative and a health professional brings an unavoidable dilemma. In addition, their privileged knowledge brings inevitable expectations from other FMs but also their own expectations of using their knowledge to protect their loved one. Consequently, these experiences have an intense impact on healthcare professionals both personally and potentially on their own practice. This interlinking of synthesised findings of this review is presented in Figure 2 and represents the complexity of the phenomenon of a health professional with a significant other who is an acutely ill patient.

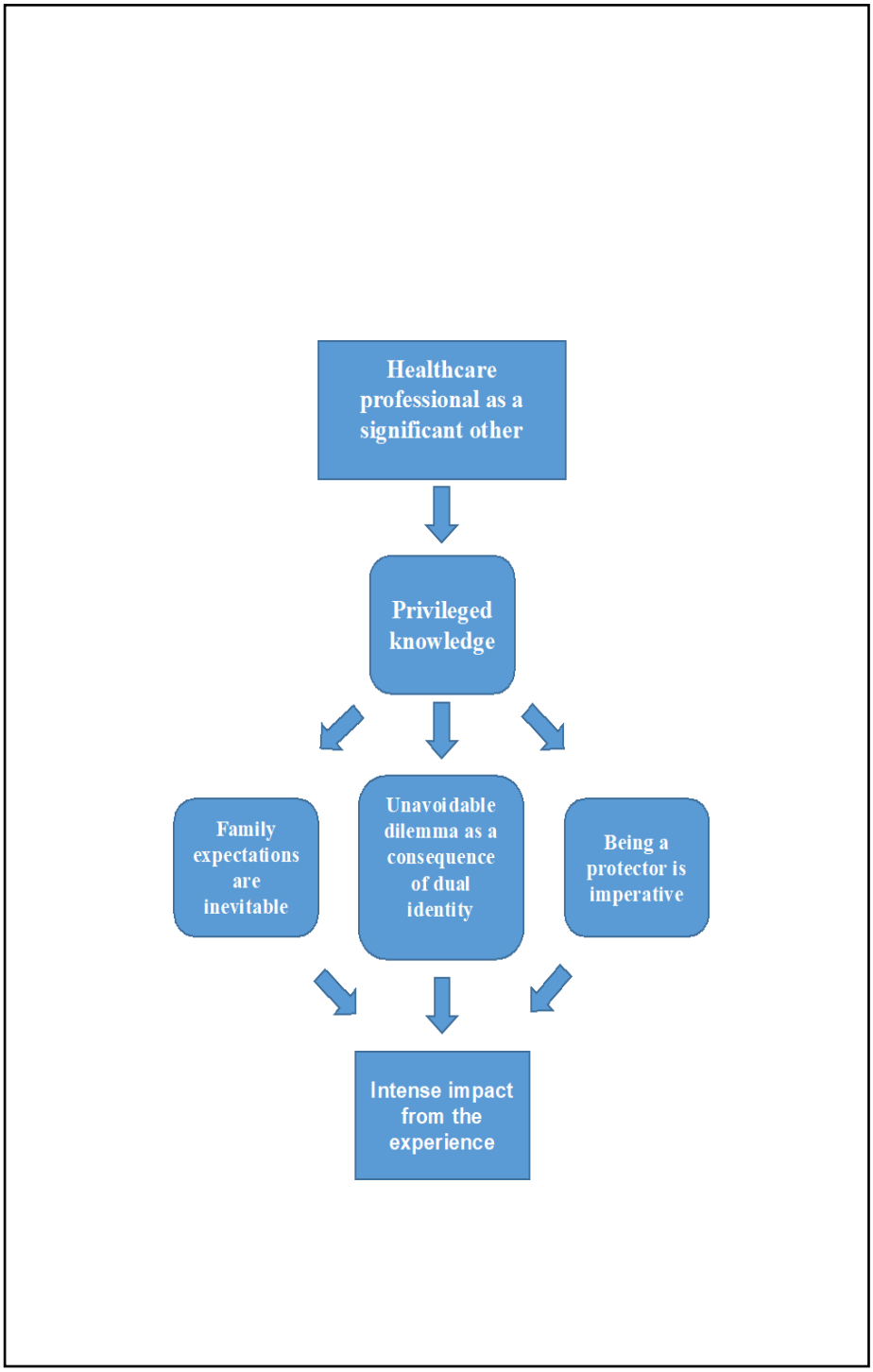

Figure 2: Model depicting the experiences of healthcare professionals as significant others to hospitalised loved ones in acute care settings and the impact from the experience.

The first synthesised finding addresses how fundamental the privileged knowledge held by healthcare professionals was when a FM was an acutely ill patient. This knowledge related to clinical aspects of care and understanding of the health system where that care was provided. Two categories were synthesised to develop synthesis finding one.

In category one, the health professionals considered that this additional knowledge was central to their experiences when a loved one was ill. They believed that there were benefits of having that knowledge

because they had a better understanding about their relatives' condition and it was much easier to navigate the system and gain access to information that would not be available to a layperson. In addition, they wanted their specialised knowledge acknowledged by staff and that it should result in more in-depth explanation about what was happening. 'We should be given more time for explanation because we need more depth and have more questions than most other people who would simply accept what was going on and the treatment offered' (Giles & Williamson 2015, p. 8). Other studies have reported that all FMs needed was to receive explicit information about their loved one (Eggenberger & Nelms 2007; Linnarsson, Bubini & Perseius 2010; Olivet & Harris 1991). The findings of this review indicate that health professionals felt they could understand more detailed information and therefore this should be given to them (Carlsson et al. 2016; Lines, Mannix & Giles 2015). Health professionals also wanted recognition that, depending on the circumstance, there might be limits to their knowledge particularly where care did not relate to their own specialty (Lines, Mannix & Giles 2015). Regardless of whether they had a specific specialist knowledge, they still felt they were better equipped to evaluate the care being given in comparison to general public-FMs.

In category two, the findings highlight that healthcare professionals used their clinical knowledge specifically to judge care provided to their ill loved ones. Healthcare professionals' possessing specialised knowledge resulted in certain expectations of staff to provide a quality of care, but these needs were not often met. 'You know the holes in the system, you know everything that could've gone wrong, did go wrong and I felt I just, I fought his corner constantly' (Mills & Aubeeluck 2006, p. 162). Given that the knowledge possessed by healthcare professionals is central to this experience, the following three synthesised findings address how having this knowledge relates to expectations of both healthcare professionals and others, including FMs and staff caring for their loved one.

The second synthesised finding (healthcare professionals experience being trapped between personal and professional identities) emphasises that having a dual identity not only became blurred, but also caused role conflict and identity confusion. Similarly, this finding is also identified in Giles and Hall (2014) review that suggests professional and personal roles can be extremely unclear. Three categories were synthesised to develop synthesis finding two.

In category one, findings highlight that healthcare professionals as FMs experienced tension between professional and personal roles that led to role conflict. The participants felt they were torn between two identities. If they were seen by staff as being a healthcare professional, then they were not then being treated as a son or daughter. This could lead to a lack of emotional support from staff. 'Yet people forget that we are human too and when it is your family it is different, often you can't shut off as easily from the emotions as you do when you are at work' (Giles & Williamson 2015, p. 9). Traditionally, the FMs' role is supporting and comforting their ill loved one (Band, Barrowclough & Wearden 2014; Gavaghan & Carroll 2002; Vandall-Walker, Jensen & Oberle 2007). The healthcare professionals saw the need to return to that role but recognised they needed to deal with their professional role first. 'They were there when I interacted with the physician requesting that care be changed. It made me feel safe. I could act like her mother for a while instead of the nurse in charge' (Salmond 2011, p. 16).

In category two, findings identify the frustration occurring among healthcare professionals as FMs when making the decision whether or not to disclose their professional identity. They could see both advantages

and disadvantages of disclosing their professional status. On the one hand, participants felt that if they did disclose their professional identity, they may be pressured to undertake more direct care of their relative (Ledwidge 2010). However, on the other hand, disclosure could bring added authority and more power to influence the care of their ill loved one. 'After 2 days of this it was time to let staff know. They even referred Mum to the stomal therapist. She ordered appropriate bags that didn't leak and Mum's legs were always elevated. Until they found out that I was an RN the staff had told my aunty that it was normal for stoma bags to leak' (Ledwidge 2010, p. 116).

In category three, the finding recognises a challenge occurring among healthcare professionals as significant others in relation to personal and professional boundaries. The participants conveyed that they were acutely aware of personal and professional boundaries when an ill loved one was hospitalised. They needed to consider when to step in, step out or even over-step these boundaries. In some cases, they themselves felt compelled to take on the professional role to intervene on their relative's behalf or even on behalf of other patients (Giles & Williamson 2015). On other occasions, they felt pressured by staff to undertake tasks that they felt would not be expected of a layperson FM. 'Dad was a very, very private person and he would have hated me doing that…and it's just something that I think about now and again and I just wished I hadn't done it because he wouldn't have liked me doing it. I think she should have asked for one of the other nurses to come and help her not me' (Ledwidge 2010).

In the third synthesised finding, the professional identity of healthcare professionals and their specialist knowledge make it imperative that they take on the role of protector of their loved one, being a protector is imperative. As expected, this finding is similar to the Giles and Hall (2014) review that states that nurse-FMs act as a protector to their ill loved one. Two categories were synthesised to develop synthesis finding three.

In category one, findings indicate that healthcare professionals cannot escape the obligation to watch over their ill loved ones' care. 'The weeks during his stay when his care was appalling were very difficult as I did not want to be over reacting but could not tolerate what was happening' (Giles & Williamson 2015, p. 8). The participants feel the need to oversee the quality of care provided because of their clinical expertise and professional role.

In category two, the findings address that when an ill loved one is admitted to a hospital, healthcare professionals as FMs are bound to be an advocate. 'I came in in the morning. They told me he was unstable. I started asking questions, his blood gas, his pH was like 7.0. I was like 'what', he's going to code. You need to do this; you need to do that…I wasn't trying to manage the situation but I knew what needed to be done and I had to be sure everything was being done' (Salmond 2011, p. 16). Participants described the necessity to advocate for their ill loved one using their clinical knowledge to interpret clinical information. In general, it can be expected that a layperson would act as an advocate for their ill relative, but the healthcare professionals understood that their knowledge put them into a unique position that could not be avoided.

In the fourth synthesised finding, the uncomfortably high expectations of other FMs on healthcare professional FMs is always apparent, family expectations are inevitable. When an ill loved one is admitted, the family expects the relative who is a healthcare professional to take the lead and be the spokesperson for the family. Correspondingly, this finding is also acknowledged in the Giles and Hall (2014) review that

there are undeniable expectations on nurse-FMs by other FMs. One category was synthesised to develop synthesis finding four.

This category states that there is considerable pressure faced by an FM who is a healthcare professional. When an ill loved one was hospitalised, participants expressed feelings of tension in becoming accountable for all parts of care and dealing with other FMs' needs. They took the obligation to convey medical information to other FMs such as translating medical terminology, discussing the care provided and answering questions relating to the loved ones' illness. Participants described themselves as 'in-charge' or 'in control' in watching over the care delivered to their ill FM. 'Oh my God, it was the scariest time of my life. But I couldn't, I wouldn't let them [family members] know how concerned I was. They looked to me for their hope and I did not want to diminish that' (Salmond 2011, p. 14).

In the fifth synthesised finding, intense impact from the experience, the healthcare professionals' clinical practice and personal state are fully influenced by their experience. Obviously, healthcare professionals as significant others experience an extreme impact personally and professionally due to their clinical expertise and professional identity. In our review, this synthesis was an important component of the participants' experience and was frequently described by healthcare professionals, in contrast with the Giles and Hall (2014) review where it was not noted. Two categories were synthesised to develop synthesis finding five.

In category one, the findings of this review stressed that the personal impact on healthcare professionals as significant others was amplified because of their professional identity (Giles & Williamson 2015; McNamara 2007; Salmond 2011). A qualitative systematic review by Linnarsson, Bubini and Perseius (2010) described the experiences and needs of [lay] FMs to critically ill patients in an acute care setting. One of the major findings of that review was that FMs experienced emotional turmoil: a 'roller coaster' of anxiety, distress and fear (Linnarsson, Bubini & Perseius 2010).

While it is logical that there will be a significant impact on healthcare professionals with an acutely ill loved one, it is their professional knowledge and identity that participants felt made the impact more intense. 'At times it was like no matter what they said to me, I could not feel comfortable and confident that everything was going to work out. I kept thinking of the 'what ifs' and kept wishing I did not know anything so I could just go in there and sit by the bedside and just be supportive. Knowing made it much harder' (Salmond 2011, p. 14).

In category two, a novel finding was the impact for healthcare professionals as significant others on their own professional practice. Participants articulated that having an ill FM admitted their clinical practice made them more aware and provided a deeper insight into how FMs are treated. 'I do a far better family handover…I have a deeper understanding of relatives and it has changed my reaction to them quite a bit. It was a huge eye opener to me just…seeing the way things happened and seeing it from the other side…' (McNamara 2007, p. 13). They emphasised a significant change in their professional practice toward FMs of patients they were caring for because of their past experiences when a loved one was ill.

Limitations to thereview

The aim of this qualitative systematic review was to identify the best available evidence on experiences of healthcare professionals when their significant others have been admitted to an acute care hospital. There

are a number of potential limitations of this qualitative systematic review. It was decided that 'significant other' was the term to be used for the review question and objectives. It was quickly identified that there are many alternative terms such as 'family member' or 'relative' that are used in different ways in different studies. While alternative terms were included in the logic grid for the search of each database, it may be possible that additional terms could be used and as a result some studies may have been missed. Second, this review aimed to include studies of both RNs and physicians. The included studies had a high number of RN participants rather than physicians, and this should be considered when reviewing the findings. In addition, limitations relate to restriction of the search strategy to English language studies only as there was no capacity for translation of other languages, and clearly the experience would not be limited to countries where English is the dominant language.

Implications for practice

The current qualitative systematic review provides evidence in relation to the experience of healthcare professionals when a significant other is admitted in an acute care setting. The needs and expectations of all FMs should be considered by staff, but when the FM is a healthcare professional there are some additional considerations. The knowledge that a healthcare professional possesses can be advantageous because they may have a deeper and more detailed understanding of the patient's history and condition, but this must not be assumed. Healthcare professionals may or may not want to disclose their professional identity to staff, and this should be respected. Depending on the context, relatives of any kind can play a role in providing some care to their loved one, but when health professionals are involved staff should be conscious of the boundaries between personal and professional care and ensure that care provided by the health professional FM is negotiated and appropriate. Finally, when dealing with an FM who is a healthcare professional staff should be aware that the knowledge that person possesses may amplify the impact of the situation. These recommendations have been assessed based on the JBI grades of recommendation: Grade A (Joanna Briggs Institute 2014).

Implications for research

The current review identified that research has been particularly focused on the experience of nurses and in particular RNs. A broader population sample should be considered to include clinicians from other disciplines. It would also be useful to consider the experience of staff when dealing with healthcare professional FMs. It is noted that most participants of included research were female. Further research exploring the experiences of male healthcare professionals in this situation may promote a more gender-balanced understanding. Finally, in this review, participants from one study reported the impact of the phenomenon on their professional practice. Therefore, further research is needed to explore how the experiences may influence professional practice.

This review offered details of article searches performed and which articles met inclusion criteria. In subsequent meta-synthesis of identified studies, seven were found to meet the inclusion criteria and were consequently included in the review. This chapter explained the findings of this review and stressed areas that have been studied. The following chapters include a conclusion chapter to this review and highlight future research into this phenomenon.

Conclusion

The qualitative systematic evidence produced a synthesis of a number of moderate quality studies that explain the experiences of healthcare professionals as significant others to hospitalised loved ones in acute care settings. The review has acknowledged that being a healthcare professional as significant other is a comprehensive and difficult experience, with connecting issues that are influenced primarily by expert knowledge and professional role. While commencing this review it was found that between the periods of 2006 to 2016 there were limited studies undertaken and published on the subject, with only seven studies meeting the inclusion criteria and being reported. Five main themes were identified: privileged knowledge, dual identity, being a protector, family expectation, and intense impact from the experience.

As a result of the systematic review, information gained highlights essential knowledge regarding the experiences of healthcare professionals as FMs of patients. In particular, uniqueness of the experience for healthcare professionals was connected with having clinical knowledge and professional identity within the healthcare service. Although the review discusses some of the various activities and role functions of healthcare professionals as significant others, it examines the issue more deeply to uncover the complex and personal side of the experience in this specific situation. Healthcare professionals and hospital administrative support staff are required to support these healthcare professionals as FMs, otherwise they appear to be at great risk of burnout due to overwhelming demands and increased pressure to fill gaps in an increasingly burdened healthcare system. The review has also provided understanding regarding the similarities and differences of experiences between the layman and healthcare professional as significant other when a loved one is admitted.

Knowledge generated by this review facilitated development of a survey study (Study 2) which examines the perception of nurses as significant others to patients admitted to an acute care hospital. In addition, to strengthen the evidence-base for understanding the lived experience of staff when dealing with healthcare professional FMs, Study 3 is a hermeneutical phenomenological study that evaluates these experiences. It is likely that continuing research is being undertaken in regards to this area.

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Appendices List

Appendix I: Searchstrategy

Database	Search Terms
Pubmed On 02/02/16 Items 2015	(((((Health Personnel[mh] OR Professional-Family Relations[mh] OR Nursing[mh] OR Nurs*[tiab] OR Nurse Family member*[tiab] OR Physician*[tiab] OR Doctor*[tiab] OR Physician Family member*[tiab])) AND (Family[mh] OR Family Relations[mh] OR Caregiver[mh] OR Relative*[tiab] OR Partner*[tiab] OR Wife[tiab] OR wives[tiab] OR Husband*[tiab] OR Family member*[tiab] OR Loved one[tiab] OR Mum[tiab] OR Father*[tiab] OR Sibling*[tiab] OR Significant other*[tiab])) AND (Attitude of Health Personnel[mh] OR Conflict[mh] OR Dual role*[tiab] OR Role conflict*[tiab] OR Conflict[tw] OR Experience*[tiab] OR Physician's role*[mh] OR Nursing role*[tiab])) AND (Acute illness*[tiab] OR Critical Care Nursing[mh] OR Critical illness[tiab] OR Acute care[tw] OR Critical care[tw] OR Intensive care[tw] OR Health care[tiab])) AND (ethnograph*[tw] OR interpretive study[tw] OR phenomenolog*[tiab] OR grounded theory[tiab] OR thematic analysis[tiab] OR focus group[tiab] OR hermeneutic*[tiab] OR qualitative research[mh:exp] OR qualitative study[tw] OR qualitative[tiab] OR interview[tw] OR lived experience[tw] OR narrative[tiab] OR mixed method[tw] OR interpretive synthesis[tw] OR meta synthesis[tw] OR key informant[tiab])
	[mh]= mesh heading, [tiab]=title and abstract, [tw]=txt word
Database	**Search Terms**
Embase On 02/02/16 Items 1522	(nurse*:de,ab,ti OR physician*:de,ab,ti OR doctor*:de,ab,ti OR 'physician family member':ab,ti OR 'physician family members':ab,ti OR 'nurse family member':ab,ti OR 'nurse family members':ab,ti AND ('family'/exp OR caregivers:ab,ti OR relative*:de,ab,ti OR 'family member':ab,ti OR 'family members':ab,ti OR 'loved one':ab,ti OR 'significant other':de,ab,ti OR 'significant others':de,ab,ti) AND ('conflict'/exp OR 'psychological aspect'/exp OR 'dual role':ab,ti OR 'dual roles':ab,ti OR 'role conflict':de,ab,ti OR conflict*:ab) AND ('acute illness':ab,ti OR 'acute illnesses':ab,ti OR 'intensive care':de,ab,ti OR 'critical illness':de,ab,ti OR 'critical illnessess':ab,ti OR 'acute care':ab,ti OR 'life threatening illness':ab OR 'health care':ab) AND ('qualitative research':de,ab,ti OR 'grounded theory':de,ab,ti OR phenomenology:de,ab,ti OR ethnography:de,ab,ti OR 'action research':de,ab,ti OR 'mixed methods':ab,ti OR narrative*:de,ab,ti OR experience*:ab,ti OR interview*:ab,ti OR 'discourse analysis':ab,ti OR 'focus group':ab,ti OR 'focus groups':ab,ti OR descriptions:ab,ti OR opinions:ab,ti OR attitude:ab,ti OR attitudes:ab,ti OR descriptive:ab,ti)
	exp=explode, ab=abstract, ti=title, de=index term
Database	**Search Terms**
CINAHL On 02/02/16 Items 1896	(MH Health Personnel OR MH Professional-Family Relations OR MM Professional-Family Relations OR MH Nurse* OR TI Nurse family member* OR AB Nurse family member* OR TI Physician* OR AB Physician* OR TI Doctor* OR AB Doctor* OR TI Physician family member* OR AB Physician family member*) AND (MH Family+ OR MH Family Relations OR TI Families OR AB Families OR TI Relative* OR AB Relative* OR TI Partner* OR AB Partner OR TI Wife* OR AB Wife* OR TI Husband OR AB Husband OR TI Family member* OR AB Family member* OR TI Loved one OR AB Loved one* OR TI Mum OR AB Mum OR TI Father* OR AB Father* OR TI

	Sibling* OR AB Sibling* OR TI Significant other* OR AB Significant other* OR MM Caregivers) AND (MH Attitude of Health Personnel OR MH Conflict OR TI Dual role* OR AB Dual Role* OR TI Role conflict* OR AB Role Conflict* OR TX Conflict* OR TI Experience* OR AB Experience* OR TI Physician's role* OR AB Physician's role* OR MH Nursing role) AND (MH Inpatients OR MH Critical Care Nursing OR TI Critical illness OR AB Critical illness OR AB Acute care OR TI Acute care OR TI Critical care OR AB Intensive care OR TI Acute illness* OR AB Acute illness* OR TI Critical condition OR AB Life-threatening illness OR TI Healthcare OR AB Healthcare) AND MH Qualitative studies+ OR TI Qualitative OR AB Qualitative OR MM life experience* OR TI experience* OR TI 'Mixed-methods' OR AB 'Mixed- Methods' OR TI 'mixed methods' OR AB 'mixed methods' OR TI narrative* OR AB narrative*OR TI interview* OR AB interview* OR TI 'discourse analysis' OR AB 'discourse analysis' OR TI " focus group*" OR AB "focus group*" OR TI descript* OR AB descript* OR TI opinion* OR AB opinion*OR TI attitude* OR AB attitude* OR TI phenomenol* OR AB phenomenol* OR TI ethnog* OR AB ethnog* OR TI "action research" OR AB "action research" OR TI "grounded theory" OR AB "grounded theory" OR AB "key informant")
	MH= main heading, TI=title, AB= abstract
Database	**Search Terms**
PsychINFO On 02/02/16 Items 83	Medical Personnel.mp OR Nurse.mp OR Physicians.mp OR Doctor.ti OR Doctor.ab OR Doctors.ti OR Doctors.ab AND Family.mp OR Family members.mp OR Caregivers.mp OR Relative*.ti OR Relative*.ab OR Loved one.ti OR Loved one.ab OR Significant other.mp AND Health Personnel Attitude.mp OR professional identity.mp OR Conflict.mp OR Role conflicts.mp OR Life Experience.mp OR Role*.ti OR Role*.ab AND Intensive care.mp OR Chronic illness.mp OR Acute care.ab OR Acute care.ti OR Critical care.ab OR Critical care.ti OR Acute illness.ab OR Acute illness.ti OR Critical condition.ab OR Critical condition.ti OR Life-threatening illness.ab OR Healthcare.ti OR Healthcare.ab AND Qualitative.ti OR Qualitative.ab OR Qualitative Research.mp OR Phenomenology.mp OR Ethnography.mp OR Narrative.ti OR Narrative.ab
	mp=mapping Alias, ti=title, ab=abstract
Database	**Search Terms**
Trove On 02/02/16 Items 84	(Nurse AND Family member AND Experience AND Health care)
Limited	**Thesis**

Appendix II: JBI-QARI Appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐ Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

_____

_____

_____

Appendix III: JBI-QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____

Journal _____ Record Number _____

Study Description

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete Yes ☐ No ☐

Appendix IV: Excluded articles

1. Fulbrook, P, Allan, D, Carroll, S & Dawson, D 1999, 'On the receiving end: experiences of being a relative in critical care. Part 1', Nursing in Critical Care, vol. 4, pp. 138-145.

2. Fulbrook, P, Buckley, P, Mills, C & Smith, G 1999, 'On the receiving end: experiences of being a relative in critical care. Part 2', Nursing in Critical Care, vol. 4, pp. 179-185.

3. Fulbrook, P, Creasey, J, Langford, D & Manley, K 1999, 'On the receiving end: experiences of being a relative in critical care. Part 3', Nursing in Critical Care, vol. 4, pp. 222-230.

Reason for exclusion: The study did not use a rigorous qualitative design. The researchers did not report the process undertaken to analyse the data. Findings from this single case study were presented as professional commentary.

Appendix V: Characteristics of included studies

Study	Methodology	Method	Phenomena of interest	Participants	Family member who were patients	Family member admitted to participant's own facility	Reasons of admissions (diagnosis)
Carlsson, Carlsson (2016) Sweden	Phenomenographic approach	Semi-structured interview	To describe how healthcare professionals understand the role of having a healthcare professional and family member of a patient admitted to a hospital.	Healthcare professionals (registered nurse, physician, assistant nurse, midwife, social officer, occupational therapist, radiographer and biomedical technician)	Spouse/fiancé Daughter/son Mother Father-in-law/ grandmother/granddaughter	Healthcare professionals' own workplace, as mentioned by participants.	Cancer, stroke, frail elderly, gastroenterology/kidney, infection/allergy, orthopaedic/surgery/ gynecology, cardiology
Giles and Williamson (2015) Australia	Descriptive approach	Online Questionnaire	To understand and interpret the experiences of nurse-family members when a family member or loved one is hospitalised.	Registered Nurses	Spouse/partner Daughter Mother Sibling Niece Daughter-in-law granddaughter	Registered Nurses' own workplace, as stated in the study.	Not stated in the study

Ledwidge (2010) Australia	Descriptive approach	Interviews and open-ended questions	To describe and interpret registered nurses' experiences as relatives during their parent's hospitalisation.	Registered Nurses Ages 40-65 yrs	Mother Father	Registered Nurses' own workplace, as stated in the study.	Cancer, stroke, cardiology, infection
Lines, Mannix (2015) Australia	Exploratory qualitative approach	Qualitative multiple case study design	To explore the experience of nurse-parents whose children were hospitalised	Registered Nurses Female	Children	Not stated in the study	Acute illness
McNamara (2007) New Zealand	Hermeneutic phenomenology approach	Semi-structured interview	The meaning of the experience for Intensive Care Unit nurses when a family member is critically ill	Registered Nurse	Brother Sister Mother Father	Registered Nurses' own workplace, as stated in the study.	Critically ill
Mills and Aubeeluck (2006) United Kingdom	Hermeneutic phenomenology approach	Semi-structured interview	To explore the information needs, support systems available, and the impact that this experience has upon the nurse's quality of life.	Senior Nurses	Not stated in the study	Not stated in the study	Life-threatening illness

Salmond (2011) United States of America	Grounded theory	In-depth, open-ended, loosely structured interviews	To explore the experience of being a nurse-family member of an adult relative hospitalised for a critical illness.	Nurse	Wife Daughter Mother Grandmother Sister Niece Daughter-in-law	Nurses' own workplace, as stated in the study.	Heart disease Cancer Trauma

Appendix VI: Synthesis finding

Finding	Category	Synthesised 1
The informed bystander: those benefits that they perceived to be related to their professional experience were; knowing the healthcare system and how to navigate the system, possessing knowledge that facilitated their understanding of the patient's illness and the communication with staff about the patient's test results and medical state, as well as about what plans were made for the patient. (C)	Having expert knowledge is central to the experience when a loved one is ill.	**Privileged knowledge:** Healthcare professionals are able to use their privileged knowledge in the provision of ill family members and evaluate the care provided.
Wanting acknowledgement of specialised knowledge: nurse-FMs believed their specialised knowledge made them different to general-public-FMs, and wanted their knowledge acknowledged and respected by staff. (U)		
Wanting specialised communication: Nurse-FMs highlighted the need for specialised communication that took into consideration previous knowledge and skills. (U)		
Specialised knowledge: Nurse-Parents found themselves in a unique position where they possessed not only an intimate knowledge of their child's personality, idiosyncrasies and medical history, but also considerable nursing knowledge and expertise. However, they were quick to acknowledge the limits of their knowledge, which was generally linked to their clinical specialty. (C)		
Knowing and not knowing: Alongside knowing, not knowing also caused feelings of anxiety and stress. Not knowing what was happening while sitting in the waiting room and not having answers for relatives created feelings of frustration and powerlessness. (C)		
Evaluating care: Nurse-Parents were aware of general standards of care expected in the hospital setting and often compared their child's care to the nursing care they would ordinarily provide. (U)	Healthcare professionals as relatives use their specialist knowledge to judge the care provided.	
Expertly observing, detecting and protecting: being vigilant served a number of purposes. (C)		
Disempowerment: All had experienced some dissatisfaction in the delivery of care and of the responses to their own needs. (C)		

Unequivocal (U) and Credible (C)

Finding	Category	Synthesised 2
Rather be treated as a lay son/daughter: staff would treat them differently and that they would be disadvantaged by disclosing their RN status so they preferred to be treated as a lay son or daughter rather than as a RN. (U)	Healthcare professionals as family members experience role conflict moving between two identities.	**Unavoidable dilemma as a consequence of dual identity:** Healthcare professionals experience being trapped in the middle between personal and professional identities.
Feeling torn: The nurse as relative cannot simply switch off the nurse in her being. Inextricable connections mean that she cannot act as a detached family member. (C)		
Personal and professional boundaries: as a consequence of being a nurse and family member, they had to deal with the difficult issue of boundaries. (C)		
Emotion vs. intellect: they stressed the importance of staff recognising both the FM-self and the nurse-self to provide effective care and support. (U)		
Resuming family roles: Development of trust was pivotal to managing the challenge of resuming family roles. (C)		
Dual role conflicts: Nurse-FMs experienced a conflict between wanting to hide and wanting to reveal their RN status. (C)	The decision to disclose their professional identity or not must be considered by the healthcare professional.	
Disclosure unnecessary: participants did not generally want or expect to take over the nursing of their parent. They expected the hospital staff to nurse their parent. (U)		
Disclosing to be treated as a peer/colleague: advised staff of RN status in order to be recognised as a peer/colleague. (C)		
Disclosing to get action: the need to advise staff of their RN status in order to gain added power to intervene in a way that was as influential as possible and resulted in getting their parent the care and attention they needed. (C)		
The carer: the informants' descriptions focused on how they not only monitored the medical status of their loved ones and took over communication with ward staff as well as the coordination of care, but also that they were forced to take over much of the care, both in hospital and at home. (C)	Healthcare professionals are confronted by personal/	

Stepping in on numerous occasions to ensure their FM received adequate nursing care, believing their specialised knowledge and skills prevented significant deterioration in the patient's condition. (U)	professional boundaries.	
Expectations placed on self: nurse-FMs actively nursed both their own FM and other patients in the vicinity. (U)		
Staff expectations: nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general-public-FM. (U)		
Filling in gaps: over-stepping boundaries and gender differences: overstepped the usual child-parent boundaries and this intruded on the parent's privacy and led to feeling uncomfortable. (U)		

Unequivocal (U) and Credible (C)

Finding	Category	Synthesised 3
The supervisor: this way of understanding was focused on monitoring the patient's medical status, test results and nursing care while staying in the background. (C)	The need to watch over their ill-loved one is inescapable for healthcare professionals.	**Being a protector is imperative:** The professional identity of healthcare professionals and their specialist knowledge make it imperative that they take on the role of protector of their loved one.
Keeping watch and advocating: nurse-FMs felt compelled to watch over and advocate for their FM, fearful that care would deteriorate in their absence. (U)		
Surveillance and protection: Vigilant observation was the key to surveillance and protection. (U)		
The advocate: the informants who understood being a family member of a hospitalised patient as being an advocate of the patient. (C)	Healthcare professionals are compelled to be an advocate for their ill-loved one.	
Being the fixer and fixing: intervene in the management of care. (C)		
Advocating for: Advocacy occurred with or without collaboration; however patient and family needs were best served when collaboration existed. (C)		

Unequivocal (U) and Credible (C)

Finding	Category	Synthesised 4
Family member expectations: nurse-FMs also felt under considerable pressure from the patient and other family members to play a particular role. (U)	There is considerable pressure to be present for family when one is a healthcare professional.	**Family expectations are inevitable:** Healthcare professionals struggle to meet the uncomfortably high expectations from family members.
Leading and staying strong at any cost: being the eldest child was an important factor in relation to taking a leading role. (C)		
Being adept at hospital language: the RN-on-standby understood 'hospital talk' and could interpret it for the family. (C)		
Keeping it real: providing reality grounding: At times participants spoke up to correct the family's misguided ideas about the parent's prognosis or expectations of improvement and this sometimes challenged family members who were in denial, or dramatically altered or shattered the family's hopes of the parent's recovery, and at times resulted in conflict between the participant and family members. (U)		
Gaining information and seeking meaning: Nurse-family members intentionally built relationships in order to facilitate acquisition of detailed information and explanation of the meaning of this information. (U)		
Required to be 'in-charge': outwardly they wore a mask so that they appeared in control. (U)		

Unequivocal (U) and Credible (C)

Finding	Category	Synthesised 5
Personal impact of child's hospitalisation: describing overall unpleasant experiences. (C)	The impact on their personal being is amplified because of their professional identity.	**Intense impact from the experience:** The experience influences the healthcare professional's clinical practice and personal state.
Specialised knowledge amplifying emotions: the impact of nurse-FMs specialised knowledge on their emotional state. (C)		
A nurse's nightmare describes unexpected intense emotions experienced by ICU nurses when a family member is admitted, critically ill, to an ICU. (C)		
Heightened emotional turmoil: They pictured different scenarios of what might happen and what might go wrong as they dealt with the present and projected ahead to 'what ifs'. (C)		
Quality of life: as a consequence of caring for their family member, they had experienced a negative impact on their quality of life. (U)		
Gaining deeper insight and new meaning: The insights have also provided their practice with new meaning. (U)	The experiences of having an ill-loved one can have a positive impact on their professional practice.	

Unequivocal (U) and Credible (C)

SECTION 3: STUDY TWO

The opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital: A quantitative study

TABLE OF CONTENTS

Chapter One: Introduction

Introduction

The average age of the population is getting older, not only in Australia but worldwide. In 2015, the World Health Organization reported a rapid acceleration in growth of the global population (World Health Organization 2015). The Australian Institute of Health and Welfare reported that in 2014 3.4 million Australians were 65 years of age or older, and by 2064 it is predicted that this number will rise to 9.6 million, accounting for 23 percent of Australia's total population (Australian Institute of Health and Welfare 2014). Technological and medical advances such as new medications, may contribute to even greater longevity in individuals. Acute care hospitals will be especially important in medical education and health care as the population ages.

With more people needing care, there is possibly no more stressful time than when a loved one is admitted to an acute care setting. This may mean that increasingly some aspects of care will be delivered not only by nurses, but also by patients' family members. The terms family member, significant other, close relative, general family member and caregiver are all used interchangeably in the literature. For consistency throughout this chapter the term 'lay-family member' will be used with the understanding that there is no agreement regarding the specific definition of patients' family member (Auslander 2011). Traditionally, hands-on care for family members in many settings, not only at home but also in the hospital, is a norm. Lay-family member refers to a member of the family without a health care background, such as a mother, who may desire to be involved in her loved one's care, physically and emotionally. The need for a family member's presence alongside an ill loved one is well documented in the literature (Linnarsson, Bubini & Perseius 2010). Therefore, nurses must provide care for their patients while also supporting family members, effectively creating a complete environment of care where quality is achievable. However, when a nurse-family member has a relative admitted to an acute care hospital, the context is different.

Context of the study

When a nurse is a member of the family of someone admitted to an acute care setting may create certain challenges in meeting the needs of the patient and other family members. Researchers have explored the experiences of nurses who are also family members; they determined that these nurses' experiences are very different from the experiences of family members who are non-nurses. For example, Salmond (2011, p. 11) described her experiences as a nurse-family member when her daughter was critically ill as 'somewhat different that the typical family member as I am nurse'. While some nurses were in support of a nurse-family member receiving different care as compared to a lay-family member, other nurses excluded nurse-family members from the process of care (Salmond 2011).

Having an ill loved one in hospital is considered a unique experience for nurse-family members. It can raise some unique concerns for nurse-family members when a loved one is admitted, especially in terms of maintaining quality of care. Before beginning this study, a qualitative systematic review (Study 1) was undertaken and results generated rich information related to the experiences of health care professionals when their significant others were admitted to hospital (Sabyani et al. 2017). The decision to conduct a qualitative systematic review (Study 1) was partly based on the lack of quantitative studies to synthesise.

This study therefore addresses a clear gap in the literature. Recommendations identified from the review were used to guide development of this descriptive study. Detailed descriptions of nurses' experiences of having family members hospitalised in acute care hospitals were provided.

Purpose of thestudy

The purpose of this descriptive study was to explore the opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital and to identify contributing factors. It is expected that the outcome of this study will provide nurses with a better understanding of current information about the experiences of nurses when their relatives are hospitalised. This may be used within the health care system to influence clinical practice policy.

Research questions

The following question guided this research: 'What are the opinions of nurses regarding their experiences when their ill loved one is admitted to an acute care hospital?'

Objectives

The study's main objective was to determine the frequency of, and explore issues related to, the experiences of nurses whose family members had been admitted in acute care hospitals. The specific objectives were as follows:

- To determine the frequency of nurses having an ill loved one hospitalised.
- To investigate nurses' use of their specialised knowledge in provision of care.
- To investigate nurses' use of their specialised knowledge to evaluate the care provided.
- To explore any perceived role conflict between nurses' personal and professional identities.
- To increase understanding of roles that nurses take on when a loved one is admitted and the factors that influence these roles.
- To explore the dynamics of nurses' relationships with other family members in relation to the experience.
- To evaluate the impact on nurses' experiences on their personal well-being and their professional practice.
- To understand how nurses perceive their experiences to be different to those of a lay-family member.

Significance of thestudy

Having a member of the family who is a nurse in a relevant clinical area is a unique experience for both nursing staff and nurse-family member. However, hospital guidelines and protocols may identify a different set of concerns and expectations of nurses, guidelines which may restrict their professional roles in the care of their ill relatives. Increased awareness of these circumstances may help health care professionals make objective judgments regarding patient care. There has been a systematic review of the experiences of a nurse-family member, but the review was primarily concerned with family members in the critical care setting (Giles & Hall 2014). In addition, a qualitative systematic review of the experiences of health care

professionals when their significant others had been admitted to the hospital, made the recommendation to conduct a further study using a broader population sample in a different setting (Sabyani et al. 2017).

Therefore, this study is an important project for nursing as there is little research on how nurses experience having a family member hospitalised in acute care settings. Also, no previous study has focused on surveying the frequency of the experiences of nurses with family members hospitalised. Providing a picture of frequency and exploring issues relating to the experiences of nurses with family members hospitalised in acute care hospitals adds to current knowledge. Furthermore, the factors that structure these experiences were also explored. The outcome of this survey will hopefully provide nurses and policy makers with the foundation for overcoming obstacles surrounding these experiences and for improving the quality of care for people admitted to hospital. Therefore, a survey of nurses' experiences with having an ill loved one placed in an acute care setting needs to be conducted.

Assumptions

The assumptions of this project were identified as follows:

- There is a need to investigate the experiences of a nurse-family member when a loved one is hospitalised.
- The experience of being a family member is different for a nurse than for a lay-family member (non-nurse) because the social context in which nurses' experiences are situated influences their experiences as caregivers.
- Nurses experience pressure when negotiating their professional role while participating in the care of an ill loved one.

Definitions of terms

For the purpose of this project, the following keywords were defined:

- A lay-family member is an individual related by blood, law, culture or friendship. For the purpose of this project, the term 'family member' refers to the following: friend, wife, husband, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother, half-sister, stepbrother, stepsister, mother-in-law, father-in-law, daughter-in-law, son-in-law, aunt, uncle, niece, nephew and first cousins. This also includes any legally recognised variation to these relationships, such as de facto, adoptive, ex-nuptial relationships, same-sex relationships or changes resulting from separation/divorce (Department for Communities and Social Inclusion 2016).
- A significant other is an individual who is important in someone's life (Gavaghan and Carroll 2002).
- A nurse is a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country (International Council of Nurses 2015). In Australia, nurses are also designated as registered nurse, enrolled nurse, and nurse practitioner.
- A nurse-family member is a member of the family of the ill patient who is a nurse (Salmond 2011).

- An acute care hospital is an inpatient care facility that provides necessary treatment for a disease or severe episode of illness for a short period of time, with the goal of discharging patients as soon as they are stable, they may also offer out-patient services (Canadian Institute for Health Information 2013).

Structure of study

To expand our knowledge of the experiences of family members who are nurses when their loved one is hospitalised and to give context for interpreting these data, the researchers surveyed a convenience sample of nurses regarding their experience. Study 2 explores the opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital. The study offers a comprehensive survey report of the research and is presented in the next five chapters.

In the first chapter, the introduction provides the background, context of the study and purposes of the study. The particular research question this study addressed is outlined as well as significance of the study. Definitions of the phrases nurse-family member and lay-family members are given and used in the study. The literature review in chapter two presents the search of the literature and discusses the nature of roles of lay-family members and nurse-family members within the acute care hospital. In general, a review of any current literature requires a specific search strategy process to achieve an accurate result. While there are several studies regarding lay-family members' experiences within the hospital setting, to date there are only a few available about the experiences of nurse-family members within this context. Chapter three details the methods used in this study. The method is outlined, including a description of research design, ethical considerations, data collection strategies, issues of validity and reliability, and statistical and qualitative analyses. The approach described by Braun and Clarke (2006) was selected as appropriate for analysis of narrative data. In chapter four, data relating to respondents' experiences of having ill family members admitted in acute care hospitals is outlined. Findings of data analysis are detailed using response rate, tables and figures. The final chapter presents the discussion, it includes restatement of study purpose and an overview of findings that highlights implications for clinical practice and further research, limitations of the study and recommendations drawn from this study.

Summary

The focus of this introductory chapter was the study context: the experiences of nurse-family members when their loved ones are admitted to hospital. There is clear acknowledgement of events in acute care hospitals, with some studies and systematic reviews providing insights into the experience of a nurse-family member. The purpose of the study was to investigate these experiences by conducting a survey to explore the opinion of nurses regarding these experiences. In addition, the chapter highlighted the main objective and used the research question as a guide for this project. To date, no previous study has involved examination of the frequency of experiences of nurses with relatives hospitalised specifically in an acute care hospital. The chapter concludes with the aim of this project: to provide a groundwork that will support policy administrators and health care institutions so they can support nurses. Also, keywords from the research question were defined in this chapter.

Chapter two: Literature Review

Introduction

This chapter presents a literature review focused on identifying current studies that investigate the experiences of nurses with family members hospitalised in acute care hospitals. A review of existing literature requires a specific search strategy process, which is discussed herein. Exploring existing studies helped add new knowledge about experiences of nurse-family members. As the outcome of the qualitative systematic review (Study 1) was used to inform this current study (Study 2), a literature review of the findings is provided to capture new studies. To the best of the researchers' knowledge, the opinions of nurses regarding their experiences when their ill loved one is hospitalised, has not been studied.

Search of theliterature

An exploration of the literature began with a search of electronic databases. Searching the databases for literature is required for a comprehensive strategy to achieve an accurate outcome (Whittemore & Knafl 2005). In this project, the search strategy was guided by using two qualitative systematic reviews conducted by Giles and Hall (2014) and Sabyani et al. (2017). Giles and Hall (2014) searched the database in April 2013, while Sabyani et al. (2017) searched the database in February 2016, as indicated in the search strategy method of both reviews. The benefit of researching the literature was to ensure that new studies that would have an impact on the literature review were captured. Consultation with a librarian provided an opportunity to review the keywords and to seek advice regarding the latest database system prior to conducting the search.

In this review, two electronic databases, comprising the Cumulative Index to Nursing and Allied Health (CINAHL) and Medline, facilitated the search strategies for health care literature. These resources are comprehensive databases providing methods to identify studies that report high quality research for application in the medical field. The use of at least two electronic databases to answer a research question is recommended (LoBiondo-Wood 2006). Other internet sources offered a huge quantity of relevant information through sites such as Google Scholar, sites of international professional organisations such as the ProQuest Dissertations and Theses Global, and of national professional organisations such as Trove. The chosen articles were not limited in terms of date of publication because there were not enough studies found; articles also had to be published in English so the investigator could review and analyse the papers. To assist identification of the range and types of studies available, the current process performed a search limitation of these databases. These limitations restricted the search to get the most related studies. As mentioned above, the search started with the use the keywords from Giles and Hall (2014) and Sabyani et al. (2017) reviews to identify relevant studies in the database search. Additionally, the MeSH database was used in the search to choose keywords. The following were the main keywords used:

- Registered Nurse OR Nurse OR Nurse family member OR Nurse Relative AND
- Family member OR Spouses OR Partner OR loved one OR Extended Family OR Immediate Family OR Close relative OR Wife OR Husband OR Mother OR Father OR Significant other OR Lay-family member AND
- Life Experiences OR Experience OR Personal experience AND

- Acute care OR Critical illness OR Hospital

Consequently, the chosen keywords were used to search databases with a combination of the words 'and' and 'or' to limit the search selection. The search was conducted during the period of January to February 2017. Using the search strategy details in Sabyani et al. (2017), a large number of studies from four different databases mentioned above were identified. All studies were screened on the basis of title and abstract. The search yielded the same studies as identified by Sabyani et al. (2017) and Giles and Hall (2014). As of this writing, a descriptive study of the frequency of experiences of nurses with family members hospitalised in acute care hospitals had not been undertaken. However, this search process confirmed the claim by Sabyani et al. (2017) that previous studies have focused on qualitative design within the critical care setting.

Review of theliterature

Considering the previous systemic review (Study 1), it is evident that a gap in current knowledge exists concerning nurse-family member experiences in the case of hospitalisation of an ill loved one. As of this writing, no additional published article has focused on the experiences of a nurse-family member. Within health care studies, this review provides a summary discussion of the nature of the roles of lay-family members and nurse-family members within the acute care setting.

Nature of lay-family member and within the hospital.

Currently, the needs of lay-family members of adult patients are of concern to health care professionals within acute care hospitals. There is a growing body of literature focused on the family, especially in the area of critical care units (Eggenberger & Nelms 2007; Engstrom & Soderberg 2007; Fateel & O'Neill 2015; Frivold, Dale & Slettebo 2015; Gavaghan & Carroll 2002; Linnarsson, Bubini & Perseius 2010; Maxwell, Stuenkel & Saylor 2007; Medina 2005; Vandall-Walker, Jensen & Oberle 2007; Verhaeghe et al. 2005), oncology (Cicchelli & McLeod 2012), palliative care (Mitnick, Leffler & Hood 2010; Namasivayam, Orb & Connor 2005) and in the community (Pickard, Jacobs & Kirk 2003). While some patients can take care of their own activities of daily living and communication, many others cannot. Worldwide, family members are often required as a primary source for obtaining information about the patient (Nevidjon 2004). As with any individual facing an illness, lay-family members often provide ongoing emotional support and physical care. However, Linnarsson, Bubini and Perseius (2010) emphasised that family members also live through strenuous and stressful experiences, not only physically and emotionally, but also occasionally, socially. While the experience of a lay-family member results in a mixture of emotions, it was acknowledged that families appreciated feeling that their loved one was cared for (Frivold, Dale & Slettebo 2015).

Several international pieces of literature focused on investigation of the frequency of family members in acute care hospitals contain data collected on those family members. In a study conducted in Israel hospitals, Auslander (2011) found that of 1,076 patients surveyed 69% had family members at their side an estimated eight hours per day. Often the main reason for this was the family member's desire to support and care for his or her loved one. However, Linnarsson, Bubini and Perseius (2010) concluded in their review that the family member faces a difficult task not only in caring for, but also in supporting their ill relatives in a hospital setting. It is clear from the literature that family members play a vital role together with health care professionals in caring for and supporting the patient. Often lay-family members have no

formal clinical experience, but they depend on what they learn from attending health care staff. Indeed, this clearly applies to nurses, as they are on the front line within health care organisations. Nurses are in a position to support family members and help them provide high quality care for their ill loved one (Gavaghan & Carroll 2002).

Most families with a member admitted to acute care hospital and may provide care at a certain level. Pickard, Jacobs and Kirk (2003, p. 93) explained care from a family's perspective as 'caring is a part of emotional relationship in which the act of caring can be described as an expression of love or of duty'. The caring relationship among family may be considered an essential concept of the lay-family member role which provides a strong sense of blessing and reward. Researchers reported a significant reward and satisfaction for lay-family members who supported loved ones during their hospitalisation in terms of lovingness and caring (Auslander 2011). In terms of feelings of self-reward, lay-family members may have felt a sense of accomplishment when involved in their loved one's activities of daily living. Health care professionals documented family members supporting and even taking part in ill loved one's caring activities, including personal care (Frivold, Dale & Slettebo 2015; Sneeuw et al. 1997; Verhaeghe et al. 2005). Lay-family members may gain a considerable degree of benefit in terms of building their relationship with their ill loved one. Some nursing researchers used reward scales to gain an understanding of family experiences during care provided when a loved one was hospitalised (Picot 1995). A rewarding experience by a lay-family member may be a highly positive outcome from provision of care.

In terms of feelings of fulfilment, lay-family members may feel a sense of satisfaction when receiving adequate information about the care of their ill loved one. Linnarsson, Bubini and Perseius (2010) highlighted in their review that to meet lay-family member's satisfaction their needs should be considered, for example clear information about an ill loved one's condition can result in a relationship of trust with health care professionals. While collaboration between health care professionals and families may provide satisfaction regarding care in some cases, it may also improve the quality of care provided (Frivold, Dale & Slettebo 2015). In addition, the presence of a lay-family member alongside the patient allowed them to watch, observe, and help when needed. In a study by Auslander (2011, p. 208), participants described their contentment by stating, 'I get satisfaction from being here.' Being with ill loved ones during hospital admission may also result in highly positive consequences for care received. Therefore, a lay-family member may be considered in all aspects of care for their ill loved one as they are able to oversee patient needs and safety in the hospital environment. However, Fateel and O'Neill (2015) reported that nurses wanted a clear policy to guide support of family members in relation to care involvement within clinical practice, to ensure patient comfort and safety. Also, lay-family members involved in care provided to their ill loved one have no formal training in keeping them safe (Alshahrani 2016; Donelan et al. 2002).

When an ill loved one is hospitalised, lay-family members are at particular risk of worry, and may become unable to cope with their concerns about the patient's safety. The Institute of Medicine described patient safety as 'the prevention of harm to patients' (Aspden et al. 2004, p. 1011). Within a hospital setting, creating a sense of patient safety is an important element for all family members, especially during acute illness (Astedt-Kurki et al. 2001). Lay-family members are aware of their ill relatives' routine, for example, providing general supervision during their feeding or showering routine, which may enhance patient safety and provide effective care during their admission. While they struggle to be with their loved ones, health

care professionals address their concerns by explaining the clinical condition and the management of care delivered (Lindhardt, Bolmsjö & Hallberg 2006). Consequently, it is important that support from health care professionals includes provision of sufficient clinical information and engagement with lay-family members regarding care to maximise patient safety. Ensuring patient safety by lay-family members is an important emphasis for nurses in the current literature (Alshahrani 2016; Sapountzi-Krepia et al. 2008). In a hospital setting, in order to deliver safe care appropriate training and competence is required. Health care professionals should be aware of the extent of lay-family members' role, and validate their capabilities in safe practice while involving them in care.

Nature of nurse-family member and within the hospital

Nurses working within the health care system, for example in hospitals, are trained to work while ensuring patient safety. When nurse-family members are with an ill loved one during an admission, they are in a different position to lay-family members in relation to recognising safe practice. This is due to their clinical skills, and it is clear that nurse-family members function at a different level when overseeing patient care (Carlsson et al. 2016), using their professional relationship to navigate the health care system and report inappropriate care. Ward-Griffin et al. (2015); Ward-Griffin et al. (2005) emphasised that when safety is jeopardised the nurse-family member steps in to protect their ill loved one, while maintaining a good relationship with hospital staff. Ledwidge (2010) supported the idea that nurse-family members switch between being the worried family member to the nurse in control of ensuring patient safety. It is clear that nurse-family members' possession of knowledge and professional identity are helpful in facilitating good care and maximising a sense of safety for their hospitalised loved one. Key literature sheds light on the experiences of nurse-family members within the hospital setting (Carlsson et al. 2016; Fulbrook, Allan, et al. 1999; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999; Giles & Williamson 2015; Ledwidge 2010; Lines, Mannix & Giles 2015; McNamara 2007; Mills & Aubeeluck 2006; Salmond 2011). All descriptions of nurse-family member experiences established in the literature were within the interpretive paradigm and were personal stories. As stated previously, studies related to lay-family members were determined by frequency and their needs, generally by the use of descriptive methods such as surveys. However, no study has examined frequency of the experience of nurse-family members in hospital to date. For the purposes of this study, results of the qualitative systematic review (Study 1) were outlined. The review identified five main themes that shape the experiences of health care professionals as a family member in acute care hospital setting: privilege knowledge, dual identity, being a protector, family expectation and intense impact from the experiences. Determining the experience of nurse-family members will help fill the gaps that occur when their ill loved one is hospitalised and current health care provided.

Summary

In today's acute care hospital environment, lay-family members may provide support for ill loved ones in addition to vital members of the professional health care team. A broad examination was conducted of the literature for studies on the experiences of nurse-family members with ill loved ones admitted to acute care hospitals, with the aim of identifying new related literature. While there were several publications regarding lay-family members' experiences within the health care setting, to date there are few available

studies regarding the experiences of nurse-family members within this context. This chapter provided an overview of the nature of lay-family members' roles within the hospital setting, who may often remain with their ill loved ones during hospitalisation and may provide care and support. The search within the database did not identify any relevant study focused on surveying frequency of the experiences of nurses with family members who have been hospitalised. Therefore, this study aims to address this gap in literature by exploring the opinions of nurse-family members. The next chapter contains a detailed discussion of methods used which includes description of research design, ethical issues, data gathering and analysis.

Chapter Three: Methods

Introduction

The previous chapter provided a literature review on the nature of lay-family member and nurse-family member roles within the hospital environment. The method chapter is a core component in the skeleton of research that investigators use to map the research process. This chapter contains a description of how the second study was undertaken and how it developed in relation to gathering and synthesis of data. It provides information on methods used and contains a description of study design. The sample, recruitment strategies, tools for reliability and validity and ethical consideration are outlined. Furthermore, the chapter highlights how data were cleaned prior to presenting findings of analysis. This is followed by definitions of data gathering and statistical instruments used in data analysis.

Description of research design

As stated earlier, Study 2 aimed to explore and determine the frequency of issues related to the experiences of nurses with family members hospitalised in acute care hospitals. A descriptive, quantitative design that involved a quantitative instrument was adopted for this study. Specifically, the study was descriptive and had a cross-sectional design that required collection of information from a different group of people. Descriptive, cross-sectional designs can provide a snapshot of numerical data regarding frequencies of certain characterises from a population group. Polit and Beck (2016, p. 725) defined cross-sectional design as 'a study design in which data are collected at one point in time; sometimes used to infer change over time when data are collected from a different age or developmental groups'. Obviously, this design is the easiest and most convenient to undertake among other descriptive designs because data are collected once without the need for repetition.

In this study, the population group investigated consisted of nurses from one metropolitan and one country hospitals. There are many advantages of conducting a descriptive cross-sectional design in the field of epidemiology. The most important are the lack of a follow-up requirement, fewer resources used and cost effectiveness (Bowling 2014; Gerrish, Lathlean & Cormack 2015). Therefore, to increase understanding of the opinions of nurses regarding their experiences when their ill loved ones are admitted to an acute care hospital and to identify contributing factors, a descriptive cross-sectional design using an online survey as a data gathering instrument was the appropriate method. The use of online survey is increasing, because its convenience and efficiency. With increased accessibility of online service in clinical practice, especially for nurses, the use of electronic communication was considered the most appropriate way to invite a large number of nurses to participate in a survey.

Study population

A study population means a group of people that are the focus of an investigation (Gerrish, Lathlean & Cormack 2015). Nurses of hospitals within South Australia were the study population. However, it was not feasible to include all nurses given the time frame of this study. Therefore, a convenience sample was selected, and the online survey was emailed to each participant. Using convenience approach in the selection of nurses to participate in a study allows participants to come forward to volunteer. Sampling of

convenience is considered an easy process in terms of recruiting participants from a specific facility, for example, the hospital setting (Polit & Beck 2016).

The inclusion criterion for this study were nurses from two large acute care hospitals. There were no exclusion criteria except that they had to have experienced the phenomena because the nature of participants, issues of age, gender and language had no impact on results. A poster inviting participation in the proposed study was placed on bulletin boards at each site. An email, which included an invitation letter, a participant information sheet and a link to Survey Monkey was sent to participants through the nursing administration. Three reminder emails were sent to nurses to increase response rate. The first reminder was sent two weeks after the survey was sent, and the second reminder was sent after five weeks. The final one was sent seven weeks after the survey commenced.

Study setting

The study sites selected were:

- One metropolitan hospital, a public acute care hospital located approximately ten kilometres west of Adelaide's city in South Australia. The facility has around 300 bed capacity, and is an acute care teaching hospital that provides health services such as inpatient, outpatient, emergency and mental health to a population of more than 250,000 people.
- One country hospital, a public acute care hospital located about 400 kilometres north of the city of Adelaide, South Australia. The facility has about 100 bed capacity, and is an acute hospital that provides general medical and surgical care services including inpatient, day surgery, intensive care unit, palliative care and bereavement, and outpatient services to a population of more than 85,000 people.

As part of the Study 2 planning, collaboration and communication with the hospitals was considered essential. With the country facility, a telephone meeting involving the research team and the Regional Director of Nursing and Midwifery was conducted to discuss the opportunity to conduct the study and their input regarding the project. For the metropolitan facility, the researcher and his supervisor had a face to face meeting with the Acting Director of Nursing to discuss the project proposal. To increase the number of nursing participants, in-service sessions were planned to provide knowledge about the project and online survey. Thus, the researcher offered an hour information session to nurses at both sites prior to opening the online survey. After ethics approval, an information session was presented to nurses at the country facility only, as the metropolitan hospital preferred to email the information sheet to nurses.

Ethical Issues and Considerations

Ethical concerns are a crucial part of method and all of processes of a research project. Ethics approval must be issued by a statutory authority, for example, Human Research Ethics Committee (HREC). Approval provides an assurance that researchers maintain ethical consideration at all parts of a human research project. Briefly, human research is 'a research conducted with or about people, or their data or tissue' (National Health and Medical Research Council 2007, p. 3). Furthermore, the investigator respected participants' rights and kept their identities anonymous. To gain knowledge and understanding of ethical

approval issues in terms of application, mechanisms and supported documents, the researcher underwent a one-day information session known as Human Research Ethics Training by HREC- University of Adelaide.

HREC: approval process

In Australia, all research projects are required to obtain an authorisation from the National Health and Medical Research Council within the Australian government health sites that meets the requirements of the National Statement on Ethical Conduct in Human Research, incorporating all updates (National Health and Medical Research Council 2007). At South Australian Health sites, prior to commencing a research project, the researchers must undertake two applications: National Ethics Application Form (NEAF) and Site Specific Assessment (SSA). These are part of an electronic system that allows investigators to fill out a request online. However, a request must be submitted electronically as a PDF (portable document format), which includes investigators' signatures and supported documents, to the HREC research governance officer of the sites. Supporting documents include a curriculum vita, a cover letter, a study protocol, participant information sheet, an email approval from hospitals, an email invitation, a poster invitation and a survey.

Ethics approval was granted by HREC with reference number: HREC/16/TQEH/240 and is valid from 04 November 2016 to 04 November 2021 (Appendix I). After NEAF approval, the committee advised contacting the Research Governance Officer (RGO) of both sites in relation to the requirement of a SSA form. The RGO office of the metropolitan hospital requested an approval for advertisement by poster invitation from the Health Communications office. After providing advertisement approval, the SSA was granted by RGO with the SSA reference number: SSA/17/TQEH/11 (Appendix II). The RGO office of the country hospital requested a certificate insurance letter from the Legal and Risk office of the University of Adelaide. After providing the letter, the SSA was approved with SSA reference number: SSA/17/SAH/4 (Appendix III). All researchers at the University of Adelaide must not commence human research without ethical approval from the University or until the project has been reviewed and authorised by another institution of HREC under an equivalent ethical standard. While all SA Health HREC's ethical approvals are accepted by the University of Adelaide, a notification of an existing ethical approval to the University is required to be submitted within two weeks. In Study 2, an acknowledgement receipt of notification of ethical approval from the University's HREC was received (Appendix IV). An email invitation which comprised a poster invitation and a participant information sheet were approved (Appendix V). Therefore, no further ethical approval for the study from the University's HREC was needed. Figure 1 outlines the process undertaken to obtain research approval from authorities.

Figure 3: Process undertaken to obtain research approval

Informed consent

The survey was online and anonymous, therefore, participation in the survey implied consent. The information collected from the survey was intended to increase understanding about the experiences of nurses with family members who had been admitted to an acute care hospital and it was made clear that there was no direct benefit to participants. Participants might have felt that some of the questions asked were stressful or upsetting. If a participant did not wish to answer a question, he or she could skip it and go to the next question, or stop immediately. If participants become upset or distressed as a result of their participation in the research project, the research team was able to arrange for counselling or other appropriate support. This was not required at any stage of data collection or research study.

Data storage

Data was stored electronically in a password protected folder on a secure server of the University of Adelaide. Only researchers have access to this password. However, once the research project is completed, the data on the server will be kept as required and then erased and not be re-accessed. No specific identifiable participant information was collected and the data gathered will be stored confidentially for 12 months.

Data Gathering Instrument

Three aspects need to be considered when developing an online survey. These are: development of the survey, piloting the survey and method of delivering the survey (for example, web based survey).

Development of the survey

When developing a survey, the researcher must create a document with a list of questions that respondents will answer individually. This document is well known as a questionnaire design, in which the wording has to be concise and clear. Bowling (2014) emphasised that the list of items in a questionnaire should align with the study of interest in terms of the objective and response format that must be created. In this study, development of the survey was based on the objective of the study, grounded in recommendations of the current systematic review (Sabyani et al. 2017). The survey was developed to explore issues relating to the experiences of nurses with family members hospitalised in acute care hospitals. By using a clear structure of heading and sub-heading, it offered a form of guidance to respondents.

In construction of this survey, three forms of questions were used: open, closed and scale type questions. The open and closed questions were formatted either as a dichotomous (yes or no) or multiple response or single response and pre-coded items plus an 'other' category where appropriate (Bowling 2014). In addition, categories of these questions were chosen carefully to ensure that respondents' answers fit with appropriate categories. The scale type question presents a range of responses, commonly known as a Likert scale (Gerrish, Lathlean & Cormack 2015). In general, the Likert scale contains a set of single items related to a question of interest which measures level of agreement or frequency. The number of points along the scale may vary, for example a range of four, five or seven pre-coded points (Polit & Beck 2016). However, a five point Likert scale was used in this survey to measure both agreement and frequency. A justification for choosing this option, could be that a 5-point Likert scale of agreement offers a neutral point, such as, uncertain, where respondents were given the option to indicate the degree to which they agree or disagree with a statement; a 5-point Likert scale of frequency offer a neutral point, such as, sometimes where respondents were given the option to indicate the degree between always to never (Bowling & Ebrahim 2007). Finally, respondents were given an option to write comments under each item of the Likert scale, which may provide freedom for elaboration of their opinion. The survey consisted of a total of 25 questions under five sections (Appendix VI), which are the following:

- Section 1: Sought demographic data including age, gender and years of nursing experience. Also, an additional question related to whether the nurse had a family member hospitalised was asked as a screening process to demonstrate the eligibility of the nurse to participate in the survey. If the nurse answered 'no' the survey was ended. (Questions: 1 to 4)
- Section 2: This section featured questions about the experience of the nurse upon hospitalisation of his or her ill loved one. (Questions: 5 to 6)
- Section 3: This section contained inquiry about the most significant experience, using multiple choice options. (Questions: 7 to 18)
- Section 4: This section made use of a 5-point Likert scale of agreement, which had five possible answers ranging from 'strongly agree' to 'strongly disagree' for statements about nurses'

specialised knowledge, provision of care, evaluation of the care provided, role conflict relationships with other family members, personal well-being and their professional practice. (Questions: 19 to 23)

- Section 5: This section made use of a 5-point Likert scale of frequency, which had five possible answers that ranged from 'always' to 'never' related to statements about nurses' specialised knowledge, provision of care, evaluation of the care provided, dual identity and how their experiences are different to those of a lay-family member. At the end of the survey, nurses had the opportunity to add additional comments, questions or concerns. (Questions: 24 to 25)

Piloting of the survey

Piloting a survey means testing questions created to ask participants in terms of wording, clarity and meaning. Piloting is an essential step in the development of any survey because "…it enables evaluation of the performance of the measure in meeting the study objectives" (Gerrish, Lathlean & Cormack 2015, p. 422). The survey was piloted using staff of the Adelaide Nursing School, the University of Adelaide. An email was sent to all staff through the school's administration office inviting them to participate and complete the survey. After two weeks, a few comments were raised in terms of clarifying the questions and terms used. Consequently, the researcher made minor changes by modifying some questions based on the supervisors' suggestions and comments. The final draft of the survey was imported to Survey Monkey. To ensure that the technicality of the online survey flowed smoothly, all supervisors tested the link prior to commencing the survey. All previous versions of the survey were deleted with the hypertext link to ensure the feasibility of the final version.

Method of delivering the survey

An internet survey is considered a useful method to access a large number of people and can be efficient in terms of time and data categorised. Gerrish, Lathlean and Cormack (2015, p. 589) highlighted that a survey is also known as a 'census', which involves gathering of data or information from a population to gain statistically descriptive data. Using a web based survey service, such as Survey Monkey, offers an easy and systematic way of gathering statistical data without changing presentation of results. Nowadays, many online surveys have been launched by many researchers in almost in all fields (Polit & Beck 2016). While there are many web based surveys, in this study the researcher created an account in a well-known service called Survey Monkey at an affordable cost. Then, all questions were imported into the survey, and a generated hypertext link was developed.

Data cleaning

Cleaning data is a useful process to check its reliability before commencing analysis. Polit and Beck (2016, p. 725) defined this process as 'the preparation of data for analysis by performing checks to ensure that the data are consistent and accurate'. The researcher collected the descriptive numerical data from Survey Monkey and computed percentages, which were then presented in table and bar chart form using SPSS 24.0 version software program. Additionally, some data variables were presented as means, ranges, standard deviations, frequencies and percentages. The survey featured yes/no questions, and others required participants to choose from different options from 'strongly agree' to 'strongly disagree' or

'always', 'often', 'sometimes', 'rarely' and 'never' in response to specific statements. As previously mentioned, the survey consisted of five sections with a total of 25 questions/statements, which will be presented in the next section. The first section of the survey was dedicated to collecting information about nurses' socio demographics characteristics. The second section related to the experience of the nurses upon hospitalisation of family members. The third section of the survey was related to the most significant experience. The fourth section made use of a 5-point Likert scale of agreement for items about nurses' specialised knowledge, provision of care, evaluation of the care provided, role conflict relationships with other family members, personal well-being and their professional practice. This section also featured questions about how their experiences were different from those of a lay-family member. At the end of the survey, the nurses had the opportunity to add comments, questions or concerns.

Issues of validity and reliability

Prior to commencing any survey, the data collection instrument must be checked for its validity and reliability. The validity and reliability of any survey tool means that the instrument measures what it is generated for (Polit & Beck 2016). Field (2013) underline that whereas validity means 'whether an instrument actually measures what it sets out to measure', reliability indicates 'whether an instrument can be interpreted consistently across different situations.' In this study, survey questions were developed from the current systematic review, existing literature and the research team's area of interest. The survey was examined to establish validity and reliability through three methods. First, the researcher's supervisors, who have experience in developing surveys, reviewed the questionnaire independently prior to the pilot study. The survey was redrafted through a process of meetings with supervisors which included creating and refining the questionnaire. Secondly, the researchers' pilot tested the survey and gained feedback from Adelaide Nursing School staff who had participated. The feedback helped to reformat the survey in a clearer more precise for the nurses. In addition, reliability was tested using Cronbach's alpha as described by Pallant (2016). The researcher suggests that these processes assisted in ensuring the instrument was valid and reliable in meeting the objective of the study.

Data analysis

Data analysis in a survey study provides information about the methods used to manage and analyse data sets and is carried out in two sub-sections: statistical analysis and qualitative analysis. While statistical analysis is an approach used to analyse numerical data, qualitative analysis is a method used to analyse non-numerical data, such as narrative comments. The purpose of this approach was to gain a comprehensive understanding of the experiences of nurses whose family members had been admitted to acute care hospitals, and from this provide a snapshot of the numerical data collected regarding the frequency with which certain characteristics were perceived by respondents. Another goal was to explore themes which highlight these experiences in detail, provide a deeper understanding and, in particular, provide an opportunity for nurses to be critical of specific aspects of the questions provided.

Statistical analysis

The researcher collected quantitative data from Survey Monkey and calculated percentages. Descriptive statistics were used to analyse the data and results were captured in Microsoft Excel. Data were then

numerically coded and analysed by using a Statistical Package for the Social Sciences program known as SPSS 24.0 version software (SPSS IBM, New York, U.S.A) for Windows. The significance level in this study was considered to be set at or less than 0.05 for all analyses. With SPSS, it is easy to report description data for variables and categorical values to guarantee that all output is appropriately reported and comprehensible (Field 2013). The data are also presented in bar graphs and tables.

The researchers used an internal consistency parameter to assess consistency of the survey by using coefficient alpha. Commonly, coefficient alpha is a statistical test to measure internal consistency reliability of questionnaires included in a survey. Bowling and Ebrahim (2007, p. 397) summarised coefficient alpha as follows: 'It is based on the average correlation among the items and the number of items in the instrument (values range from 0 to 1)'. Thus, in Study 2, the survey features multiple Likert items that form a scale, and it is necessary to determine if the scale is reliable. However, this is explored in detail in the reliability analysis section in the following chapter. To enhance understanding of the SPSS program in terms of application, tools and analysis procedure, the researcher undertook a three-day workshop on introductory SPSS run by the Centre of Research Excellence at the University of Adelaide. In addition, as the process of analysis starts during data gathering, consulting with a statistician in Adelaide Health Technology Assessment at the University of Adelaide provided information about maintaining data sets, data analysis and manuscript preparation.

Qualitative analysis

Thematic analysis is 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke 2006, p. 79). In this survey, narrative free-text responses provided by respondents were analysed using thematic analysis. The Braun and Clarke (2006) approach is considered to be one of the most structured approaches for qualitative analysis when gathering narrative data. This approach aligns with narrative data, which focuses on the description and interpretation of the respondents' experiences. While there are a variety of approaches used to analyse narrative data (Gerrish, Lathlean & Cormack 2015), Braun and Clarke (2006) was selected as appropriate for Study 2, which focused on gathering information about nurse's experiences when their ill loved ones were admitted to an acute care hospital. The Braun and Clarke (2006, p. 97) approach offers the researcher core skills of 'flexibility' and 'rigor' in thematic analysis. For narrative data, the perception and standpoint of the individual's experience is acknowledged through recognised key themes. Braun and Clarke (2006, p. 87) recommend six stages of the analysis process that provide a structured approach useful in undertaking thematic analysis based on understanding of individual experiences. The six stages are as follows:

Stage 1: Familiarising yourself with your data: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.

Stage 2: Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

Stage 3: Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.

Stage 4: Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.

Stage 5: Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions.

Stage 6: Producing the report: Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Summary

This chapter contained details about the design of the study and the method used to conduct Study 2. It also featured a description of the study population, the setting and recruiting process. An overview of ethical issues was provided from the perspective of obtaining ethical approval from multiple sites. The data gathering instrument was presented in relation to development of the survey, the online survey and piloting process. The following chapter provides an outline of how the survey was validated and tested for reliability. The objective of the study is also outlined, and the major findings presented.

Chapter Four: Survey Findings

Introduction

In this chapter, the survey response rate and findings of Study 2, the online survey, are presented. The aims of this study were to examine the experiences of nurses with hospitalised family members to determine the frequency of this experience and explore related issues. The following question guided this survey: 'What are the opinions of nurses regarding their experiences when their ill loved one is admitted to an acute care hospital?' Descriptive numerical data from the survey are presented using response rate, tables and figures. Qualitative data are reported using themes to offer an understanding of the whole context of the experience of nurses.

Response rate

Of 700 nurses from one metropolitan and one country hospital invited to participate in the survey, 116 responded (17%). Of these six were excluded, two respondents stated that they had not experienced having an ill family member hospitalised, one was classified as a midwife during hospitalisation of the ill loved one, while two mentioned that their experience had taken place in a paediatric setting and one nurse's family member had been hospitalised in a maternity setting. Thus, responses from 110 of 700 eligible nurses were included in the study.

Survey results

Section 1: Nurses' socio demographics characteristics

Participants' demographic information was collected, in particular, age, gender, nursing experiences and employment setting. As shown in table 1 below, age ranged from 21 to 64 years, with most being female and relatively experienced. The majority of respondents were from the metropolitan area.

Table 4: Socio demographic characteristics of participants

Age (y)	Mean (SD) 46 (10.6), Range 21-64
Gender	Female 101 (91.8%) and Male 9 (8.2%)
Nursing experience (y)	Mean 23.25, Range 1- 47, Standard deviation (SD): 11.8
Employment setting	Metropolitan area 100 (90.9%) and Country area 10 (9.1%)

Legend: y: Years, SD: Standard deviation

Section 2: The experience of nurses during hospitalisation of family members

This section featured questions about each nurse's experience of hospitalisation of his or her ill family member. Nurses were first asked to report the number of times a loved one had been hospitalised. As shown in table 2, the largest number of respondents 42.7% (n=47) indicated that they had experienced this on two to three occasions.

Table 5: Number of occurrences of the experience

Occurrence	Frequency	Percent (%)
1 episode	13	11.8
2-3 episodes	47	42.7
4-5 episodes	22	20.0
>5 episodes	28	25.5
Total	110	100

The second question asked nurses to identify their relationship with the patient family member who was hospitalised and respondents were able to indicate all relationships that applied. Most respondents identified parents as the category of family 39.9% (n=87), with siblings being the least common category 6.5% (n=14). As shown in figure 3 below, children and partners or spouses were also commonly indicated. In addition, some respondents identified other family relationships, such as uncle, aunt, in-law, grandparent, grandchild, stepfamily, niece and cousin.

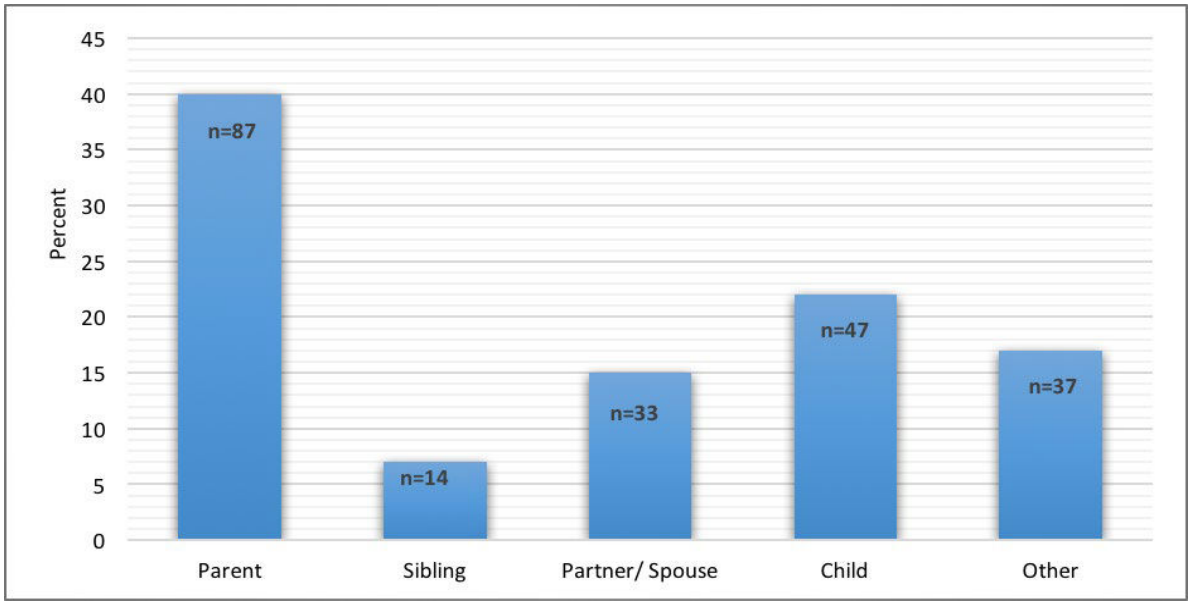

Figure 4: Types of relationship with patient/s (multi-select items)

Section 3: Inquiry about the most significant experience.

At the beginning of this section, nurses were asked about their most significant experience with a patient family member. They were able to select from multiple choice options to identify the following: relationship with the patient, whether the ill family member was a health care professional, location for the majority of their stay, how long ago the admission had occurred, their primary professional role, area of practice and classification level at the time of the experience. In addition, nurses were asked to report whether they had experience in the practice area in which the patient spent the majority of the admission and whether at the time of hospitalisation another member of their immediate family was a nurse. At the end of the section, they were requested to indicate whether they had an enduring medical power of attorney and whether their family member was admitted to their own workplace.

Results show that the most significant experiences concerned the admission of their mother or son/daughter (each with 26.4%; n=28). Father and husband/partner were less commonly reported. Respondents were asked whether their ill family members were also health care practitioners at the time of the experience and only four (3.8%) indicated this was the case (table 3).

Table 6: What was your relationship with the patient for the one experience you considered to be the most significant

Category	Frequency	Percent (%)
Mother	28	26.4
Son/ Daughter	28	26.4
Father	15	14.2
Husband/Partner	15	14.2
Other (Uncle, Aunt, Sister, Step-father, Grand-daughter, Niece)	9	8.5
Grand-father/Mother	8	7.5
Father/Mother-In-Law	3	2.8
Total	106	100

The question concerning the area of admission that described the majority of the patient's stay was completed by 103 respondents. As presented in table 4, medical/surgical was the most common response and mental health and emergency categories were in the minority.

Table 7: The area of admission for the majority of their stay

Category	Frequency	Percent (%)
Medical/Surgical	81	78.6
Critical care	17	16.5
Palliative Care	3	2.9
Mental health	1	1.0
Emergency	1	1.0
Total	103	100

In terms of occurrence of the experience, many respondents 44.7% (n=46) of 103 who answered the question indicated that their most significant experience had occurred in the year prior to the study, while others (39%; n=41) referred to experiences that had occurred one to five years prior. As shown in table 5, most respondents surveyed (84.5%; n=87) selected 'clinician' as their primary professional role during the time of the experience.

Table 8: Primary professional role at the time of this experience

Category	Frequency	Percent (%)
Clinician	87	84.5
Manager	11	10.7
Educator	3	2.9
Not employed as nurse	2	1.9
Total	103	100

In terms of area of practice, 103 respondents specified that their most significant experience with the hospitalisation of their family members occurred when they were working in Medical/Surgical 57.3% (n=59) and critical care 24.3% (n=25). Respondents who worked in mental health 1.9% (n=2), in the community 4.9% (n=5) were less commonly reported. Other categories were represented by only 11.6%

(n=12) of the sample but included the following: student programs, radiology, peri-operative, infection control, projects, education, women service and nursing informatics were represented.

The nurses' professional classifications at the time of their experiences were evaluated under categories of enrolled nurse (EN) and registered nurse (RN). As seen in figure 4, most respondents were level RN 1 and RN 2. However, there were 15.5% (n=16) RN 5 or higher.

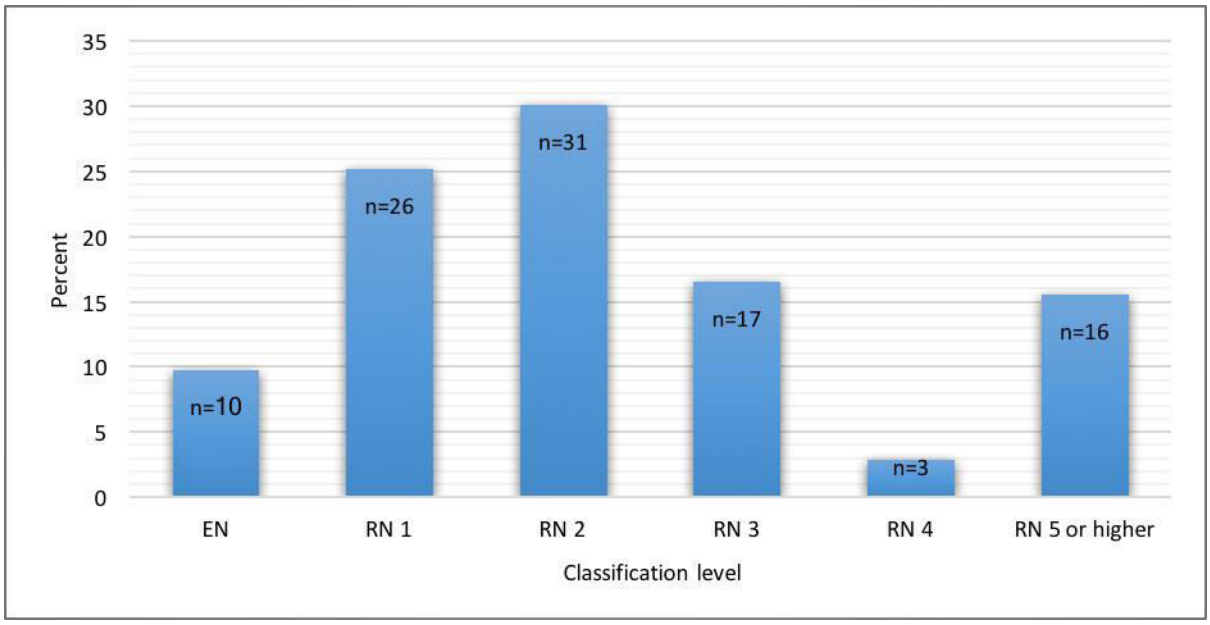

Figure 5: Classification level at the time of this experience.

Nurses were asked if they had any experience in the practice area in which their ill family member had spent the majority of their admission. The option 'yes' was most frequently selected 70.9% (n=73) of 103 respondents. Perhaps this question was slightly ambiguous, because they could have interpreted it as short placement as having worked in that area.

In answering the question of whether the ill loved one was admitted to the nurses' workplace, 37.9% (n=39) of 103 respondents confirmed 'yes'. The 39 respondents were then asked where the admission had occurred, and results showed that while most respondents (81.1%; n=30) indicated that their ill loved ones were admitted to other wards/units, others (16.2%; n=6) reported that their loved ones were admitted to the same ward/unit and only 2.7% (n=3) respondents stated that they had experienced both. Of 103 respondents surveyed, 23.3% (n=24) indicated that, at the time of hospitalisation, another member of their immediate family was also a nurse. In addition, 32% (n=33) of respondents had an enduring medical power of attorney for the care of their ill loved one.

Section 4: Likert scale of agreement as perceived by nurses

This section presented a 5-point Likert scale for nurses to rank their opinions under six categories: nurses' knowledge, satisfaction with care, ability to evaluate care, different expectations on nurses, self-impact, and relationship with staff. Nurses were also asked how they felt their experiences differed from those of a lay-family member.

Section 4.1: Elements relating to the nursing knowledge, its impact and the delivery of care.

In this section, participants responded to 12 items by selecting from a 5-point Likert scale. They were asked to state their opinions regarding their nursing knowledge, its impact and the delivery of care provided to their ill loved ones. Figure 4 presents results for this particular element. Of 110 respondents, 100 completed the 12 items relating to experience.

Figure 4 shows that more than 86% (n=86) of respondents agreed (strongly agreed and agreed) with items 1, 2 and 3, but almost 60% (n=60) disagreed (strongly disagreed and disagreed) with statement 4. Respondents were almost equal in both agreement and disagreement for statements 5 and 9. Regarding items 6, 8, 10 and 11, more than half of respondents agreed. However, the figure also indicates that some respondents disagreed with number 7 which presents only 39% (n=39). Finally, with regards to the final statement, 45% (n=45) of respondents surveyed stated that they either disagreed or strongly disagreed, while 29% (n=29) expressed uncertainty.

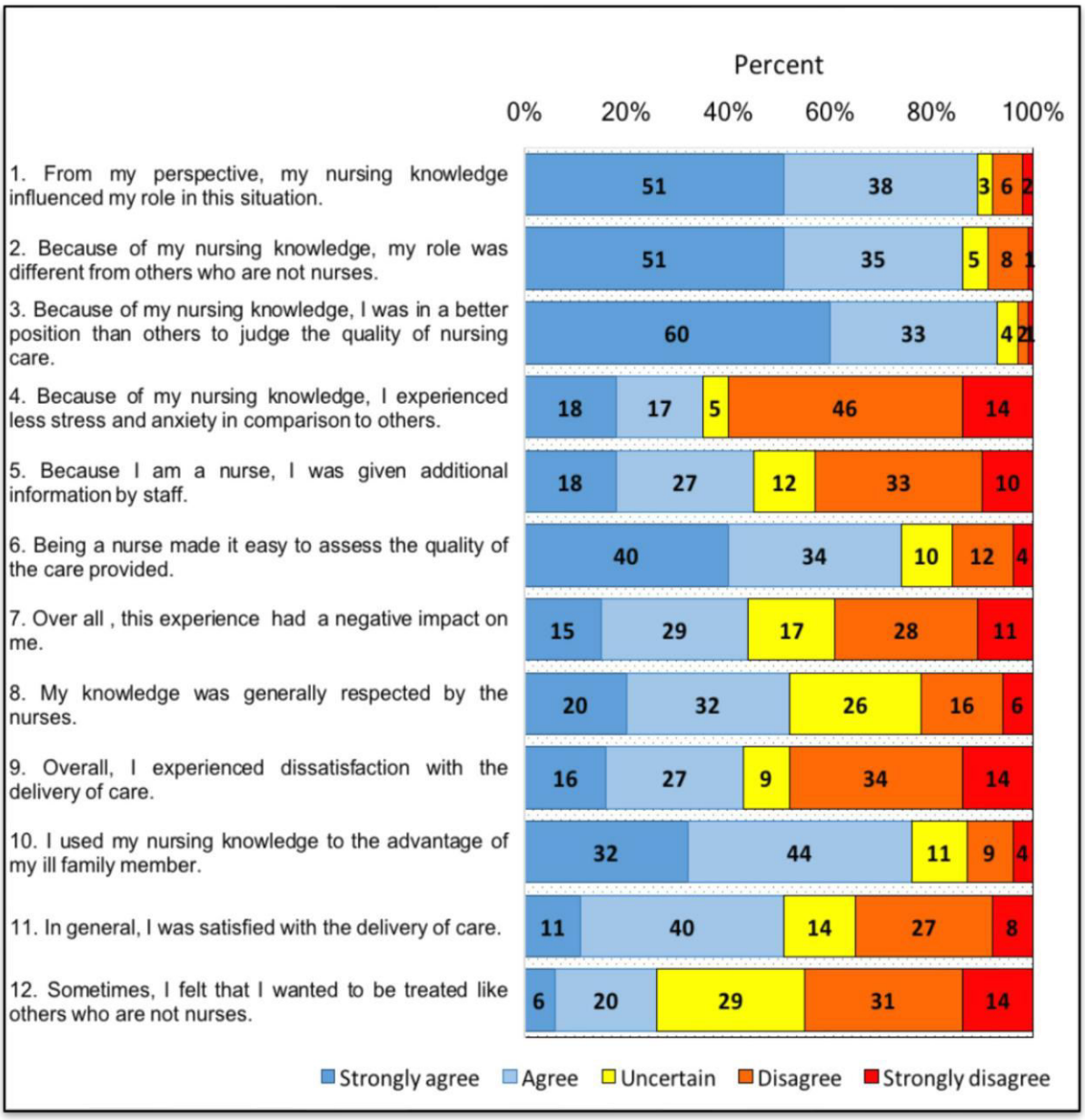

Figure 6: Please indicate the extent to which you agree or disagree with each of the following items relating to the experience.

Content analysis

In addition, nurses were given the opportunity to comment on various items in each element. These comments were analysed using content analysis, employing an inductive approach. Main categories developed from the small number of respondents who made comments mostly reinforce the overall view given in the Likert scale. The particular respondent's number is identified alongside the text to facilitate an audit trail. For each of the items the Likert responses are discussed with content analysis of comments given.

Item 1: From my perspective, my nursing knowledge influenced my role in this situation. Most respondents agreed with the statement with nine writing comments which revealed one main category and two sub-categories.

Main category1.1: Nurses' knowledge

Sub-category 1.1.1: *Being an advocate* (Respondents No. 50, 94, 9, 38, 3)

Sub-category 1.1.2: *Had to explain everything* (Respondents No. 59, 90, 93, 115)

Item 2: Because of my nursing knowledge, my role was different from others who are not nurses. In this item seven respondents provided comment, three gave insights which did not relate to the issue and four comments were analysed which revealed one main category and two sub-categories.

Main category1.2: Nurses' knowledge

Sub-category 1.2.1: *Being Vocal* (Respondent No. 9)

Sub-category 1.2.2: *Stepping in* (Respondents No. 67, 50, 59)

Item 3: Because of my nursing knowledge, I was in a better position than others to judge the quality of nursing care. For this item seven respondents commented revealing one main category and two sub-categories.

Main category1.3: Ability to evaluate care

Sub-categories 3.3.1: *Ability to recognise* (Respondents No. 59, 44, 9, 94, 38, 3)

Sub-categories 3.3.2: *Fear to jeopardise the care* (Respondent No. 8)

Item 4: Because of my nursing knowledge, I experienced less stress and anxiety in comparison to others. In this item 15 respondents commented revealing one main category and two sub-categories. Overall, the majority of these respondents disagreed with this statement.

Main category 4.1: Self impact

Sub-categories 4.4.1: *The stress of knowing* (Respondents No. 9, 6, 24, 38, 43, 94, 95, 106, 115, 59, 83, 90, 67, 8)

Sub-categories 4.4.2: *Ignorance is not **always** bliss* (Respondent No. 79)

Item 5: Because I am a nurse, I was given additional information by staff. For this item 15 respondents commented revealing one main category and two sub-categories. However, five gave insights which did not relate to the issue.

Main category 5.1: Nurses' knowledge

Sub-categories 5.5.1: *Additional information provided when requested* (Respondents No. 9, 62, 8, 111, 95, 38)

Sub-categories 5.5.2: *Extremely difficult to get information* (Respondents No. 44, 85, 94)

Item 6: Being a nurse made it easy to assess the quality of the care provided. In this item six respondents commented, three gave insight which did not relate to the issue and three comments were analysed which revealed one main and two sub- category.

Main category 6.1: *Ability to evaluate care*

Sub-categories 6.6.1: *Recognising deteriorating care* (Respondents No. 90, 43, 106)

Item 7: Over all, this experience had a negative impact on me. For this item 19 respondents commented which revealed one main category and two sub-categories but three gave insights which did not relate to the issue.

Main category 7.1: Self-impact

Sub-categories 7.7.1 *Anger and frustration with care*(Respondents No. 6, 9, 25, 43, 51, 58, 83, 108, 94, 21, 77, 24, 90)

Sub-categories 7.7.2 *Positive impact* (Respondents No. 79, 85, 93)

Item 8: My knowledge was generally respected by the nurses. In this item of 100 respondents who completed, 12 respondents commented which revealed one main category and two sub-categories and one gave insight which did not relate to the issue.

Main category 8.1: *Nurses' knowledge*

Sub-categories 8.8.1: *Avoidance* (Respondents No. 6, 77, 12)

Sub-categories 8.8.2: *Acknowledged by most nurses* (Respondents No. 9, 59, 111, 93, 112, 67, 79, 94)

Item 9: Overall, I experienced dissatisfaction with the delivery of care. In this item 11 respondents commented which revealed one main category and one sub-category.

Main category 9.1: *Satisfaction with care*

Sub-categories 9.9.1: *Poor care delivered* (Respondents No. 9, 24, 25, 49, 77, 95, 90, 91, 93, 74, 67)

Item 10: I used my nursing knowledge to the advantage of my ill family member. For this item 13 respondents wrote comments which revealed one main category and one sub-category. However, one gave insight which did not relate to the issue.

Main category 10.1: Nurses' knowledge

Sub-categories 10.10.1: *Assertive to gain appropriate care* (Respondents No. 9, 38, 43, 24, 58, 77, 79, 105, 106, 90, 94, 112)

Item 11: In general, I was satisfied with the delivery of care. In this item more than half of the respondents agreed with the statement, however, some respondents disagreed with nine writing comments which revealed one main category and one sub-category.

Main category 11.1: Satisfaction with care

Sub-categories 11.11.1: *Dissatisfaction with care* (Respondents No. 6, 9, 35, 104, 12, 108, 105, 94, 106)

Item 12: Sometimes, I felt that I wanted to be treated like others who are not nurses. For this item nine respondents wrote comments which revealed one main category and two sub-categories but three gave insights which did not relate to the issue.

Main category 12.1: Self-impact

Sub-categories 12.12.1: *Wanted to be acknowledged* (Respondents No. 67, 77, 93, 94)

Sub-categories 12.12.2: *Didn't want to be a nurse* (Respondents No. 79, 49)

Table 6: Categories for the elements relating to the nursing knowledge, its impact and the delivery of care, illustrates the categories developed from the responses to this items.

Table 9: Categories for the elements relating to the nursing knowledge, its impact and the delivery of care

Main Category	Sub-Category	Quote
Nurses' knowledge	Being an advocate	Able to advocate for family and others (50)
	Had to explain everything	Had to explain everything to patient and the rest of my family so they knew what was happening, also had to liaise with hospital staff regarding discharge to a safe environment (59)
	Being Vocal	Probably more vocal in my expectations (9)
	Stepping in	I attended observations I thought were missed/lacking (67)
	Additional information provided when requested	To some degree yes but had to ask too (sic) to seek information (9)
	Extremely difficult to get information	To talk with a doctor was extremely difficult (44)
	Avoidance	I was avoided at all costs (6)
	Acknowledged by most nurses	Respected or a better term would be acknowledged (111)
	Assertive to gain appropriate care	Advocacy/discussion of care pathways/at time assertive to gain appropriate care (38)
Ability to evaluate care	Ability to recognise	Ability to recognise appropriate and timely care (59)
	Fear to jeopardise the care	Can be a bit more reticent as you don't want to put the team who is managing your loved one, off-side in any way. You don't want to jeopardise their care if the team caring for your loved one feels undermined or questioned (No. 8)
	Recognising deteriorating care	The quality of care in ED excellent, went down after (90)
Self-impact	The stress of knowing	I think there was more stress knowing what I know (9)
	Ignorance is not always bliss	Sometime ignorance really is bliss, although I believe knowledge is power also and it allowed me to be more involved in decision making regarding my son's care (79)

	Anger and frustration with care	Frustration about poor care and lack of quality care (6)
	Positive impact	Well, nursing my ill son for 10 years and hi subsequent death did affect me negatively, it also allowed me to grow as a person and as a nurse. (79)
	Wanted to be acknowledged	I wanted my knowledge and experience acknowledged, and for communication with the nurses to reflect that knowledge, instead they barely even gave me eye contact let alone inform me of the nursing care plan for my daughter (77)
	Didn't want to be a nurse	Occasionally this was the case (79)
Satisfaction with care	Poor care delivered	Medication error during surgery. Doctors refused to explain. Mum had 2 extra days in hospital for cardiac monitoring (25)
	Dissatisfaction with care	I was disappointed with the lack of nursing attention. It was accreditation time and that was the focus. Not patient care. Call bell didn't work in toilet patients were supposed to be supervised back to bed until physio cleared them. Not timely in repair (9)

Section 4.2: Elements relating to personal and professional practice

This section contained six items that made use of a 5-point Likert scale. The nurses were asked to state their opinion regarding their practice, its impact on their personal and professional practice and their practice and attitude with other patients' family members. Of 110 respondents, 98 completed the six items relating to practice. Figure 5 presents the results for this particular element.

Regarding items 1 and 6, Figure 5 indicates that respondents equally agree and disagree that their experience has an impact on their practice. While only 24% (n=24) respondents felt uncertain about statement 2, 60% (n=60) of respondents strongly agreed that the experience had an impact on their professional practice. In relation to items 3 and 4, however, respondents reported their agreement with the statement but also strongly disagreed that their future interactions with a nurse-family member will be affected.

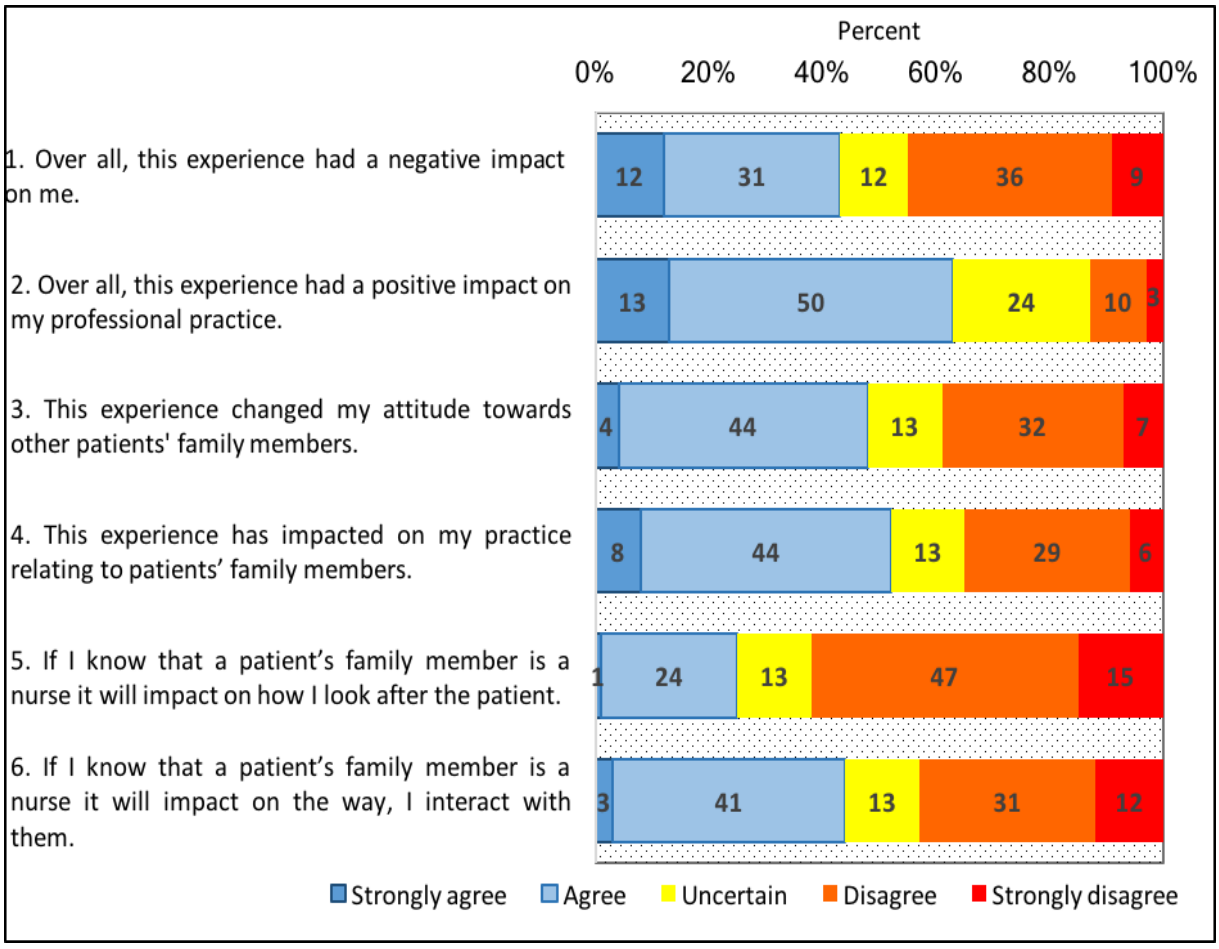

Figure 7: Please indicate the extent to which you agree or disagree with each of the following items relating to your practice

Content analysis

Item 1: Overall, this experience had a negative impact on me. In this item 45% of respondents disagreed with the statement, however, some respondents agreed with six writing comments which revealed one main category and one sub-category, one gave insight which did not relate to the issue.

Main category 1.1: Self-impact

Sub-categories 1.1.1: *Wearying experience* (Respondents No. 6, 9, 93, 108, 90)

Item 2: Overall, this experience had a positive impact on my professional practice. Overall, the majority of respondents agreed with this statement with 11 writing comments which revealed one main category and one sub-category.

Main category 2.1: Self-impact

Sub-categories 2.1.1: *Reinforced the need for empathy and care* (Respondents No. 43, 9, 12, 38, 58, 79, 87, 111, 6, 72, 67)

Item 3: This experience changed my attitude towards other patients' family members. In this item 15 respondents provided comments which revealed one main category and two sub-categories.

Main category 3.1: Self-impact

Sub-categories 3.1.1: *Reinforced communication and rapport* (Respondents No. 8, 105)

Sub-categories 3.1.2: *Family always treated well* (Respondents No. 1, 6, 39, 72, 77, 94, 103, 106, 111, 9, 3, 90, 67)

Item 4: This experience has impacted on my practice relating to patients' family members. In this item seven respondents provided comment, one gave insight which did not relate to the issue and six comments were analysed which revealed one main category and two sub-categories.

Main category 4.1: Self-impact

Sub-categories 4.1.1: *Strengthened family involvement* (Respondents No. 8, 93)

Sub-categories 4.1.2: *Have always treated the same* (Respondents No. 9, 72, 103, 111)

Item 5: If I know that a patient's family member is a nurse it will impact on how I look after the patient. Generally, the majority of respondents disagreed with this statement with 14 providing comments which revealed one main category and two sub-categories.

Main category 5.1: Self-impact

Sub-categories 5.1.1: *Everyone is important* (Respondents No. 38, 43, 58, 90, 104, 106, 108, 116, 9)

Sub-categories 5.1.2: *Gaining professional respect through altered language* (Respondents No. 6, 3, 111, 15, 6, 67)

Item 6: If I know that a patient's family member is a nurse it will impact on the way I interact with them. For this item 14 respondents gave comments, three gave insights which did not relate to the issue and 11 comments were analysed which revealed one main category and two sub-categories.

Main category 6.1: Self-impact

Sub-categories 6.1.1: *Use different language* (Respondents No. 58, 104, 116, 111, 38, 56)

Sub-categories 6.2.2: *Equal Interaction* (Respondents No. 6, 9, 24, 62, 105)

Table 7: Categories for the elements relating to personal and professional practice, illustrates the categories developed from the responses to this items.

Table 10: Categories for the Elements relating to personal and professional practice

Main Category	Sub-Category	Quote
Self-impact	Wearying experience	Very tiring times for all of us (93)
	Reinforced the need for empathy and care	Reinforced a more caring attitude to caring for the elderly (38)
	Reinforced communication and rapport	Reinforced my belief in good communication and building rapport with the patient and their significant others. (8)
	Family always treated well	Always have a positive attitude to contributions of family (6)
	Strengthened family involvement	Reinforced my belief that the patient and their significant others must be engaged in the care plans or decisions made in an intentional way by the nurse of primary carer for the patient in the clinical setting (8)
	Have always treated the same	Have always treated all patients & families with respect (72)
	Everyone is important	We should treat everyone the same regardless of whether their family member is a nurse or not (43)
	Gaining professional respect through altered language	Professional respect and courtesy always. Also being able to incorporate that family members' concerns/queries into my assessments (6)
	Use different language	Language used is different (116)
	Equal Interaction	I don't see it matters I treat all family members equally (9)

Section 4.3: Elements relating to the disclosure of identity.

This section contained six items and made use of a Likert scale. Nurses were requested to state their opinion regarding their dual identity, dual role, involvement in the care and disclosure of their identity. Of 110 respondents, 97 completed the six items relating to identity. Figure 6 presents the results for this particular element.

Figure 6 shows that more than 50% of respondents reported their disagreement with items 1, 2, 3, 5 and 6, but most (nearly 70%) disagreed with statement 4. However, the figure also indicates that a small number of respondents expressed uncertainty about statement 4.

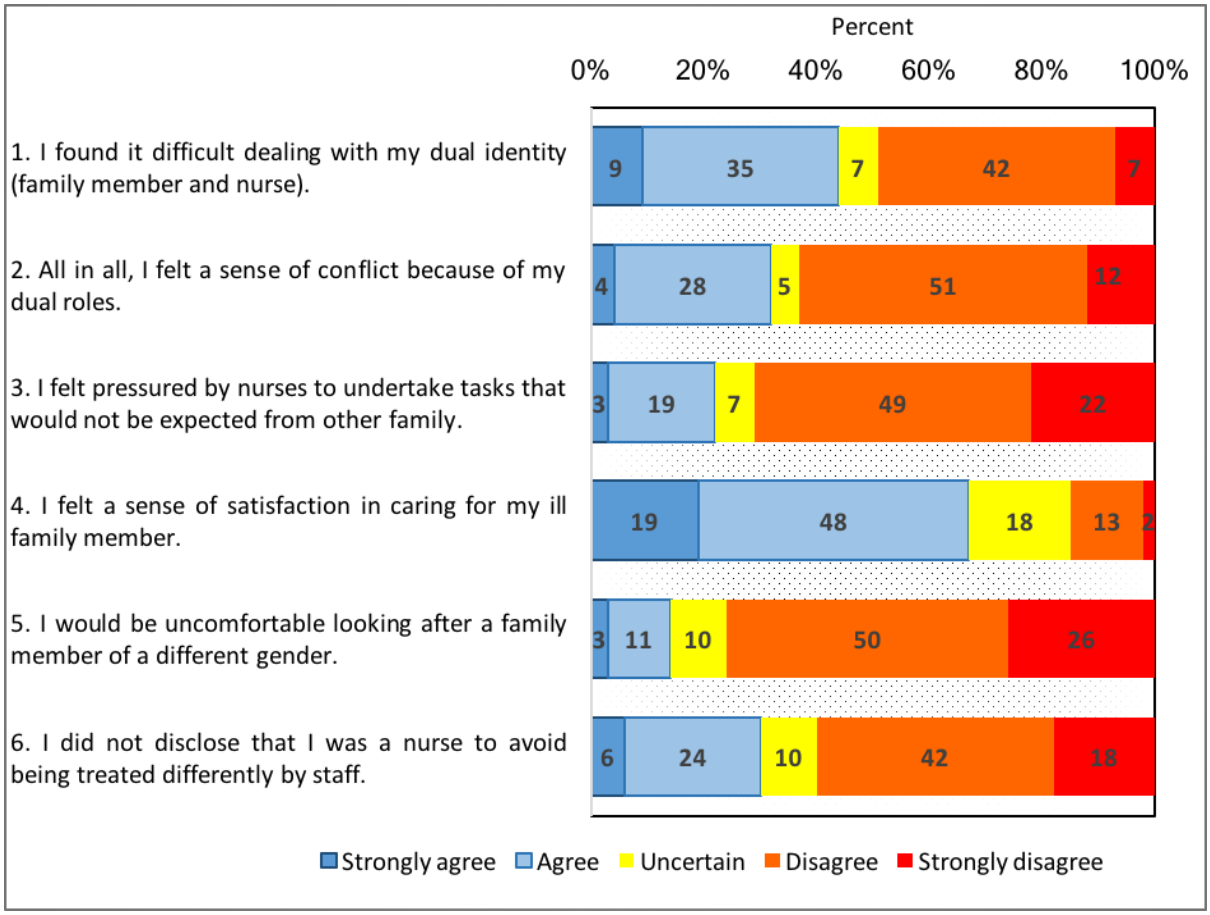

Figure 8:Please assess the extent to which you agree or disagree with each of the following items relating to your identity.

Content analysis

Item 1: I found it difficult dealing with my dual identity (family member and nurse). In this item 13 respondents commented revealing one main category and two sub-categories. Overall, almost half of the respondents disagreed with the statement

Main category 1.1: Self-impact

Sub-categories 1.1.1: *Not at all probably glad of it* (Respondents No. 9, 58, 90)

Sub-categories 1.1.2: *Always struggle* (Respondents No. 106, 85, 106, 62, 116, 56, 111, 41

108, 15, 93)

Item 2: All in all, I felt a sense of conflict because of my dual roles. In this item nine respondents wrote comments, two gave insights which did not relate to the issue and seven commented which revealed one main category and two sub-categories.

Main category 2.1: Self-impact

Sub-categories 2.1.1: *Conflict does not exist* (Respondents No. 6, 9, 106, 90)

Sub-categories 2.1.2: *Pressure from other family* (Respondents No. 38, 79, 93)

Item 3: I felt pressured by nurses to undertake tasks that would not be expected from other family. While the majority of respondents disagree with this item, 13 respondents commented which revealed one main category and two sub-categories.

Main category 3.1: Different expectations on nurses

Sub-categories 3.1.1: *Occasionally, felt pressured* (Respondents No. 8, 44, 75, 79, 62, 6, 90)

Sub-categories 3.1.2: *Never asked* (Respondents No. 93, 105, 106, 58, 9, 1)

Item 4: I felt a sense of satisfaction in caring for my ill family member. In this item eight respondents provided comments which revealed one main category and one sub-categories. Two gave insights which did not relate to the issue.

Main category 4.1: Self-impact

Sub-categories 4.1.1: *Derived satisfaction* (Respondents No. 9, 58, 106, 111, 67, 56)

Item 5: I would be uncomfortable looking after a family member of a different gender.

Generally, the majority of respondents disagreed with this statement with five writing comments which revealed one main category and two sub-categories.

Main category 5.1: Self-impact

Sub-categories 5.1.1: *Gender does not matter* (Respondent No. 9)

Sub-categories 5.1.2: *Depends On Patient's Condition* (Respondents No. 62, 93, 85, 112)

Item 6: I did not disclose that I was a nurse to avoid being treated differently by staff. For this item 27 respondents provided comments which revealed one main category and three sub-categories.

Main category 6.1: Self-impact

Sub-categories 6.1.1: *I was found out* (Respondents No. 3, 13, 21, 24, 44, 67, 70, 77, 79, 43)

Sub-categories 6.2.2: *Staff familiarity* (Respondents No. 85, 90, 93, 100, 62, 105, 106, 83)

Sub-categories 6.2.2: *Disclosed when needed* (Respondents No. 6, 9, 54, 56, 111, 8, 104, 89, 75)

Table 8: Categories for the elements relating to the disclosure of identity, illustrates the categories developed from the responses to this items.

Table 11: Categories for the elements relating to the disclosure of identity.

Main Category	Sub-Category	Quote
Self-impact	Not at all probably glad of it	Not at all probably glad of it I think I was taken more seriously. (9) However, some respondents agreed with this statement.
	Always struggle	Always struggle with this! (106)
	Conflict does not exist	I don't feel a conflict, I just know it impacts the patient, staff and me. Your family member isn't just 'another patient', they are 'the nurse who works in education's aunt'. (106)
	Pressure from other family	Pressure from siblings. (38)
	Derived satisfaction	I felt when I was there that I could help so I did. (9)
	Gender does not matter	Previously assisted in care of my Uncle. Not phased by gender. (9)
	Depends On Patient's Condition	Not difficult looking after someone in the family only difficult dealing with the way they deal with their illness. (62)
Different expectations on nurses	Occasionally, felt pressured	Yes, at times, although I was also so involved in my son's care that I did most of it instinctively. (79)
	Never asked	Was never asked to undertake any tasks. (58)
Relationship with staff	I was found out	Eventually, I was found out but not because of being treated differently. (44)
	Staff familiarity	They knew who I was because it was where I work. (93)
	Disclosed when needed	I only mentioned I was a nurse when I noticed them do something that I wouldn't have done. (104)

Section 4.4: Elements relating to advocacy

This section featured 11 items and made use of a Likert scale. Nurses were asked to state their opinion regarding their personal role as an advocate, observer of the care delivered and decision maker. Of 110 respondents, 97 completed the 11 items relating to the personal role. Figure 7 presents the results for this particular element.

The figure 7 shows that more than 70% of respondents stated that they agreed with items 1, 4, 5, 6 and 11, but almost 60% disagreed with statement 9. Statements 2 and 3 were met with equal agreement and disagreement. Over half of respondents reported their agreement with items 7, 8 and 10. However, the figure also indicates that some respondents, although a much lower percentage, were uncertain about these items.

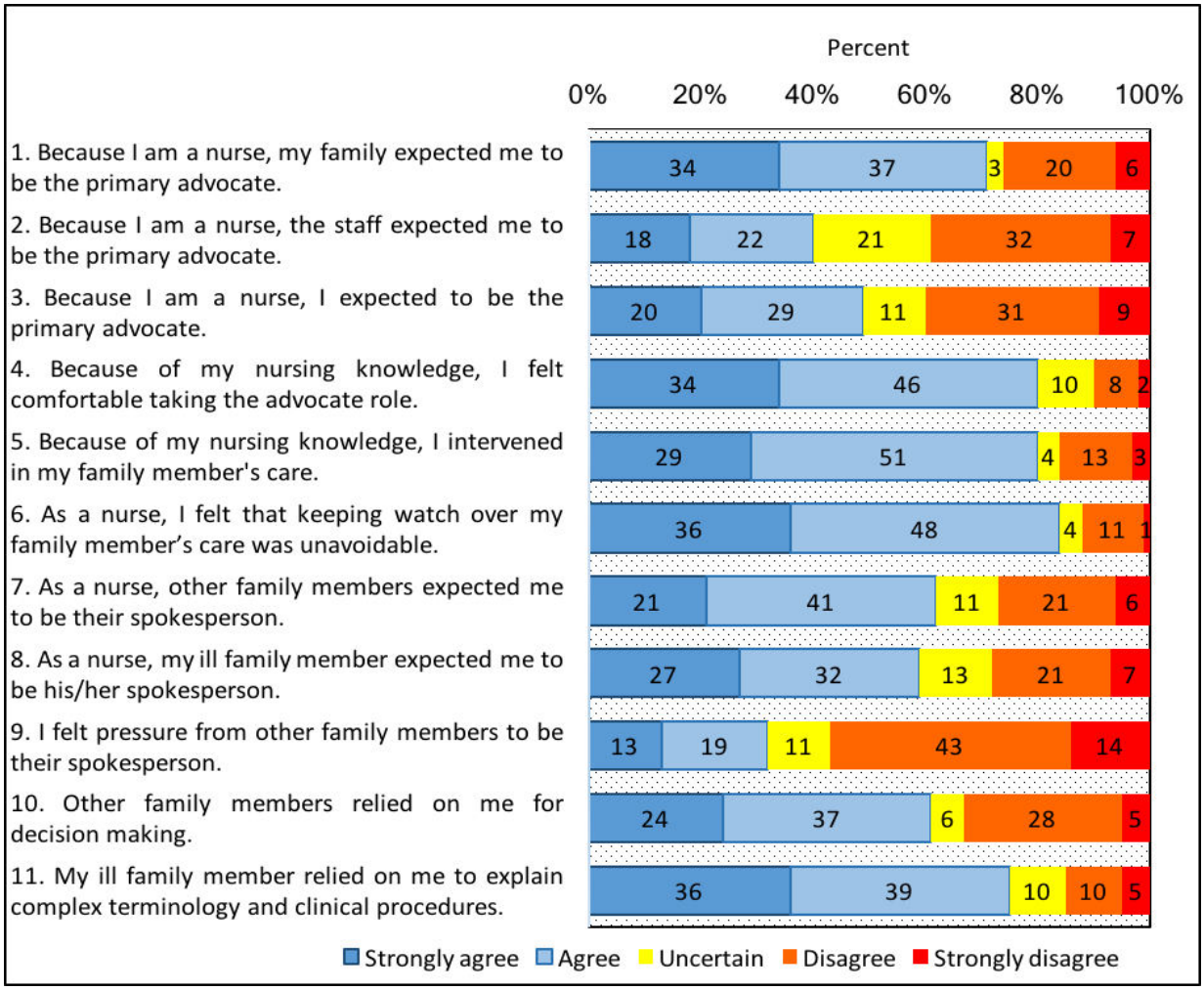

Figure 9: Please indicate the extent to which you agree or disagree with each of the following items relating to your personal role

Content analysis

Item 1: Because I am a nurse, my family expected me to be the primary advocate. Overall, the majority of respondents agreed with the statement with eight written comments which revealed one main category and two sub-categories.

Main category 1.1: Different expectations on nurses

Sub-categories 1.1.1: *Just for advice* (Respondents No. 3, 69, 106, 87)

Sub-categories 1.1.2: *Being a primary advocate* (Respondents No. 9, 111, 38, 93)

Item 2: Because I am a nurse, the staff expected me to be the primary advocate. In this item seven respondents wrote comments, four gave insights which did not relate to the issue and three comments were analysed which revealed one main category and one sub-category.

Main category 2.1: Different expectations on nurses

Sub-categories 2.1.1: *Agreed role* (Respondents No. 24, 54, 9)

Item 3: Because I am a nurse, I expected to be the primary advocate. For this item seven respondents provided comments, three gave insights which did not relate to the issue and four comments were analysed which revealed one main category and one sub-category.

Main category 3.1: Different expectations on nurses

Sub-categories 3.1.1: *Expected to be the advocate* (Respondents No. 9, 56, 72, 38)

Item 4: Because of my nursing knowledge, I felt comfortable taking the advocate role. In this item six respondents commented, two gave insights which did not relate to the issue and four comments were analysed which revealed one main category and two sub-categories.

Main category 4.1: Nurses' knowledge

Sub-categories 4.1.1: *Very comfortable* (Respondents No. 9, 67, 81)

Sub-categories 4.1.2: *Occasionally uncomfortable* (Respondent No. 111)

Item 5: Because of my nursing knowledge, I intervened in my family member's care. The majority of comments indicated that respondents intervened because they had no choice with 16 writing comments, one gave insight which did not relate to the issue and 15 comments were analysed which revealed one main category and one sub-category.

Main category 5.1: Nurses' knowledge

Sub-categories 5.1.1: *Had no choice* (Respondents No. 3, 8, 21, 73, 77, 6, 9, 24, 38, 44, 49, 58, 54, 56, 113)

Item 6: As a nurse, I felt that keeping watch over my family member's care was unavoidable. For this item five respondents commented, one gave insight which did not relate to the issue and four comments were analysed which revealed one main category and one sub-category.

Main category 6.1: Different expectations on nurses

Sub-categories 6.1.1: *I did not trust care* (Respondents No. 9, 38, 44, 77)

Item 7: As a nurse, other family members expected me to be their spokesperson. In this item four respondents provided comments, one gave insight which did not relate to the issue and three comments were analysed which revealed one main category and one sub-category.

Main category 7.1: Different expectations on nurses

Sub-categories 7.1.1: *It was a given* (Respondents No. 1, 9, 103)

Item 8: As a nurse, my ill family member expected me to be his/her spokesperson. Overall, the majority of respondents agreed with the statement with six giving comments, two gave insight which did not relate to the issue and four comments were analysed which revealed one main category and two sub-categories.

Main category 8.1: Different expectations on nurses

Sub-categories 8.1.1: *Always a spokesperson* (Respondents No. 1, 95, 111)

Sub-categories 8.1.2: Other family is the spokesperson (Respondent No. 3)

Item 9: I felt pressure from other family members to be their spokesperson. The majority of respondents disagree with this item and did not relate to the issue.

Item 10: Other family members relied on me for decision making. More than half of the respondents agreed with this item there were various comments revealed in this statement. Six respondents wrote comments which revealed one main category and three sub-categories.

Main category 10.1: Different expectations on nurses

Sub-categories 10.1.1: *Shared decision making* (Respondents No. 8, 75)

Sub-categories 10.1.2: *Others make decision* (Respondents No. 90, 93)

Sub-categories 10.1.2: *Relied upon me* (Respondents No. 9, 111)

Item 11: My ill family member relied on me to explain complex terminology and clinical procedures. The last item received responses from 12 respondents who provided comments, one gave insight which did not relate to the issue and 11 comments were analysed which revealed one main category and two sub-categories.

Main category 11.1: Different expectations on nurses

Sub-categories 11.1.1: *Had to explain* (Respondents No. 1, 9, 58, 83, 106, 112, 98)

Sub-categories 11.1.2: *Unable to comprehend* (Respondents No. 6, 24, 56, 72)

Table 9: Categories for the elements relating to advocacy, illustrates the categories developed from the responses to this items.

Table 12: Categories for the elements relating to advocacy

Main Category	Sub-Category	Quote
Nurses' knowledge	Very comfortable	Very comfortable with taking the role of advocate (9)
	Occasionally uncomfortable	Not always comfortable. Occasionally my hand was forced by blatant errors that the staff should have known better. I can be reluctant but not scared of advocating if I need to (No. 111)
	Had no choice	I had no choice as his care was inadequate (58)
Different expectations on nurses	Just for advice	They looked to me for advice (69)
	Being a primary advocate	Yes, my role of advocate and medical attorney has been sort because of my nursing background (9)
	Agreed role	Despite informing them of the family agreement that I would be the primary advocate they regularly communicated with a less experienced family member (24)
	Expected to be the advocate	Yes, I probably expected to be the advocate (9)
	I did not trust care	I did not trust the care (44)
	It was a given	It wasn't that they expected me to be the spokesperson, it was a 'given' as I was the nurse (1)
	Always a spokesperson	I reassured my father that I would be his spokesperson and he trusted me with this (1)
	Other family is the spokesperson	My Grandmother was happy with her daughter, my aunt, as advocate and me to help with determination of care needs (3)
	Shared decision making	All was discussed between family (75)
	Others make decision	If decisions needed to be made my husband made them (90)
	Relied upon me	Yes, because they trusted I would be able to advocate for them (9)
	Shared decision making	All was discussed between family (75)

	Others make decision	If decisions needed to be made my husband made them (90)
	Relied upon me	Yes, because they trusted I would be able to advocate for them (9)
	Had to explain	If I didn't explain it, no-one else took the time to explain it (1)
	Unable to comprehend	Mum was unable to comprehend complex terminology and clinical procedures (6)

Section 4.5: Likert scale of frequency as perceived by the nurses

There were 11 items that made use of a Likert scale in this section. Nurses were asked to state their opinion regarding the frequency of information provided, their satisfaction with the care provided to their loved ones, involvement with care and disclosure of identity. Of 110 respondents, 95 to 97 completed the 11 items relating to the frequency as perceived by the nurses. Figure 8 presents the results for this particular element.

For item 1, although 31% of respondents received significant information often, 40% of respondents only *sometimes* received information. However, an equal percentage of respondents often and sometimes agreed with item 2, and the percentage was almost equal for item 3. Regarding item 4, 38% of respondents stated that they would rather be treated like a family member who is not a nurse. An almost equal number of respondents chose rarely and never for item 5. In response to items 8 and 9, respondents strongly stated 'never'. For the final item, while 32% of respondents reported that they never experienced avoidance by respondents, others (28% in both cases) reported that they experienced avoidance either sometimes or rarely.

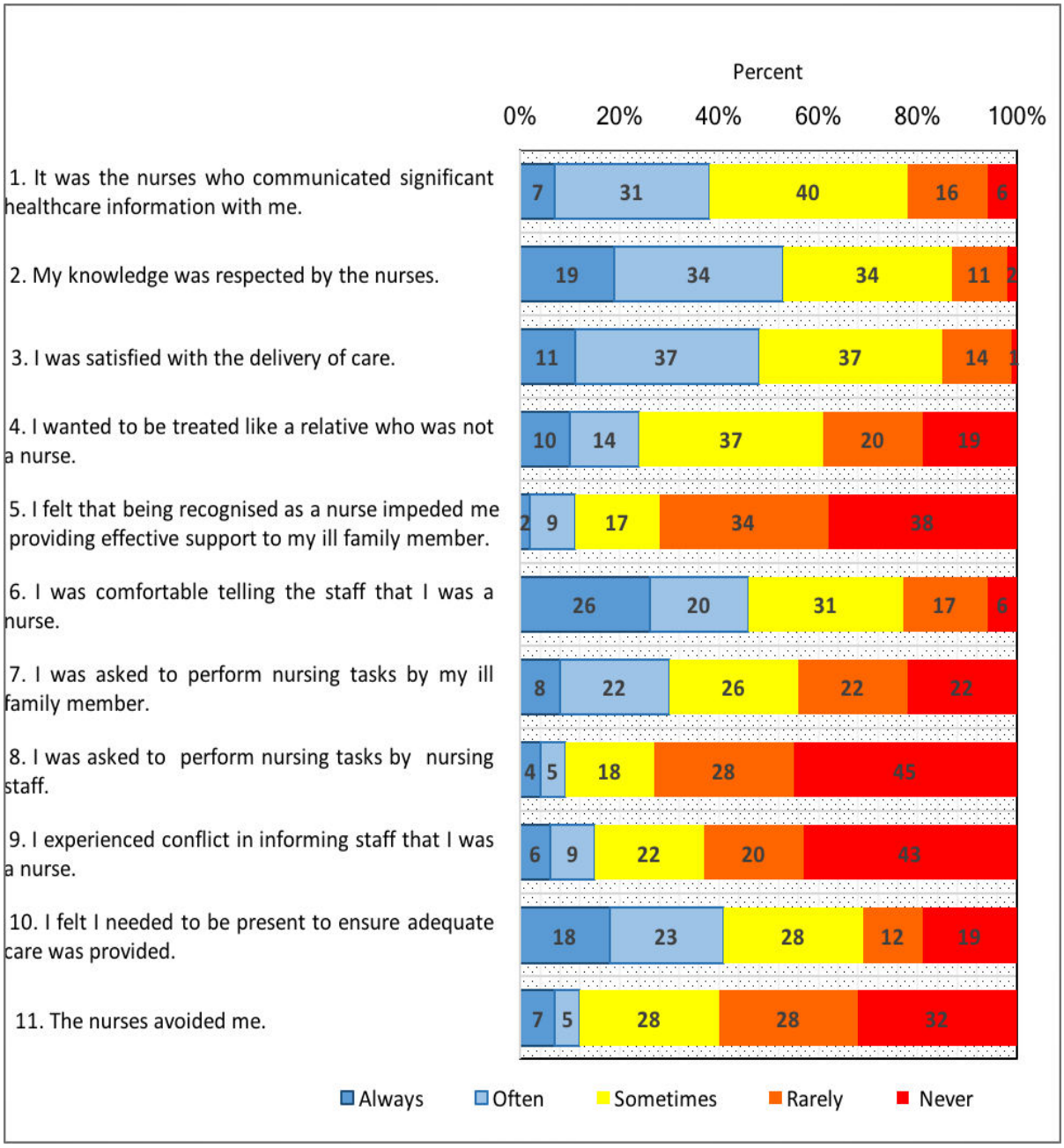

Figure 10: Please indicate how often the following items apply to your experience

Content analysis

Item 1: It was the nurses who communicated significant healthcare information with me. The experience was variable, with four writing comments, one gave insight which did not relate to the issue and three comments were analysed which revealed one main category and two sub-categories.

Main category 1.1: Relationship with staff

Sub-categories 1.1.1: *Not enough information* (Respondents No. 6, 75)

Sub-categories 1.1.2: *Information from other staff* (Respondents No. 103)

Item 2: My knowledge was respected by the nurses. For this item, the two most common categories were often and sometimes, with four respondents providing comments, two gave insights which did not relate to the issue and two comments were analysed which revealed one main category and one sub-category.

Main category 2.1: Nurses' knowledge

Sub-categories 2.1.1: *My knowledge was a thorn in their side* (Respondents No. 3, 6)

Item 3: I was satisfied with the delivery of care. Although the majority of respondents were distributed between often and sometimes, some were dissatisfied. In this item, four respondents wrote comments, two gave insights which did not relate to the issue and two comments were analysed which revealed one main category and one sub-category.

Main category 3.1: Satisfaction with care

Sub-categories 3.1.1: *It was bad* (Respondents No. 3, 90)

Item 4: I wanted to be treated like a relative who was not a nurse. For this item, answers from respondents were spread among the categories, where four respondents commented, three gave insights which did not relate to the issue and one comment was analysed which revealed one main category and one sub-category.

Main category 4.1: Self-impact

Sub-categories 4.1.1: *Except in communication* (Respondents No. 3, 38, 111)

Item 5: I felt that being recognised as a nurse impeded me providing effective support to my ill family member. Overall, the majority of respondents were distributed between rarely and never, with three respondents commenting, two gave insights which did not relate to the issue and one comment was analysed which revealed one main category and one sub-category.

Main category 5.1: Self-impact

Sub-categories 5.1.1: *After disclosure of identity* (Respondent No. 54)

Item 6: I was comfortable telling the staff that I was a nurse. In this item, the respondents appeared to be completely happy or sometimes happy, with seven respondents provided comments, one gave insight which did not relate to the issue and six comments were analysed which revealed one main category and two sub-categories.

Main category 6.1: Relationship with staff

Sub-categories 6.1.1: *Healthcare staff familiarity* (Respondents No. 56, 85, 93)

Sub-categories 6.1.2: *Disclosed when asked* (Respondents No. 93, 111)

Item 7: I was asked to perform nursing tasks by my ill family member. For this item, answers from respondents were spread among the categories except for the always category, four respondents provided comments which revealed one main category and one sub-category.

Main category 7.1: Different expectations on nurses

Sub-categories 7.1.1: *Was a given* (Respondents No. 6, 9, 56, 111)

Item 8: I was asked to perform nursing tasks by staff. Generally, the majority of respondents answered never, with two writing comments, one gave insight which did not relate to the issue and one comment was analysed which revealed one main category and one sub-category.

Main category 8.1: Different expectations on nurses

Sub-categories 8.1.1: *I just did it* (Respondent No. 6)

Item 9: I experienced conflict in informing staff that I was a nurse. The majority of respondents were distributed between never, rarely and sometimes, four respondents provided comments which revealed one main category and two sub-categories.

Main category 9.1: Relationship with staff

Sub-categories 9.1.1: *Well received by staff* (Respondents No. 9, 111)

Sub-categories 9.1.2: *Never acknowledged* (Respondents No. 77, 108)

Item 10: I felt I needed to be present to ensure adequate care was provided. In this item answers from respondents were spread among the categories, eight respondents commented, one gave insight which did not relate to the issue and seven comments were analysed which revealed one main category and one sub-category.

Main category 10.1: Relationship with staff

Sub-categories 10.1.1: *Wanted to be present* (Respondents No. 3, 9, 17, 56, 93, 95, 6)

Item 11: The nurses avoided me. For this item answers from respondents were spread among never, rarely and sometimes categories except for the always and often categories, three respondents wrote comments which revealed one main category and one sub-category

Main category 11.1: Relationship with staff

Sub-categories 11.1.1 *Avoided at times* (Respondents No. 6, 95, 111)

Table 10: Categories for the Likert scale of frequency as perceived by the nurses, illustrates the categories developed from the responses to this items.

Table 13: Categories for the Likert scale of frequency as perceived by the nurses

Main Category	Sub-Category	Quote
Nurses' knowledge	My knowledge was a thorn in their side	It was more 'thorn in their side' (3)
Different expectations on nurses	Was a given	Yes, when visiting I was asked to do things (9)
	I just did it	I did them anyway, just to provide safe care for mum (6)
Relationship with staff	Not enough information	Not enough BUT (sic) much more than medical staff who were rarely seen (6)
	Information from other staff	As well as medical & physio staff (103)
	Healthcare staff familiarity	They all knew I was a nurse (93)
	Disclosed when asked	Only if they asked. Or if I had to point out an error and letting the staff know of the evidence underpinning my criticism (111)
	Well received by staff	Well received (9)
	Never acknowledged	They knew but never acknowledged it, I was offended by that (77)
	Wanted to be present	At times as I knew which staff were less than capable of providing adequate unsupervised care, however I did not ask for them not to look after him I just wanted to be present (56)
	Avoided at times	Eventually, after repeated confrontations without resolution (95)
Satisfaction with care	It was bad	Care in ward was bad (90)
Self-impact	Except in communication	Except in communication. Happy (sic) to have more technical jargon than simplified (111)
	After disclosure of identity	Only after I advised them of my role (54)

Reliability Analysis

Reliability analysis offers an indication of how the scale items fit together by assessing internal consistency. Internal consistency reliability was analysed using the Cronbach's alpha instrument. Cronbach's alpha is used to assess the reliability of a questionnaire and internal consistency of the scale as a whole. The 5-point Likert scale of agreement and frequency as perceived by the nurses was used for 46 items which are grouped under six categories:

- Nurses' knowledge,
- Satisfaction with care,
- Ability to evaluate care,
- Different expectations on nurses,
- Self-impact, and
- Relationship with staff.

However, one item, a standalone question, did not fit any category and was excluded from the analysis. In addition, some items were reverse scored to maximise reliability of the survey and are presented in Appendix VII. The alpha analysis revealed values ranging from 0.595 to 0.884 and descriptive statistics, including the mean and standard deviation within each category, are presented in Table 6.

Table 14: Cronbach's alpha

Category	Number of respondents	Number of Items	Possible Range	Actual Range	Mean (SD)	Cronbach's alpha
Nurses' knowledge*	97	8	8-40	8-34	17.49 (4.88)	.703
Satisfaction with care*	97	3	3-15	3-15	8.38 (3.17)	.884
Ability to evaluate care	100	2	2-10	2-10	3.57 (1.60)	.695
Different expectations on nurses	96	12	12-60	15-59	33.94 (9.42)	.876
Self-impact	96	14	14-70	25-65	42.71 (7.25)	.700
Relationship with staff*	94	6	6-30	10-30	20.18 (4.16)	.595

*less than 10 items, Abbreviations: SD (Standard Deviation) (A five point Likert scale of agreement, which had five possible answers ranging from '1=strongly agree' to '5= strongly disagree' and A five point Likert scale of frequency, which had five possible answers that ranging from '1= always' to '5= Never')

A Cronbach's alpha value of 0.7 or above is considered to indicate an adequate reliability score (Nunnally 1994). However, the low alpha score of relationship with staff may be because of the low number of items. Pallant (2016) highlighted that a low Cronbach's alpha score can occur when there are less than 10 items while Hinton, McMurray and Brownlow (2004, p. 364) indicated that '0.5 to 0.7 scores show moderate reliability'. If there are less than 10 items, it should be the case that Cronbach's alpha scores greater that 0.5 are acceptable. Therefore, the alpha values in this study were considered to indicate an adequate reliability score.

Linear regression was used to evaluate the relationship between the six category outcomes and the predictor: nursing experience (adjusting for the confounders: age and gender). A *p* value of more than 0.05 was adopted as not statistically significant and less than 0.05 was significant. As shown in table 7, a limited number of significant relationships were found between outcomes and predictors. A statistically significant, negative correlation was found between different expectations on nurses and nursing experience in both unadjusted ($r[96] = -0.163, p = .042$) and adjusted models ($r[96] = -0.331, p = .019$).

In both models, for nurses in this survey, the greater the experience in nursing practice, the higher is the expectations of others (patient, family and health care team). This suggests that nurse-family members with more years in practice, have more expectations to be the primary advocate, spokesperson and the decision maker from others, than nurses' with fewer years of practicing nursing. Furthermore, these expectations have varying effects on the experiences of nurse-family members in the hospital settings. However, there were no significant associations found between different expectations on nurses and nursing experience with either age or gender. For all models, scatter plots and histograms were used to test normality of residuals and homoscedasticity, and these assumptions of a linear regression were found to be upheld in each case.

Table 15: Results from Linear Regression Models of six outcome categories versus nursing experience, unadjusted and adjusted for age and gender

		Unadjusted Model		Adjusted Model*	
Category	Predictors	B-coefficient (95% CI)	*p*-Value	B-coefficient (95% CI)	*p*-Value
Nurses' knowledge	Nursing experiences	-.054 (-.136 to .029)	.204	-.140 (-.285 to .005)	.058
	Age			.118 (-.046 to .281)	.158
	Gender**			-.336 (-4.044 to 3.373)	.859
Satisfaction with the care	Nursing experiences	-.007 (-.061 to .047)	.801	.011 (-.085 to .107)	.826
	Age			-.024 (-.132 to .084)	.659
	Gender			-.598 (-3.048 to 1.851)	.632
Ability to evaluate care	Nursing experiences	.006 (-.022 to .033)	.691	-.031 (-.077 to .016)	.198
	Age			.048 (-.004 to .100)	.072
	Gender			-1.117 (-2.237 to .004)	.151
Different Expectations on Nurses	Nursing experiences	**-.163** (-.321 to -.006)	**.042**	**-.331** (-.608 to -.055)	**.019**
	Age			.229 (-.082 to .541)	.150
	Gender			1.380 (-5.685 to 8.445)	.702
Self-impact	Nursing experiences	.073 (-.050 to .196)	.243	.194 (-.020 to .408)	.076
	Age			-.163 (-.405 to .078)	.185

	Gender			3.202 (-2.276 to 8.679)	.252
Relationship with staff	Nursing experiences	.025 (-.048 to .097)	.505	-.027 (-.151 to .098)	.676
	Age			.070 (-.071 to .210)	.331
	Gender			2.759 (-.649 to 6.168)	.113

*Adjusted for Age (years) and Gender. **Gender comparison is females versus males. Abbreviations: CI, confidence interval. Significant *p*- Value set at (<.05).

Further analysis

An ordinal logistic regression model was used to evaluate the relationship between dependent variables (Likert scales agreement) and the predictor: 'Did you have an enduring medical power of attorney?' As shown in table 8, there is a statistically significant association between 'Because of my nursing knowledge, I felt comfortable taking the advocate role' and whether the nurse had enduring medical power of attorney (global P value= .027). When the nurse had enduring medical power of attorney they were 2.8 times more likely than nurses without enduring power of attorney to have agreement with the statement 'Because of my nursing knowledge, I felt comfortable taking the advocate role' (odds ratio=2.8, 95% confidence interval: 1.6 to 4.7).

In addition, an ordinal logistic regression model was used to evaluate the relationship between dependent variable (Likert scales agreement and frequency) and the predictor: 'Was your family member admitted to your workplace?'. There was a statistically significant association between whether the nurse was comfortable telling staff that she/he was a nurse and whether the family member was admitted to their workplace (global P value=0.001). When the nurse's family member was admitted to their workplace, they were 3.9 times more likely to be always or often be comfortable telling staff that she/he was a nurse (odds ratio=3.9, 95% confidence interval: 1.7 to 8.9), as presented in table 8.

All outcomes of the Likert scale items of agreement and frequency are presented in Appendix VIII

Table 16: Results from an ordinal logistic regression model

Outcome	Likert scales	Predictor	Comparison	Reference	Odds Ratio	95% CI	*p*-value*
Q24T1	Agreement	Did you have an enduring medical power of attorney?	YES	NO	1.271	.585 to 2.764	0.545
Q24T2	Agreement	Did you have an enduring medical power of attorney?	YES	NO	.794	.375 to 1.682	0.547
Q24T3	Agreement	Did you have an enduring medical power of attorney?	YES	NO	1.548	.727 to 3.296	0.257
Q24T4	Agreement	Did you have an enduring medical power of attorney?	YES	NO	**2.844**	**1.611 to 4.67**	**0.027**
Q24T7	Agreement	Did you have an enduring medical power of attorney?	YES	NO	1.660	.757 to 3.640	0.206
Q24T8	Agreement	Did you have an enduring medical power of attorney?	YES	NO	1.658	.774 to 3.555	0.194
Q24T9	Agreement	Did you have an enduring medical power of attorney?	YES	NO	.747	.342 to 1.632	0.464
Q24T11	Agreement	Did you have an enduring medical power of attorney?	YES	NO	1.197	.552 to 2.597	0.649
Q21T5	Agreement	Was your family member admitted to your workplace?	YES	NO	1.891	.899 to 3.980	0.093
Q24T2	Agreement	Was your family member admitted to your workplace?	YES	NO	1.405	.661 to 2.987	0.377

Q25T1	Frequency	Was your family member admitted to your workplace?	YES	NO	2.003	.911 to 4.404	0.084
Q25T6	Frequency	Was your family member admitted to your workplace?	YES	NO	**3.903**	**1.718 to 8.867**	**0.001**
Q25T8	Frequency	Was your family member admitted to your workplace?	YES	NO	1.013	.468 to 2.195	0.974
Q25T10	Frequency	Was your family member admitted to your workplace?	YES	NO	.970	.467 to 2.015	0.936
Q25T11	Frequency	Was your family member admitted to your workplace?	YES	NO	.889	.419 to 1.884	0.758

*Significant *p*-Value set at (<.05).

Section 5: Additional comments, questions or concerns related to the experience

The final question of the survey requested voluntary comments, questions or concerns. Twenty-six of 110 respondents provided additional notes. While four respondents gave insights which did not relate specifically to the study question, 22 comments were analysed revealing four themes. Although some comments were only brief, others provided in-depth statement.

Theme 1: *Dissatisfaction with the care provided* (11 comments)

Comments: The way my step father was treated was unprofessional and no action was taken. (No. 2)

Theme 2: *Difficulty communicating with staff* (6 comments)

Comments: Most of my concerns 're' (sic) care arose from nurses who had trained overseas. Language barriers and general basic care was a real concern. Misinterpreted orders 'ect' (sic) how to use basic equipment as well as implementing patient concerns when patient deteriorating a real problem (No. 114)

Theme 3: *Being ignored by staff* (3 comments)

Comments: As a family member who is also a nurse it was extremely frustrating not to be able to influence decisions (e.g. wound dressing choice) even when rationale expressed and evidence provided. As a Clinical Nurse I am confident with making clinical decisions and changes to patient care. I felt that nurses were following established patterns of care rather than providing care individualised to changing clinical signs (No. 112)

Theme 4: *Being an advocate* (2 comments)

Comments: Very difficult being a family member over seeing their care in hospital. You are limited with information and you also take on the emotional rollercoaster of emotions. At times I had to fight for certain patient's rights so my father would be more comfortable and pain free at the end of his journey. I was always confident that I made the right decision for my father and would not change my decisions. (No. 93)

Summary

Results of the online survey provide details about how nurses experienced the admission of their loved ones to acute care hospitals. Of 116 respondents, 110 met the inclusion criteria to participate in the online survey, with a response rate of 17%. Most nurses who responded in the study were female with a mean age of 46 years. Additionally, most respondents were working in metropolitan Adelaide with previous relevant work experience ranging from 1 to 46 years. Most respondents indicated they had experienced two to three instances of having family members hospitalised in acute care hospitals. Parents were identified as the most significant category of relationship: 87 (39.9%) of nurse respondents chose this option.

Medical/surgical area was the main category of admission for 81 (78.6%) respondents. Also, 46 (44.7%) respondents indicated that their experience with patient family members had occurred within a year previous to the study. Most respondents were clinicians 87 (84.5%) at the time of the experience and 59 (57.3%) respondents specified that their most significant experiences with the hospitalisation of their family members occurred when they were working in medical/surgical area.

Most respondents strongly agreed or agreed that their nursing knowledge influenced their role as nurse-family member. They stated that this knowledge put them in a better position to judge the quality of care their loved ones were receiving, but also made them different to other relatives. In addition, the majority of respondents positively agreed that their experiences impacted their professional practice and the way they interacted with other patients' family members. Half of respondents reported that they disagreed or strongly disagreed that they felt a sense of conflict because of dual identity. Most respondents agreed or strongly agreed that they took on an advocate role, intervened and kept watch over their ill loved ones' care. Moreover, nurses with more years of experience reported that they had more expectations to be the primary advocate and spokesperson, than nurses with fewer years experience. Lastly, most respondents stated they rarely or never felt that being recognised as a nurse impeded them from providing effective support to their ill family members and being asked to perform nursing tasks by staff. Some respondents offered their own thoughts in comments and expressed their experiences using their own terms. Qualitative analysis of narrative data led to an understanding of the nursing experience as described above. The following chapter features discussion of these results with recommendations for future practice.

Chapter Five: Discussion And Conclusion

Introduction

Chapter five presents the final component of Study 2 and provides a comprehensive discussion of findings, which aligns with the literature and study purpose. Results of the study are discussed in terms of main findings and their relevance to clinical practice. Finally, the discussion outlines limitations of the study, implications of the results and need for further research.

Restatement of the study purpose

The experience of caring for a patient who has a relative who is a nurse is different than that of caring for other patients. There may be different expectations of those caring for the patient and the nurse who is also the family member. The systematic review (Study 1) highlighted the importance of how these experiences can impact the quality of patient care and offered the researchers a focus for the current study. Study 2 aimed to explore the opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital. Particularly, the aim of this study was to answer the research question: 'What are the opinions of nurses regarding their experiences when their ill loved ones are admitted to acute care hospitals?' This issue was examined with a cross-sectional survey (Study 2) which contributed to this portfolio of research. It was conducted in one metropolitan and one country hospital in South Australia. Furthermore, the data collected may be used within the health care system to develop clinical practice policy.

Discussion of findings

The previous chapter contained descriptions of the experiences of nurses whose loved ones were hospitalised. However, it was unclear what the nurses' views were on how they would like to be supported during such a stressful event. Study 2 offered insight into nurses' opinions of these unique experiences and revealed their standpoint in terms of the need for clinical support. Nurses experience significant challenges when an ill loved one is hospitalised. While the experience of family members has been widely researched, it could be expected that nurse-family members would have similar experiences. However, it could be anticipated that there are significant differences in nurse-family experiences. To the best of our knowledge, no study has specifically studied these issues from a quantitative perspective. Study 2 is a unique study in the following respects: it was conducted in two different areas (metropolitan and country) within the Australian community, and participants were nurses who had experienced having an ill loved one hospitalised.

Main Findings

Section 1: Nurses' sociodemographic characteristics

Over the past decade, the nursing workforce is considered part of the aging population which dramatically increased in Australia and globally. The finding of this study reflected the Australian profile of nurses, with the average nurse age exceeding 45 years, and almost all being women.

This trend is aligned with Australia's Future Health Workforce Nurses report that shows an increasing average age of nurses (44.6 years) and a majority of female nurses (Health Workforce Australia 2014). The female respondents in this age group are likely to take on the responsibility of caring for dependent family members, such as parents. This means that that the majority of participants were experienced nurses and have greater expectations coupled with a responsibility to their hospitalised ill relatives.

Section 2: The experience of nurses during the hospitalisation of family members

The survey revealed that the majority of respondents indicated they had experienced having an ill loved one hospitalised on more than two occasions. It is apparent that this finding reflects a common experience among nurses to accompany loved ones during hospitalisation. This may potentially influence the factors that include, but are not limited to, communication with staff, role conflict and expectations of care provided. Moreover, being a nurse with an ill family member may provide a more complex experience in both personal and professional relationships (Cicchelli & McLeod 2012; Wilson & Ardoin 2013). At the same time, the findings of this study identified parents as the most frequent category of family relationship hospitalised. Generally, parents take the responsibility of looking after their sick children in a hospital, but in this study, the case is different, where nurse-family members assume the multiple responsibilities in the involvement of hospital care. Indeed, the aging population is growing steadily which may suggest that adult children are more likely to care for their parents (Ledwidge 2010). In Canada, there is a growing body of literature focused on nurse-family members caring for their aging parents (Taverner, Baumbusch & Taipale 2016; Ward-Griffin et al. 2015; Ward-Griffin et al. 2005). Therefore, it seems that having a nurse-family member alongside his or her ill parent is something common in the hospital environment.

Section 3: Inquiry about the most significant experience

In the current study, it was apparent that nurses reported that the area of admission for the majority of relatives' admission was the medical/surgical area. Commonly, this area is considered to be an accessible space for family members during visiting periods and a space for supporting ill loved ones physically and psychologically. In terms of occurrence of experiences, almost 50% of respondents indicated that their most significant experience had occurred in the year prior to the study; however, others referred to experiences that had occurred one to five years prior. This indicated that the experiences were still fresh and vivid in the respondents' memories. This is similar to the study findings of Ledwidge (2010), where nurse-family members had experienced the admission of their ill loved ones to hospitals within a five-year period. In this study, it seems that the recent nature of such events for nurse-family members made them easier to recall. Recent events, whether good or bad, are more easily recalled and form lasting memories. Therefore, significant and more recent experience will provide a more accurate finding because details are remembered.

The survey showed that the majority of respondents were taking a 'clinician' role during the time of the experience and specified that they were working in the medical/surgical area. The medical/surgical area is classified under the umbrella of acute care sectors which provide necessary treatment for a short period of time for an illness such as acute infection. This trend is similar to the findings outlined in the Australia's Future Health Workforce Nurses' report, which highlighted that most nurses work in the acute sector as clinicians (Health Workforce Australia 2014).

As mentioned previously, most ill family member admissions were aligned with the nurse-family members' areas of practice, which gave them awareness of the care being provided. Having expert knowledge in the specialty where the relative was admitted may impact on the nurses' opinions regarding care that should be provided for their ill loved one. Moreover, the survey revealed that while some nurses reported that their ill loved one was admitted at their own workplace, the majority of admissions occurred in other wards/areas. Having an ill family member admitted to nurse- family members' own workplace is common (Cicchelli & McLeod 2012; Fulbrook, Allan, et al. 1999; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999; Giles & Williamson 2015; Ledwidge 2010; McNamara 2007; Salmond 2011). The literature highlights the advantages of having an ill family member admitted at the workplace are easy access and familiar environment. However, based on findings of this study, it can be questioned whether the nurse-family members were being supported by their colleagues and managers at their workplace during these stressful events. Ledwidge (2010) found that participants indicated there was support from the workplace and considered themselves fortunate, while others said there was no support. It seems that workplace support is not consistent among nurses, but is considered an important element in an effective health promotion strategy.

In the current study, respondents were evaluated by their professional classifications: most respondents were level registered nurse (RN) 2, and some were level RN 5 or higher. The majority of participants were experienced, skilled and, in some cases, had management roles, which may have influenced care provided to their ill loved ones. Because of their seniority, they may have expected or requested more specialised care for their ill loved ones compared to non-nurse-family members. These nurses may have more access to privileges, such as private rooms, due to their positions in the workplace. In addition, the survey shows that more than a third of respondents confirmed that their ill loved ones were admitted at their own workplace. Having an ill loved one admitted at the nurses' workplace is not new, nor uncommon, within acute care hospitals (Fulbrook, Allan, et al. 1999; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999; Ledwidge 2010; McNamara 2007; Salmond 2011). This study revealed that when the nurse's relative was admitted to their own workplace, they were comfortable disclosing their identity to the hospital staff. Based on findings yielded in this study, while nurses were well known and respected at their familiar workplace, it can be questioned whether the experience would have been different in an unfamiliar workplace, for example a different department.

In South Australia, medical power of attorney or power of attorney for health care 'authorizes the agent, subject to the conditions (if any) stated in the power of attorney, to consent or to refuse consent to medical treatment if the person who grants the power is incapable of making the decision on his or her own behalf' (Ashby & Wakefield 1993, p. 279). This is also known as 'Advanced Directive' which allows individuals to make healthcare decisions when ill loved ones are unable to make their own (Mitnick, Leffler & Hood 2010). The individual the patient chooses as an agent should be someone who they know and trust, such as a key family member. Often, parents, siblings, spouses, children, or significant others are individuals who may be authorised as the medical power of attorney for their ill loved one. An interesting finding of this survey is that a third of respondents had an enduring medical power of attorney for the care of their ill loved one. These nurses felt more comfortable taking the advocate role than nurses without an enduring medical power of attorney. Therefore, a key area for enquiry is whether nurses find this useful in providing care to their ill loved one, as well as whether this is higher in the nursing population than in lay-family members.

Section 4: Likert scale of agreement as perceived by nurses

Respondents were asked for their opinions regarding their experiences when their ill loved ones were admitted to acute care hospitals. A 5-point Likert scale of agreement and frequency was used to evaluate six different concepts (categories): nurses' knowledge, satisfaction with care, ability to evaluate care, different expectations on nurses, self-impact and relationship with staff.

Category 1: Nurses' knowledge

Nurse-family members are in a unique position. Their position and the knowledge they have gained through their work means they are able to navigate the healthcare system, interpret signs, symptoms and laboratory information, and they may be the knowledgeable health care provider. When a family member of a nurse is admitted to hospital, nurses may have a desire to appear clinically knowledgeable regarding care provided. Where clinical knowledge is used as an advantage to influence their role, for example when taking an advocate role, intervening in the care and being respected by the nursing staff. In general, respondents in this study show agreement that knowledge they possess plays a pivotal role that influences their experience during an ill family members' hospitalisation. This is consistent with previous literature that nurses have a unique position to influence their ill loved ones' care, not only because of their clinical knowledge, but also their status within the hospital system (Carlsson et al. 2016; Giles & Hall 2014; Giles & Williamson 2015; Ledwidge 2010; Lines, Mannix & Giles 2015; McNamara 2007; Mills & Aubeeluck 2006; Salmond 2011). Nurses viewed use of specialised knowledge and clinical experience as essential tools to ensure good care. In other words, nursing knowledge and the privilege that comes with the position become useful and relevant resources for nurses when a loved one falls ill. Indeed, when nurses were involved in their ill family member's care they found that their role as a family member impacted family members because of their clinical knowledge. Therefore, nursing knowledge may enable nurses to help their ill family member to receive the best care. However, based on the findings yielded in this study, it is worth questioning whether there was mutual communication between the nurse-family member and health care team regarding the treatment of their ill relative.

Category 2: Satisfaction with care

Nurse-family members' satisfaction with care provided to their ill loved one was one of the prominent issues addressed in this survey. Most respondents agreed on satisfaction items related to delivery of care. Satisfaction with care was identified in previous literature as an outcome of mutual collaboration between the nurse-family member and health care staff which gives the family member satisfaction that their ill loved one is being cared for appropriately (Salmond 2011). In addition, studies show that nurse-family members were satisfied with care provided because they were involved in it (Cicchelli & McLeod 2012; Ledwidge 2010). It seems that satisfaction with the outcome of care delivered is influenced by the nurse-family members' views of ideal care.

Although a minority of nurses disagreed on satisfaction items related to care provided, they provided strong views to support their claims through written comments. For example, some nurses mentioned a lack of nursing attention that led to a medication error which further led to one participant saying that the 'care in the ward was bad'. Certainly, the nurse-family member visualises him- or herself in a position that

is crucial to the patient's satisfaction and a positive patient outcome. It is worth considering if nurses feel a need to be part of some aspects of care to be satisfied with the level of care their loved ones receive.

Category 3: Ability to evaluate care

The concept of evaluating care is considered an important component in ensuring that high quality care is provided. The ability to judge quality of care requires skill in observing, analysing and evaluating patient care. In general, lay-family members may be able to see things that are comforting and observe care provided. However, when the family member is a nurse, the context is different because nurses may have greater capacity to evaluate care delivered. Because of his or her training, it is reasonable to assume that a nurse may have a solid baseline of skill when it comes to fundamentals of care, which is a unique resource to evaluate care. Most nurses surveyed acknowledged the significance of their ability to evaluate quality of care provided. Research conducted with nurses whose family members were critically ill often features a similar description of 'the ability to evaluate' care provided (Salmond 2011). This could present a threat to staff, as results of this survey show that some staff avoided nurse-family members. Given their knowledge of standards of practice and resources available to evaluate patient care, it may be hypothesised that nurses apply the same evaluation skills to assessment of care for all individuals, be they family members or other patients.

Category 4: Different expectations for nurses

A fourth concept within nurse-family member experiences involves different expectations of them when they stay with their ill loved ones in hospital. In this category, a combination of personal and professional expectations expected of nurses by family members and the health care team were identified. Personal expectations are related to the obligation that the nurse-family member has during their family member's admission. This study revealed that most respondents indicated agreement that, because of their nursing knowledge, overseeing the care delivered to their ill loved one was unavoidable. In addition, some nurses stressed that they expected to take the role of an advocate for appropriate care for their ill relatives. On the other hand, professional expectations of others (patient, family and health care team) are related to involvement with and advocating for care provided for their loved one. While the majority of respondents in this study agreed that acting as an advocate is a prominent expectation from others, they felt no outside pressure to be involved in performing nursing tasks.

However, these personal and professional expectations of others may have a direct impact on clinical practice, which may affect the care delivered to the ill loved one, such as participating in providing care. This is consistent with findings from previous study of nurse-family members alongside their ill loved ones during hospitalisation (Carlsson et al. 2016; Giles & Hall 2014; McNamara 2007; Mills & Aubeeluck 2006; Salmond 2011). What has not been explored is whether nurse-family members prefer to participate in the care of the ill loved one and to what degree, as well as the type of care activities. The survey results demonstrate that nurses with a greater number of years in practice rated their expectations of themselves more highly than those who had fewer years of experience. The assumption behind this is that nurse-family members feel a greater obligation because of their extensive nursing knowledge gained during their years of practice. However, it can be questioned whether there was a difference between nursing experience and area of speciality.

Category 5: Self-impact

The fifth prominent concept was nurse-family members' self-impact, which relates to a mixture of personal and professional boundaries in their relationship with a loved one when he or she falls ill and is hospitalised. Finding and identifying personal and professional boundaries can be challenging for nurse-family members, which may indicate a feeling of conflict. In other words, being with an ill relative the nurse-family member may experience difficulty in setting the boundaries of being a nurse and a family member in the context of care. This study revealed that most respondents agreed that the experience had a negative impact on them personally because of their professional knowledge and often led to stress and anxiety. However, the majority of respondents claimed that the experience had a positive impact on their professional practice in relation to the way they look after and interact with patients' family members. This finding concurs with the findings of studies conducted by Mills and Aubeeluck (2006); Ward-Griffin (2004) which suggest that knowing the condition of ill family members creates an emotional tension but, at the same time, enables nurses to extend their professional knowledge as part of their daily practice. Indeed, the recognition of being a nurse within a family relationship puts nurses in a unique position during an ill loved one's admission. Although the majority of respondents agreed that they wanted to be treated as nurses, some confirmed that conflict did not exist as a consequence of dual roles. However, dealing with dual roles while caring for ill loved ones during their admission was balanced and intertwined in previous literature (Salmond 2011). Therefore, an important question is whether nurses are able to set a strategy to manage the boundaries between their professional role and their personal life as a relative who is a nurse.

Category 6: Relationship with staff

Relationships with staff is the final consideration within the experiences of nurse-family members when loved ones are hospitalised. This category reported the relationship of nurse-family members and health care staff in relation to disclosing their identities and communicating some aspects of care provided to the ill relatives. Previous studies have focused on the nurse's identity as a family member in critical care (Mills & Aubeeluck 2006; Salmond 2011), and this survey extends the understanding of this professional identity in the acute care area. This study revealed that the majority of respondents agreed they were comfortable disclosing their profession to staff, indicating that being available while their family member is hospitalised ensures that optimal care is delivered through proper communication with staff. This is consistent with findings from previous research that nurse-family members tried to establish rapport with staff to gain information (Giles & Hall 2014; Salmond 2011). Similarly, Eggenberger and Nelms (2007) reported that lay-family members identified communication as a key to establishing a relationship with nursing staff to gain accurate information. Even though most nursing staff were not avoided some were which was consistent with Alshahrani (2016) findings. However, based on findings yielded in this study, it can be asked whether the relationship of nurse-family member is considered similar to that of the lay-family member in terms of disseminating information.

Section 5: Additional comments, questions or concerns related to the experience

The online survey provided an opportunity for nurses to express their opinions regarding their experiences.

In particular, nurses specified an informative comment in regards to their experiences during family members' admission. The majority of the nurses surveyed (97 respondents) were satisfied with delivery of care provided to their ill loved ones, as in the agreement scale. However, although less than a quarter of respondents wrote in the additional comments section of the 'satisfaction with care' category, comments gave useful insights about these experiences and factors of important concern. The findings highlighted that the majority of the nurses who wrote comments were unsatisfied with the care provided. They felt unhappy with some aspects of care given to their ill loved ones and felt it was unprofessional. Therefore, the assumption that can be made from this is that nurses utilise their knowledge to evaluate care delivered. Indeed, nurse-family members were alert to the quality standards of care expected in an acute care setting and commonly compared their ill loved ones' care to the nursing care they would routinely deliver. These findings were consistent with those described in the literature reviewed where the concerns of nurses using their specialised knowledge to evaluate care provided were stressed (Giles & Williamson 2015; Lines, Mannix & Giles 2015; McNamara 2007; Mills & Aubeeluck 2006; Sabyani et al. 2017; Salmond 2011).

It is clear that nurse-family members possess sufficient knowledge to evaluate the quality of care that their ill relatives receive and have an awareness of resources to access quality care within the health care system. In our study, this experience was an important component of the categories based on the previous section. It can be concluded that privileged knowledge has significant potential to challenge nurse-family members' ability to provide a high quality of care to their ill loved ones.

Summary

The purpose of this chapter was to discuss outcomes of the online survey conducted for Study 2. The survey revealed it was common for nurses to have ill loved ones hospitalised, and some respondents indicated that the admission, most frequently a parent, had occurred at their own workplace. Nurses indicated that their most significant experience had occurred in the year prior to the study. Moreover, the majority of respondents were older nurses with several years of experience, and some were working in management roles, which put them in control of care delivered at their workplace. This experience often led nurses to demand specialised care for their ill loved ones.

It further became apparent that nurse-family members perceive their experiences to be different to those of lay-family members. Nurses' knowledge, satisfaction with care, ability to evaluate care, different expectations, self-impact and relationship with staff were the six issues identified by nurses who had experienced staying with their ill loved ones in hospital. Given their knowledge and professional role, nurse-family members are in a unique position as compared to general public family members. The nurses observed delivery of care and stated that they felt confident in evaluating care because of their background knowledge. While some nurses expressed satisfaction with care provided to their ill loved ones, others stressed that they were unhappy with some aspects of care. The survey findings further showed that nurses with more years of practice have higher expectations to be the primary advocate for others, than nurses with fewer years of nursing experience. Additionally, nurse-family members expressed that, in the context of care, they want to be identified and treated as nurses rather than just family members. In the following sections, the limitations of this study are outlined as well as the implications of findings and recommendations for future research.

Limitations and issues in the study

While results from this study contributed valuable information about how nurses experience hospitalisation of loved ones, the study has four major limitations which may have had an impact on accuracy:

- The response rate in both hospital settings was low. Specifically, the largest cohort of respondents came from the metropolitan hospital, which may limit the generalisability of findings. It does, however, provide information that may be useful in developing guidelines to improve clinical practice in the management of patient situations. In addition, the information may be valuable for nursing staff and the health care team in supporting nurse-family members to improve the overall experience of clinical practice.
- The survey specifically created for this study may require further validation in this population and in others. Moreover, with the Likert scale response, there was a variance on the number of participants answering some items. Because of this, the results may not represent the participants' experiences completely.

Implications of the study

This survey offers new evidence and rich data regarding the nurse-family member's experience during an ill loved one's hospitalisation. Several implications for nursing practice and nursing education can be drawn from study findings:

Practice recommendation:

From survey findings, it is clear that nurse-family members have a certain level of awareness of their loved ones' care needs. Thus, there are a number of ways that health care staff may attempt to meet these needs. It is essential that health care providers not assume that all nurse-family members desire the same level of information that is provided to lay-family members. Because of their nursing knowledge, nurse-family members want to be treated like a nurse by health care providers to gain information about their loved ones' care. Additionally, health care providers should understand and acknowledge that nurse-family members judge the quality of nursing care provided and maintain a high standard of care. However, any involvement in the care must be under the health care providers' consultation and based on hospital policy. Health care providers need to understand that nurse-family members may experience stress and anxiety which may be different than that of lay-family members and provide support.

The findings also indicated that there are high expectations placed on nurse-family members to take the roles of advocate, spokesperson and decision maker from health care providers. Health care providers need to identify these expectations by engaging in an open dialogue with nurse-family members to understand their role within the family relationship to avoid conflict. Health care administrators may provide suitable resources to health care providers to increase their awareness when dealing with family members who are also nurses with a relative undergoing treatment.

Particularly, for new staff members or even nursing students, on-going nursing education can help address the challenges faced within the hospital setting when supporting a family member who is a nurse. Health care administrators must be cognizant that health care providers need to be able to use all the information and resources available, not only to improve the quality of care but also to provide sufficient support to all family members.

Education recommendation:

In general, the needs of family members in clinical practice are embedded in the nursing curriculum at nursing schools and universities worldwide. Given the findings of this study, it would be beneficial to add to the learning curriculum a module aimed at increasing nurses' awareness of the unique experience and challenges faced when a patient's family member is a nurse. Understanding the experience of the nurse-family member will help students develop skills in managing these situations and help avoid conflict. Learning the value of family relationships as part of the care process will allow future nurses to competently evaluate and respond to the needs of nurse-family members and their loved ones.

Direction for FurtherStudy

The direction for future research is related to the paucity of studies relevant to nurse-family members' experiences during the admission of ill loved ones. This survey indicates that these experiences are common in clinical practice. Thus, future studies are recommended as follows:

- The study surveyed only 110 participants as the sample of this study. In the future, a larger sample size may be considered. Moreover, the study selected nurses only from South Australian hospitals. Therefore, expanding the survey to other locations in Australia will improve the generalisability of this research.
- Future studies could particularly examine the impact of this in the country setting where nurses are much more likely to have a relative admitted to their hospital. In addition, further research could include comparisons of experiences and needs of nurses working in private hospitals where the system may be different to that found in public hospitals.
- Research into the experiences of nursing staff assigned to patients whose family members are nurses (Study 3).
- Also, the experiences of patients whose family members are nurses may be of value.

In general, more studies are needed to build evidence demonstrating how nurse-family members' experience the admission of their loved ones to optimise the care provided. Finally, health care professionals and researchers need to understand the reasons that studies of the experiences of family members who are health care professionals are important by gathering information and adding knowledge, which may include replicating the current study.

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List Of Appendices

Appendix I: HREC approval

Government of South Australia
SA Health

Central Adelaide Local health Network
Human Research Ethics Committee (TQEH/LMH/MH)
The Queen Elizabeth Hospital
Basil Hetzel Institute – DX465101
28 Woodville Road
Woodville South SA 5011
Telephone: 08 8222 6841
Email: Health.CALHNResearchEthics@sa.gov.au

Approval date: 04 November 2016

HREC Reference number: HREC/16/TQEH/240

CALHN reference number: Q20161005
please quote this number on all future correspondence

Mr Hussamaldeen Sabyani
Nursing
UNIVERSITY OF ADELAIDE

Dear Mr Sabyani

Project Title: When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions

Thank you for submitting the above project for ethical review. The project was considered by the Chairman of The Queen Elizabeth Hospital Human Research Ethics Committee (TQEH/LMH/MH).

I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research* (2007), incorporating all updates. The documents reviewed and approved include:

Document	*Version*	*Date*
Covering Letter	-	10 October 2016
LNR Application (AU/1/B889215)	-	19 October 2016
Protocol	2	04 November 2016
Participant Information Sheet - TQEH	2	04 November 2016
Participant Information Sheet – Whyalla	2	04 November 2016
Poster Invitation	-	-
Email Invitation	-	-
Email – staff survey - TQEH	-	02 November 2016
Email – staff survey - Whyalla	-	03 November 2016

Sites covered by this approval:

- The Queen Elizabeth Hospital, SA : CPI - Mr Hussamaldeen Sabyani
- Whyalla Hospital and Health Service, SA: CPI - Mr Hussamaldeen Sabyani

HREC approval is valid from **04 November 2016 to 04 November 2021**

GENERAL TERMS AND CONDITIONS OF ETHICAL APPROVAL:

1. This HREC is the South Australian 'lead HREC' for the purpose of this ethics approval. Any study sites that are not listed on this letter are not covered by this ethics approval. For any SA study-sites within the public health system that are proposed to be added, the CPI must write formally to this HREC requesting the additional study site and a separate formal letter will be issued.
2. Adequate record-keeping must be maintained in accordance with GCP, NHMRC and state and national guidelines. The duration of record retention for all clinical research data is 15 years from the date of publication.

3. Researchers are required to immediately report to this HREC anything which might warrant review of ethical approval of the study, including:
    (a) serious or unexpected adverse effects on participants which warrant protocol change or notification to participants;
    (b) proposed changes in the study; and
    (c) premature termination of the study.
4. Confidentiality of the research subjects shall be maintained at all times as required by law.
5. Approval is valid for **5 years** from the date of this letter, after which an extension must be applied for.
6. Annual review reports must be submitted to the HREC, every **12-months from the date of approval.** Failure to submit reports may result in the HREC suspending its approval. Each site covered by this HREC must submit a report, and it is the responsibility of the Coordinating Principal investigator to ensure this is carried out. http://www.basilhetzelinstitute.com.au/research/information-for-researchers/human-research-ethics-committee/
7. The HREC must be advised with a final report, or in writing, and a copy of any published material within 30 days of completion of the project.

This Committee is constituted in accordance with the NHMRC *National Statement on the Ethical Conduct of Human Research (2007) and incorporating all updates.*

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a SA Health site until governance authorisation at that site has been obtained. Please contact the CALHN Research Office *Health.CALHNResearchLNR@sa.gov.au*

Should you have any queries about the HREC's consideration of your project please contact the HREC Executive Officer on 08 8222 6841 or CALHNResearchEthics@sa.gov.au

The HREC wishes you every success in your research.

Yours sincerely

Professor Richard E Ruffin
Chairman, Human Research Ethics Committee (TQEH/LMH/MH)

RR: **LB**

Appendix II: SSA approval (TQEH)

Government of South Australia
SA Health

Central Adelaide Local Health Network
Research Office
Level 4, Women's Health Centre
North Terrace, Adelaide SA
Australia 5000
T : 08 8222 3839

27 January 2017

Mr Hussamaldeen Sabyani
Faculty of Health Sciences
The University of Adelaide

Dear Mr Sabyani,

HREC reference number: HREC/16/TQEH/240

SSA reference number: SSA/17/TQEH/11

Governance reference number: 8627

Project title: When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions

RE: Site Specific Assessment Review

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to commence at The Queen Elizabeth Hospital, SA.

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Authorisation is limited to the site/s identified in this letter only.
2. Project authorisation is granted for the term of your project outlined in Section 9 of the SSA, or until the project is complete (whichever date is earlier).
3. The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, SA Health policies, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research* (2007) and the *Australian Code for the Responsible Conduct of Research* (*2007).*
4. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the HREC for review, are copied via email to this Research Governance Office;
5. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted via email to this Research Governance Office;
6. For all clinical trials, the study must be registered in a publicly accessible trials registry prior to enrolment of the first participant.
7. Proposed amendments to the research protocol or conduct of the research which may affect both the ongoing ethical acceptability of the project and the site acceptability of the project are to be submitted to this Research Governance Office after a HREC decision is made.
8. A copy of this letter should also be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.
9. Notification of completion of the study at this site is to be provided to this Research Governance Office.

If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.

We wish you every success in your research project.

Yours sincerelv

Bernadette Swart
Manager, CALHN Research Office
Ph: 8222 3890
Email: bernadette.swart@sa.gov.au
Email: Health.ResearchGovernanceIP&Contracts@sa.gov.au

Appendix III: SSA approval (WH&HS)

Government of South Australia
SA Health

Mr Hussamaldeen Sabyani
University of Adelaide
School of Nursing
Faculty of Health Sciences
Room EH3-35 Level 3 Eleanor Harrald Building
Adelaide Nursing School
Adelaide SA 5000

Country Health SA Local Health Network Inc.
Adelaide Office
Level 1 & 2
22 King William Street
Adelaide SA 5000
PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243
Tel 08 8226 6120
Fax 08 8226 7170
ABN 96 157 660 816
www.countryhealthsa.sa.gov.au

Dear Hussam

RE: SITE SPECIFIC ASSESSMENT – AUTHORISATION

Project Title: When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions

SSA Reference: SSA/17/SAH/4

Site Name: Whyalla Hospital and Health Services

Thank you for submitting the site specific assessment (SSA) form for the above named project.

Following a review of the SSA form and attachments for the above project, and noting the protocol was ethically approved in full by the Queen Elizabeth Hospital Human Research Ethics Committee (HREC/16/TQEH/240), I am pleased to advise that your project is now authorised at the above site and may commence.

Please note the following conditions of authorisation:

- Authorisation is limited to the site identified in this letter only.
- Project authorisation is granted for the term of your project outlined in Section 9 of the SSA, or until the project is complete (whichever date is earlier). Should you require an extension to this timeframe, please submit an amendment to the SSA with a brief justification.
- The Coordinating Principal Investigator is responsible for notifying the institution via the Research Governance Officer of any changes to the status of the project within a timely manner, including discontinuation or withdrawal of the study at the named site, or changes to the scope of the project including the participants, research staff, site resources or other governance matters affecting the site.
- If University personnel are involved in this project, the Principal Investigator should notify the University before commencing their research to ensure compliance with University requirements including any insurance and indemnification requirements.

- The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research (2007)*.
- The Coordinating Principal Investigator must ensure regular (at least annual) progress notes are submitted. These progress reports should be submitted directly to the Research Governance Officer.
- A copy of this letter should be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.

Should you have any queries regarding your project authorisation, or any other matters pertaining to research governance, please contact andrea.church@sa.gov.au Ph: (08) 8553 4208; or researchgovernance@sa.gov.au Ph: (08) 8226 7461.

Yours sincerely

Andrea Church
RESEARCH GOVERNANCE OFFICER
Country Health SA Local Health Network Inc

16 January 2017

Appendix IV: Notification of ethical approval from the University's HREC

Notification of ethics approval form_Hussam

HREC

Tue 15/11/2016 11:35 AM

Dear Hussam

Our automated email addressed to you failed to send overnight and was returned to us.

I've therefore set out below the contents of the email which acknowledges receipt of the notification approval for HREC/16/TQEH/240.

With thanks
Kind regards
Coleen
Coleen Roddam
Office of Research Ethics, Compliance and Integrity
Research Branch, The University of Adelaide
Level 4, Rundle Mall Plaza, 50 Rundle Mall
ADELAIDE SA 5000
AUSTRALIA
Telephone: +61 8 8313 4417
Facsimile: +61 8 8313 3700
E-mail: coleen.roddam@adelaide.edu.au
http://www.adelaide.edu.au/rb/oreci

This is an automated email message generated by ResearchMaster. For any queries about this email, please contact hrec@adelaide.edu.au

RECEIPT OF HREC APPROVAL NOTIFICATION FORM

Dear Mr Sabyani

Project No.: HREC/16/TQEH/240

Project Title: When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions

HREC approval granted by: Human Research Ethics Committee (The Queen Elizabeth Hospital, Lyell McEwin Hospital and Modbury Hospital)

Date of HREC approval: 4/11/2016

This is to advise that the notification of Human Research Ethics Committee approval listed above was received by the Office of Research Ethics, Compliance and Integrity at the University of Adelaide on 14/11/2016.

Details of this ethics approval will be provided to the University Insurance Office for the purposes of reporting to the University's insurers.

Personnel named in this notification:
Dr Francis Donnelly
Dr Richard Wiechula
Judith Magarey
Mr Hussamaldeen M Sabyani

To obtain certificates of insurance, please complete the 'Human Research Projects- Application to Request a Certificate of Insurance' form and email it to helpdesklegal@adelaide.edu.au. The Application form is available at: http://www.adelaide.edu.au/legalandrisk/insurance/clinicaltrials
Alternatively, please ring the Legal and Risk Branch on (08) 8313 4539.
This ensures that the University staff and students who undertake the project (as named in the 'personnel named' listed above) are covered by the University's insurance policies.

You are reminded that it is the responsibility of all researchers to:
- comply with the Australian Code for the Responsible Conduct of Research (2007) and the National Statement on Ethical Conduct in Human Research (2007);
- immediately report any notifiable event to the University HREC Secretariat (hrec@adelaide.edu.au). Information about Notifiable events is available at: http://www.adelaide.edu.au/legalandrisk/insurance/notifiableevents/.

You are also reminded that it is your responsibility to notify the HREC Secretariat (hrec@adelaide.edu.au) of any changes to this human research ethics approval including a revised end date, new University researchers (staff or students) working on the project, changes to the number of participants involved in the project, changes to indemnity status and at project completion.

Yours sincerely

Human Research Ethics Secretariat
Office of Research Ethics, Compliance and Integrity
Research Branch, The University of Adelaide
Level 4, Rundle Mall Plaza, 50 Rundle Mall
ADELAIDE SA 5000 AUSTRALIA
Ph : +61 8 8313 5137
Fax : +61 8 8313 7000
E-mail: hrec@adelaide.edu.au
Website: http://www.adelaide.edu.au/rb/oreci/human/

CRICOS Provider Number 00123M

Appendix V: An email invitation, a poster invitation and a participant information sheet

Dear Sir or Madam,

As a nurse have you had a family member admitted to an acute care hospital? We are very interested in investigating this experience through a survey.

My name is Hussamaldeen. I am a doctoral candidate in the Adelaide Nursing School at the University of Adelaide, South Australia. Currently, I am conducting a research study as part of the requirement of my degree in Doctor of Nursing. I am studying the experiences of nurses who have had family members hospitalised in acute care hospitals. Specifically, I am interested in answering the question: What are the opinions of nurses regarding their experiences when their ill family member is admitted to an acute care hospital? This will be conducted under the supervision of Associate Professor Judy Magarey, Dr Rick Wiechula and Dr Frank Donnelly.

The project has ethical approval Human Research Ethics Committee (TQEH/LMH/MH) number HREC/16/TQEH/240. I would like to invite you to participate in a confidential questionnaire survey.
Participation is voluntary and that there will be no way of the researchers or nursing administration knowing who does or does not complete the survey. If you decide to take part in the research project, you will be asked to complete an online survey. Completing the survey will take approximately 15-20 minutes.

The survey will ask questions about basic demographic information and some questions about your views concerning your experience of having a family member hospitalized. The survey is completed anonymously and no information which may identify you as an individual will be recorded. The survey can be accessed online by clicking the following link: https://www.surveymonkey.com/r/Hussam

If you would like additional information about the project, please see the attached participant information sheet. Thank you sincerely for your participation and I hope to receive a positive response.

Warm regards,

Hussamaldeen Sabyani
HDR candidate (DRNRS)
ANS representative for "HeSPA" committee
Adelaide Nursing School
Adelaide Health & Medical Sciences Building (AHMS)
Corner of North Terrace and George street, Adelaide
T. +61(0) 8 8313 0428

THE UNIVERSITY of ADELAIDE

Who AM I?

I am Hussamaldeen, a nurse with a background in acute care and a student in a research program in the Adelaide Nursing School at the University of Adelaide. I am initiating my thesis research project to learn about the experiences of nurses when they have a family member admitted to an acute care hospital.

Are you a NURSE who has had a family member admitted to an acute care hospital?

If so, I would welcome your participation in this survey which is designed to investigate your experiences and opinions. Completing an online survey may take approximately 15-20 minutes in your own time. **An email with instructions will be sent to your email address by the nursing administration. Alternatively,** the survey can be accessed online by the following link: https://www.surveymonkey.com/r/Hussam **OR** if you would like additional information about the project please feel free to contact me on

NO identifying information will be used.
NO interview or meeting necessary.

HREC Reference number: HREC/16/TQEH/240

PARTICIPANT INFORMATION SHEET

The University of Adelaide

Title	When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions
Approval number	HREC/16/TQEH/240
Principal Investigator	Hussamaldeen Sabyani
Associate Investigator(s)	Assoc. Prof. Judy Magarey, Dr. Rick Wiechula, Dr. Frank Donnelly
Location	Adelaide

1. Introduction

You are invited to take part in this research project, which is called "**When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions".** You have been invited because you are a nurse working in an acute care hospital and this research will explore issues relating to the experiences of nurses who have had an ill family member hospitalised in an acute care hospital. This Participant Information Sheet tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research. Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.
Participation in this research is voluntary. If you don't wish to take part, you don't have to.

2. What is the purpose of this research?

The main objective is to determine the prevalence of and explore issues relating to the experiences of nurses who have had family members hospitalised in acute care hospitals. In particular, the study will examine how nurses perceive their experiences to be different from those of family members who are not nurses. The results of this research will be used by the researcher as part of his Doctor of Nursing research at the Adelaide Nursing School at the University of Adelaide.

3. What does participation in this research involve?

If you decide to take part in the research project, you will be asked to complete a brief online survey; this will determine if you are eligible to take part. Completing the survey will take approximately 15-20 minutes. If the screening questionnaire shows that you meet the requirements, then you will be able to start the research project. This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids jumping to conclusions. There are no costs associated with participating in this research project, nor will you be paid.

4. Other relevant information about the research project

One metropolitan hospital and one country Hospital are the two hospitals taking part in this project. At each site we aim to recruit participants to complete the online survey.

5. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. If you do decide to take part, you will be given this Participant Information document. Participation in the survey indicates your consent. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect you, your relationship with professional staff or your relationship with the University of Adelaide or employer.

6. What are the possible benefits of taking part?

There is no direct benefit to you for your participation, however the information collected from the survey will increased understanding about nurses' experiences who had a family member admitted in an acute care hospital.

7. What are the possible risks and disadvantages of taking part?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Please contact the researchers regarding arranging counselling. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

8. What if I withdraw from this research project?

If you decide to withdraw from the project, you may simply choose not to continue the survey.

9. Could this research project be stopped unexpectedly?

It is not anticipated that this research will be stopped unexpectedly.

10. What happens when the research project ends?

At the end of this research, the data collected will be analysed and written up for a doctoral portfolio which will be deposited in the library at the University of Adelaide. The research may be published in an electronic journal and may be presented at conferences. If you would like to receive a written summary of the results, you may request this to the research team. The completed project would be available by the end of 2019.

11. Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

12. Who is organising and funding the research?

This research project is being conducted by Hussamaldeen Sabyani through the University of Adelaide.

13. What will happen to information about me?

The information gathered will be stored confidentially for 12 months. Summary data without identification of participants will be saved on a password protected computer file in a confidential staff server and submitted as required to the Adelaide Nursing School with the final project documentation. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. The personal information that the research team collect and use is basic demographic information and some questions about your views concerning your experience of having a family member admitted to an acute care hospital.

14. Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of TQEH/LMH/MH. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15. Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the HREC Executive Officer and the Research Governance Officer.

Research contact person

Name	Hussamaldeen Sabyani.
Position	Research Candidate
Telephone	+61(0) 8 8313 0428
Email	

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Research Governance Officer

Name	Ms Bernadette Swart
Position	Manager, CALHN Research Office
Telephone	(08) 8222 3890
Email	Health.CALHNResearchGovernanceIP&Contracts@sa.gov.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	TQEH/LMH/MH HREC
HREC Executive Officer	Ms Heather O'Dea
Telephone	(08) 8222 6841
Email	Health.CALHNResearchEthics@sa.gov.au

PARTICIPANT INFORMATION SHEET

The University of Adelaide

Title	When a nurse has a family member admitted to an Acute Care Hospital: experiences and opinions
Approval number	HREC/16/TQEH/240
Principal Investigator	Hussamaldeen Sabyani
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The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the HREC Executive Officer and the Research Governance Officer.

Research contact person

Name	Hussamaldeen Sabyani.
Position	Research Candidate
Telephone	+61(0) 8 8313 0428
Email	

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Name	Ms Andrea Church
Telephone	(08) 8553 4208
Email	Andrea.Church@sa.gov.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	TQEH/LMH/MH HREC
HREC Executive Officer	Ms Heather O'Dea
Telephone	(08) 8222 6841
Email	Health.CALHNResearchEthics@sa.gov.au

Appendix VI: Survey

1. Welcome to My Survey

Are you a nurse who has had a family member admitted to an acute care hospital?

If so, I would welcome your participation in this survey which is designed to investigate your experiences and opinions.

Participation is voluntary and that there will be no way of the researchers or nursing administration knowing who does or does not complete the survey. If you decide to take part in the research project, you will be asked to complete an online survey.

Thank you in anticipation for your time and support.
Please start with the survey now by clicking on the next button below.

2. **Section 1**

This section is designed to collect some personal information. Please indicate your response.

* 1. Please indicate your age in years.

* 2. Please indicate your gender.

- ◯ Female
- ◯ Male
- ◯ Other

* 3. Please indicate your nursing experience in years.

* 4. Have you had an ill family member hospitalised?

- ◯ Yes
- ◯ No

3. **Section 2**

The following questions inquire about the experience you had when an ill family member was hospitalised, please indicate your response.

* 5. How many times have you had this experience?

- ◯ 1
- ◯ 2-3
- ◯ 4-5
- ◯ > 5

* 6. Relationship with the patient/s (tick as many that apply):

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Husband
- ☐ Wife
- ☐ Partner
- ☐ Son
- ☐ Daughter
- ☐ Other (please specify)

4. **Section 3.1**

Please relate the following questions to the one experience you consider to be the most significant, please indicate your response.

* 7. What was your relationship with the patient?(choose only one) If you had more than one family member involved in a particular incident, please relate it to one.

- ◯ Father
- ◯ Mother
- ◯ Brother
- ◯ Sister
- ◯ Husband
- ◯ Wife
- ◯ Partner
- ◯ Son
- ◯ Daughter
- ◯ Other (please specify)

* 8. Was the ill family member a current healthcare practitioner?

- ◯ Yes
- ◯ No

5. **Section 3.2**

9. If Yes, he/she is a:

- ◯ Nurse
- ◯ Doctor
- ◯ Other (please specify)

* 10. What was the area of admission for the majority of their stay?

- ◯ Medical
- ◯ Surgical
- ◯ Critical care
- ◯ Mental health
- ◯ Other (please specify)

11. Approximately how long ago did this significant experience occur?

- ◯ Past year
- ◯ 1- 5 years Ago
- ◯ 6-10 years Ago
- ◯ >11 years Ago

* 12. Please indicate your primary professional role at the time of this experience:

- ◯ Clinician
- ◯ Educator
- ◯ Manager
- ◯ Other (please specify)

* 13. Please indicate your area of practice at the time of this experience:

- ◯ Medical
- ◯ Surgical
- ◯ Critical care
- ◯ Mental health
- ◯ Other (please specify)

* 14. Please indicate your classification level at the time of this experience:

- ◯ EN
- ◯ RN 1
- ◯ RN 2
- ◯ RN 3
- ◯ RN 4
- ◯ RN 5 or higher
- ◯ Other (please specify)

* 15. Have you had experience in the practice area in which the patient spent the majority of the admission?

- ◯ Yes
- ◯ No

* 16. Was another member of your immediate family currently a nurse?

- ◯ Yes
- ◯ No

* 17. Did you have an enduring medical power of attorney?

- ◯ Yes
- ◯ No

18. Was your family member admitted to your workplace?

- ◯ Yes
- ◯ No

6. **Section 4.1**

* 19. If yes,

* 20. Using the following 5-point scale of agreement, please indicate the extent to which you agree or disagree with each of the following statements relating to the experience.

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
From my perspective, my nursing knowledge influenced my role in this situation.	○	○	○	○	○
Because of my nursing knowledge, my role was different from others who are not nurses.	○	○	○	○	○
Because of my nursing knowledge, I was in a better position than others to judge the quality of nursing care.	○	○	○	○	○
Because of my nursing knowledge, I experienced less stress and anxiety in comparison to others.	○	○	○	○	○
Because I am a nurse, I was given additional information by staff.	○	○	○	○	○

Comment

Comment

Comment

Comment

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Comment					
Being a nurse made it easy to assess the quality of the care provided.	○	○	○	○	○
Comment					
Over all, this experience had a negative impact on me.	○	○	○	○	○
Comment					
My knowledge was generally respected by the nurses.	○	○	○	○	○
Comment					
Overall, I experienced dissatisfaction with the delivery of care.	○	○	○	○	○
Comment					
I used my nursing knowledge to the advantage of my ill family member.	○	○	○	○	○
Comment					
In general, I was satisfied with the delivery of care.	○	○	○	○	○
Comment					
Sometimes, I felt that I wanted to be treated like others who are not nurses.	○	○	○	○	○

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree

Comment

7. **Section 4.2**

* 21. Using the following 5-point scale of agreement, please indicate the extent to which you agree or disagree with each of the following statements relating to your practice.

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Over all, this experience had a negative impact on me.	○	○	○	○	○
Comment					
Over all, this experience had a positive impact on my professional practice.	○	○	○	○	○
Comment					
This experience changed my attitude towards other patients' family members.	○	○	○	○	○
Comment					
This experience has impacted on my practice relating to patients' family members.	○	○	○	○	○
Comment					
If I know that a patient's family member is a nurse it will impact on how I look after the patient.	○	○	○	○	○
Comment					
If I know that a patient's family member is a nurse it will impact on the way, I interact with them.	○	○	○	○	○

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree

Comment

8. **Section 4.3**

* 22. Using the following 5-point scale of agreement, please assess the extent to which you agree or disagree with each of the following statements relating to your identity.

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
I found it difficult dealing with my dual identity (family member and nurse).	○	○	○	○	○
Comment					
All in all, I felt a sense of conflict because of my dual roles.	○	○	○	○	○
Comment					
I felt pressured by nurses to undertake tasks that would not be expected from other family.	○	○	○	○	○
Comment					
I felt a sense of satisfaction in caring for my ill family member.	○	○	○	○	○
Comment					
I would be uncomfortable looking after a family member of a different gender.	○	○	○	○	○
Comment					
I did not disclose that I was a nurse to avoid being treated differently by staff.	○	○	○	○	○

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree

Comment

9. **Section 4.4**

* 23. Using the following 5-point scale of agreement, please indicate the extent to which you agree or disagree with each of the following statements relating to your personal role.

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Because I am a nurse, my family expected me to be the primary advocate.	○	○	○	○	○
Comment					
Because I am a nurse, the staff expected me to be the primary advocate.	○	○	○	○	○
Comment					
Because I am a nurse, I expected to be the primary advocate.	○	○	○	○	○
Comment					
Because of my nursing knowledge, I felt comfortable taking the advocate role.	○	○	○	○	○
Comment					
Because of my nursing knowledge, I intervened in my family member's care.	○	○	○	○	○
Comment					
As a nurse, I felt that keeping watch over my family member's care was unavoidable.	○	○	○	○	○

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Comment					
As a nurse, other family members expected me to be their spokesperson.	○	○	○	○	○
Comment					
As a nurse, my ill family member expected me to be his/her spokesperson.	○	○	○	○	○
Comment					
I felt pressure from other family members to be their spokesperson.	○	○	○	○	○
Comment					
Other family members relied on me for decision making.	○	○	○	○	○
Comment					
My ill family member relied on me to explain complex terminology and clinical procedures.	○	○	○	○	○
Comment					

10. **Section 5**

* 24. Using the following 5-point scale of frequency, please indicate how often the following statements apply to your experience.

	Always	Often	Sometimes	Rarely	Never
It was predominantly the nurses who communicated with me.	○	○	○	○	○
Comment					
My knowledge was respected by the nurses.	○	○	○	○	○
Comment					
I was satisfied with the delivery of care.	○	○	○	○	○
Comment					
I wanted to be treated like a relative who was not a nurse.	○	○	○	○	○
Comment					
I felt that being recognised as a nurse impeded me providing effective support to my ill family member.	○	○	○	○	○
Comment					
I was comfortable telling the staff that I was a nurse.	○	○	○	○	○
Comment					
I was asked to perform a nursing task by my ill family member.	○	○	○	○	○

	Always	Often	Sometimes	Rarely	Never
Comment					
I was asked to perform a nursing task by staff.	○	○	○	○	○
Comment					
I experienced conflict in informing staff that I was a nurse.	○	○	○	○	○
Comment					
I felt I needed to be present to ensure adequate care was provided.	○	○	○	○	○
Comment					
The nurses avoided me.	○	○	○	○	○
Comment					

* 25. Do you have any other comments, questions, or concerns?

Appendix VII: Cronbach's alpha

8	Likert scale	Nurses' Knowledge	.703
Q21T1	Agreement	From my perspective, my nursing knowledge influenced my role in this situation.	
Q21T2	Agreement	Because of my nursing knowledge, my role was different from others who are not nurses.	
Q21T11	Agreement	I used my nursing knowledge to the advantage of my ill family member.	
Q24T4	Agreement	Because of my nursing knowledge, I felt comfortable taking the advocate role.	
Q24T5	Agreement	Because of my nursing knowledge, I intervened in my family member's care.	
Q21T5	Agreement	Because I am a nurse, I was given additional information by staff.	
Q21T9	Agreement	My knowledge was generally respected by the nurses.	
Q25T2	Frequency	My knowledge was respected by the nurses.	

3	Likert scale	Satisfaction with care	.884
Q21T10_R*	Agreement	Overall, I experienced dissatisfaction with the delivery of care.	
Q21T12	Agreement	In general, I was satisfied with the delivery of care.	
Q25T3	Frequency	I was satisfied with the delivery of care.	

*The score of this item was reversed

2	Likert scale	Ability to evaluate care	.695
Q21T3	Agreement	Because of my nursing knowledge, I was in a better position than others to judge the quality of nursing care.	
Q21T6	Agreement	Being a nurse made it easy to assess the quality of the care provided.	

12	Likert scale	Different Expectations on Nurses	.876
Q23T3	Agreement	I felt pressured by nurses to undertake tasks that would not be expected from other family.	
Q24T1	Agreement	Because I am a nurse, my family expected me to be the primary advocate.	
Q24T2	Agreement	Because I am a nurse, the staff expected me to be the primary advocate.	
Q24T3	Agreement	Because I am a nurse, I expected to be the primary advocate.	
Q24T7	Agreement	As a nurse, other family members expected me to be their spokesperson.	
Q24T8	Agreement	As a nurse, my ill family member expected me to be his/her spokesperson.	
Q24T6	Agreement	As a nurse, I felt that keeping watch over my family member's care was unavoidable.	
Q24T9	Agreement	I felt pressure from other family members to be their spokesperson.	
Q24T11	Agreement	Other family members relied on me for decision making.	
Q24T12	Agreement	My ill family member relied on me to explain complex terminology and clinical procedures.	
Q25T7	Frequency	I was asked to perform nursing tasks by my ill family member.	
Q25T8	Frequency	I was asked to perform nursing tasks by staff.	

14	Likert scale	Self-impact	.700
Q21T4_R*	Agreement	Because of my nursing knowledge, I experienced less stress and anxiety in comparison to others.	
Q21T8	Agreement	Over all, this experience had a negative impact on me.	
Q21T13	Agreement	Sometimes, I felt that I wanted to be treated like others who are not nurses.	
Q22T1	Agreement	Over all, this experience had a negative impact on me.	
Q22T2	Agreement	Over all, this experience had a positive impact on my professional practice.	
Q22T3	Agreement	This experience changed my attitude towards other patients' family members.	
Q22T4	Agreement	This experience has impacted on my practice relating to patients' family members.	
Q22T5	Agreement	If I know that a patient's family member is a nurse it will impact on how I look after the patient.	
Q22T6	Agreement	If I know that a patient's family member is a nurse it will impact on the way, I interact with them.	
Q23T1	Agreement	I found it difficult dealing with my dual identity (family member and nurse).	
Q23T2	Agreement	All in all, I felt a sense of conflict because of my dual roles.	
Q23T4	Agreement	I felt a sense of satisfaction in caring for my ill family member.	
Q25T4	Frequency	I wanted to be treated like a relative who was not a nurse.	
Q25T5	Frequency	I felt that being recognised as a nurse impeded me providing effective support to my ill family member.	

*The score of this item was reversed

6	Likert scale	Relationship with staff	.595
Q23T6	Agreement	I did not disclose that I was a nurse to avoid being treated differently by staff.	
Q25T1	Frequency	It was the nurses who communicated significant healthcare information with me.	
Q25T6_R*	Frequency	I was comfortable telling the staff that I was a nurse.	
Q25T9	Frequency	I experienced conflict in informing staff that I was a nurse.	
Q25T10	Frequency	I felt I needed to be present to ensure adequate care was provided.	
Q25T11	Frequency	The nurses avoided me.	

*The score of this item was reversed

1	Likert scale	This item has been removed from Cronbach's alpha	
Q23T5	Agreement	I would be uncomfortable looking after a family member of a different gender.	excluded from analysis

Appendix VIII: An ordinal logistic regression model

Performing an ordinal logistic regression model in SPSS

Did you have an enduring medical power of attorney?
Yes (1)
No (2)

8	Likert scale	Advocate role
Q24T1	Agreement	Because I am a nurse, my family expected me to be the **primary advocate.**
Q24T2	Agreement	Because I am a nurse, the staff expected me to be the **primary advocate.**
Q24T3	Agreement	Because I am a nurse, I expected to be the **primary advocate.**
Q24T4	Agreement	Because of my nursing knowledge, I felt comfortable taking the **advocate role.**
Q24T7	Agreement	As a nurse, other family members expected me to be **their spokesperson.**
Q24T8	Agreement	As a nurse, my ill family member expected me to be **his/her spokesperson.**
Q24T9	Agreement	I felt pressure from other family members to be **their spokesperson.**
Q24T11	Agreement	Other family members relied on me for **decision making.**

Did you have an enduring medical power of attorney?

	Frequency	Percent
Yes	33	32.0
No	70	68.0
Total	103	100.0

Was your family member admitted to your workplace?
Yes (1)
No (2)

7	Likert scale	Relationship with staff
Q21T5	Agreement	Because I am a nurse, I was given additional information by staff.
Q24T2	Agreement	Because I am a nurse, the staff expected me to be the primary advocate.
Q25T1	Frequency	It was the nurses who communicated significant healthcare information with me.
Q25T6	Frequency	I was comfortable telling the staff that I was a nurse.
Q25T8	Frequency	I was asked to perform nursing tasks by staff.
Q25T10	Frequency	I felt I needed to be present to ensure adequate care was provided.
Q25T11	Frequency	The nurses avoided me.

Was your family member admitted to your workplace?

		Frequency	Percent
	Yes	39	37.9
	No	64	62.1
	Total	103	100.0

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SECTION 4: STUDY THREE

The lived experiences of nurses in general wards caring for adult patients who have a family member who is a nurse: a qualitative study

TABLE OF CONTENTS

Chapter One: Introduction

Hospitalisation of an ill loved one is often a crisis for the patient and their family. In such situations health care staff may find themselves working with family members who consider themselves accountable for the care of an ill loved one. For example, family members may take on roles such as 'spokesperson' and 'protector' if the patient is unable or unwilling to speak for themselves (Gavaghan & Carroll 2002, p. 64). To fulfil these roles family members often provide physical support, psychological support and emotional support in the hospital care of an ill loved one (Laitinen 1992). Spending considerable periods of time with a loved one who is admitted to hospital is often a stressful and demanding experience. While a patient's family may take on some aspects of care during the illness of their loved one, especially in an acute care setting, the expectation is that health care staff are the main carers, the front line. Bridgman and Carr (1997) identify that within the overall health care team it is nurses who are mostly involved in interacting with families. However, interactions become more complex when one or more of the family members visiting or supporting the patient is themselves a nurse. The complexity of this situation is such that little is known of how nurses feel or react to this situation. For the purposes of this study the term 'nurse-family member' is used (Olivet & Harris 1991, p. 248). In situations where a nurse-family member is visiting a patient relative the nurse providing care may be faced with a range of conflicting responsibilities, emotions and family expectations. Understanding the lived experience of nursing staff working with nurse-family members is important at many levels of the patient care episode.

Context of the study

In an acute care hospital, nurses regularly communicate and consult with family members in many aspects of patient care. However, when family members are also nurses, a unique and challenging situation may present. By investigating the experiences of family members who are also nurses, scholars have determined that those nurses' experiences of their loved ones admission are different to the experiences of family members who are not nurses (Giles & Hall 2014; Sabyani et al. 2017). When a family member is also a nurse there may be different expectations and challenges for the attending nurse that may impact on the delivery of care to an ill loved one. While the experiences of family members who are nurses has been explored, an extensive search of the literature revealed that very few nurses have published their personal reflections about their experiences when caring for patients with nurse-family members. A number of personal and reflective writings published by McCahon (2001); Olivet and Harris (1991); Spear (2002) suggest that caring for a patient whose family member is a nurse is more complicated and different to working with general public family members. These reflections noted that some nurses felt uncomfortable in the presence of a nurse-family member, while others felt supported by the nurse-family member. Conducting a formal study to explore these experiences provides an important contribution to this field of study.

Purpose of the study

The purpose of this study was to gain understanding of the experiences of nurses working in general wards when caring for adult patients with a nurse-family member. This study focused specifically on experiences of general ward nurses as some previous research has focussed on the critical care environment (Giles & Hall 2014). It is suggested that the lower acuity nature of the general ward, where there is less emphasis

on technology, may alter the dynamic between nurses and the nurse-family member. In relation to nurses caring for adult patients, in the presence of a nurse-family member, the specific study objectives were to explore:

- Lived experiences and challenges nurses face when caring for patients with nurse-family members.
- Dynamics of the relationships with patients and nurse-family members.
- Impact on nurses' experiences and professional practice.

Statement of the Study Question

This study addressed the research question: 'What are the lived experiences of nurses in general wards caring for adult patients who have a family member who is a nurse?' By enabling staff to share their experiences this study contributes to understanding how to improve the experience of nursing care for both staff and patients.

Significance of the current study

While some nurses may deal easily with medical care of patients whose family member is a nurse, others may feel stressed and apprehensive. An increased awareness of these situations and the dynamics they create may help nurses to develop trusting and confident relationships, not only with the patient, but also the nurse-family member. With little guidance to support nurses working with patients with a nurse-family member, this information may also be useful to development of policies to inform best practice. As a thread joining together the three studies, it has been shown the essential nature of trust is a central aspect of the nurse/patient/family relationship, one that depends on open channels of communication. With this critical emphasis it was important to use insights from the development of the research proposal from Study 1 to help guide the design of this study.

Study Assumptions

Throughout this study it was important for the investigator to identify and recognise prior beliefs and assumptions. As a registered nurse with more than 15 years of experience working in public hospitals in Saudi Arabia in clinical and educational roles, the researcher had experienced managing complex family relationships. Acknowledging and making explicit, personal assumptions is an important component of the qualitative research process. The assumptions for this study are acknowledged as follows:

- It is meaningful to study the experiences of nurses supporting nurse-family members during the admission of their ill-loved ones in a general ward.
- Nurses experience some degree of tension when providing care to patients who have a nurse-family member in attendance.
- Qualitative study was a suitable method for collection of rich information about the way in which nurses consider and support nurse-family members. This approach may also be suitable to explore how other professionals, such as doctors, manage such relationships.

Definitions of terms

For the purpose of this project, the following keywords were defined:

- **Nurses** are personnel who provide nursing care to inpatients in a health care facility, for example, acute care hospital (Grossman & Valiga 2016). In Australia, the title 'nurse' is protected by law (Nursing and Midwifery Board of Australia 2016).
- **Nurse-family member** is a member of the family of the ill patient who is a nurse (Salmond 2011).
- **Lay-family member** is a member of the family who is not a nurse (Girardin & Widmer 2015).
- **Significant other** is an individual who is important in someone's life (Gavaghan and Carroll 2002).
- **General wards** are acute inpatient care areas usually with lower acuity than intensive care, emergency, burns and high dependency (Dai et al. 2013).
- **Phenomenology** is a philosophy that focuses on the 'life-world' or 'lived experience' of human beings through their own descriptions (Holloway 2005). The phenomenology expressions 'life-world' and 'lived experience' are synonymous with this study design.
- **Phenomenological study** is an approach of inquiry in which the researcher finds the essence of human experiences (the life-world) about a phenomenon as sources of narrative evidence (Gerrish, Lathlean & Cormack 2015).

Structure of Study3

Study 3 presents a hermeneutic phenomenological study to investigate nurses' experiences when caring for an adult patient who has a family member who is a nurse. Outlines of all the chapters are presented below.

Chapter one is the introduction and offers an outline of the background, aims and significance of this study. The research question that addressed is, 'What are the experiences of nurses in general wards caring for adult patients who have a family member who is a nurse?' Summaries of the other chapters are given in this chapter.

Chapter two is the literature review. It offers an overview of evidence-based literature related to the experience of managing nurse's family members. While the practice of caring for a patient whose family member is a nurse is not uncommon, some authors have noted the situation may impact on nursing care provided to the patient. However, no research to date has investigated this context using a qualitative study.

Chapter three presents the methodology and discusses the theoretical perspective of this research study. It provides an introduction to hermeneutic phenomenology and Heidegger's philosophical position, which underpins this study (Heidegger 1962). In addition, it gives clear justification for the chosen methodology. This chapter describes van Manen's methodological structure, which was used to inform the connection between a philosophical idea and a hermeneutical process (van Manen 1997).

Chapter four describes the methods used to undertake this research. It restates the research question and the aim of the study. The chapter provides detailed descriptions of the following: study setting, participants, inclusion and exclusion criteria, recruitment strategies, ethical issues and the demonstration of the rigour and trustworthiness of the study. The six steps of van Manen's structure are used to analyse the interview transcripts.

Chapter five reports the results of the thematic analysis regarding the nurses' experiences of working with nurse-family members who have adult relatives in general wards. Five face-to-face interviews with Registered Nurses are presented in this chapter.

The final chapter concludes this hermeneutic phenomenological research. This chapter highlights the main themes and their meanings in relation to the research question. The significance of results is discussed in the context of literature reviewed. This is followed by discussion of study limitations, as well as recommendations for further investigation and clinical implications.

Summary

The context of this study considers the experiences of nurses when caring for an adult patient whose family member is a nurse. In an acute care hospital, family members' needs are important considerations when care is provided to patients. However, when one or more family members is a nurse, the context of these considerations alters, warranting further investigation. To date, nursing research has not explored the experience of nurses caring for a patient with a family member who is a nurse. An understanding of these experiences may assist nurses in being better able to support the nurse-family member and his/her ill-loved one. The purpose of the study and its specific aims and objectives were outlined in this introductory chapter. Finally, a summary of the structure of Study 3 was also provided. The next chapter presents the literature review.

Chapter Two: Literature Review

Introduction

As an institution delivering health care, a hospital is an organisation within which a diverse group of health care staff play a role in providing care for patients and support patients' families. Nurses encounter the activities of family members, individuals without medical training, who offer whatever help they can to their ill loved one during the period of their hospitalisation. Nurses work to build relationships with family members collaborating to deliver the best possible care they can. Interacting with family members is clearly a significant part of the nurse's role. Nurses are educated to deal professionally with family members' concerns as part of their ordinary workflow (Levine & Zuckerman 2000). The literature review confirmed and clarified that there were no studies published on the experiences of nurses in general ward settings caring for patients who have nurse-family members.

Phenomenological studies in nursing research

Nursing is concerned with the psycho-social well-being of people and their unique experiences. Nurse scholars, in conducting phenomenological studies, attempt to provide in-depth information about people's experiences. Nursing research regarding people's experiences stems from a holistic approach to quality of care. In general, phenomenological studies explore complex experiences and in the health care context may include patients, nurses, administrators and other professionals. Phenomenological studies have become popular over the past two decades, specifically regarding the life experiences of people and their whole being (van Manen 1990). Phenomenological research has gained recognition among nurse researchers as an alternate research approach to that used in naturalistic inquiry (Gerrish, Lathlean & Cormack 2015). Nurse researchers are concerned with understanding individuals and their life experiences within clinical practice. In other words, nursing scientists adopt phenomenology, based on the understanding that an individual's experiences focuses on being in the world (Creswell 2013). Through the lens of phenomenological study design, nurses can seek to better understand the dynamic relationship between the world and the human. Giorgi (2000, p. 13) stressed that 'they [nurses] are asking for descriptions of situations in the world as experienced by human subjects!'.

In the human sciences, phenomenological principles provide a means of knowing individuals as attributed to their phenomena (Polit & Beck 2016). In such situations, nurse researchers consider that phenomenology explains deep knowledge because it not only verbalises the nature of knowing (van Manen 1990), but also discovers, explores, and describes the phenomena. Additionally, with a description of lived experience, nursing investigators use phenomenology as a way to illustrate the art of a human oriented science. While this knowledge may not directly inform practice, such awareness certainly enlightens practice (van Manen 1997). However, some alternative positions and debate on nursing phenomenology suggest that it is: 'betraying the fundamental tenets of phenomenology and of misconstruing the key concepts' (McNamara 2005, p. 695). Koch notes that key to a successful study is to ensure data are contextualised and as such can be viewed as primary data (Koch 1996). To be able to critically appraise and evaluate research data, research method fundamentals must be clear to understand the essence of the research.

In a phenomenological sense, there is understanding that the main focus is on describing experiences or how phenomena are interpreted. This view suggests that phenomenology should be the method of choice when aiming to understand the meaning of the experience of a phenomenon. van Manen (2016) advocated that phenomenological studies have an interpretive component which avoids any predetermined set of fixed procedures and systems. This is necessary knowledge for the novice researcher as it means there is no fixed blueprint for the conduct of phenomenological study. In order to reach a place of understanding of experience, it is necessary to develop an integrated and reflective position about the experience that is ideally beneficial in nursing research. Indeed, phenomenology has become established as a research method for nursing science and is an element of many qualitative nursing studies concerned with the concept of subjective meaning and experience (Omery 1983). Although discussion continues in literature about principles of phenomenology and use of this methodology in research, it is clear that it contributes to advancement of the holistic context of nursing research.

As the largest group of health care professionals, it is very likely that at some stage of their career a nurse will care for someone who has a nurse within their immediate family circle. While the practice of caring for a patient whose family member is a nurse is not uncommon, some authors have noted the situation may impact on nursing care provided to the patient (Carlsson et al. 2016; Fulbrook, Allan, et al. 1999; Fulbrook, Buckley, et al. 1999; Fulbrook, Creasey, et al. 1999). Due to the insights and knowledge that the nurse-family member possesses, supporting them might be considered a privilege and challenge for nurses. While some nurses manage these challenges easily, others may feel significant personal or professional pressure and may even make an effort to avoid such encounters (Alshahrani 2016).

The literature concerning family members and their role in care is diverse. For the purpose of this study, review of the existing literature is presented under two headings, working towards a succinct and critical description of the literature. The headings for this review are based on the broad themes within the literature, namely: family members within general wards and the perception nurses have of nurse-family members.

Family members within general wards

In many cultures there is a long and well-established pattern of family caring for ill loved ones. This care, while traditionally provided in home, may also extend to the care of a family member in an acute care hospital setting. Indeed, when an ill family member is hospitalised support may be needed from a range of family members. Patients may need their family to be present to provide assistance with activities of daily living, to promote well-being, to advocate and communicate with health care professionals and possibly to assist the patient to become familiar with the health care system (Fink 1995; Verhaeghe et al. 2005). For example, in general wards, such as surgical and medical wards, a parent may assist with the care of their son or daughter following an operation. Family members may include, but are not limited to, husbands, wives, mothers, fathers, sons, daughters, brothers, sisters and friends. During such caring events, family members may experience a range of emotions due to strange and unfamiliar ward settings. They may also experience a profound sense of responsibility to care for and support their loved one (Linnarsson, Bubini & Perseius 2010). Lay-family members often have understanding and knowledge about the condition of their loved one and contribute to the delivery of care.

Since 1970, there has been a considerable amount of research that has documented family members accompanying their ill loved ones during admission in acute and critical care settings (Verhaeghe et al. 2005). While quantitative research has usually been directed to the more measurable needs of the family with their ill-loved one (Auslander 2011), the use of specific forms of qualitative research has been less common (Linnarsson, Bubini & Perseius 2010). Of qualitative studies conducted, the majority relate to critical care areas, such as intensive care units (Frivold, Dale & Slettebo 2015), or have been specifically focused on the individual family member involved, such as an elderly relative (Pickard, Jacobs & Kirk 2003). Further studies have explored the phenomena in the context of specific patient conditions, such as cancer (Sneeuw et al. 1997), or on one aspect of concern, such as family involvement in care (Fateel & O'Neill 2015). Some have focused on one facet of the experience of hospitalisation, such as vigilance (Carr & Fogarty 1999), while others have been specific to family member gender (Anjos, Ward-Griffin & Leipert 2012), specific to the family member as a professional (Ward-Griffin et al. 2015), or related to the development of a program to meet the needs of family members with ill loved ones (Mass et al. 1994). Family members often have special needs because of the support involved in care provided to ill loved ones during their time in hospital. Consistently, published papers show that family members are committed to the comfort of their ill loved ones during general wards admission (Alshahrani 2016; Auslander 2011).

In an acute care hospital, the general ward setting usually accounts for the largest number of admissions and bed occupancy. Treatment in these wards is for patients with less complex and life threatening medical conditions than critical care patients (Dai et al. 2013). In such wards some patients can manage their condition with regards to daily activities, such as hygiene, nutrition and hydration. However, others rely heavily on assistance from nurses and/or family members. At times family members take a caregiver role when their loved one is admitted to a general ward. Even though nurses are ultimately responsible and accountable for daily care, a sensible acknowledgement and integration of some care activities being performed by family members is helpful. Congdon (1994, p. 127) emphasised that assistance provided by family members may include the following activities of daily living: 'bathing, dressing, preparing meals…'. Mass et al. (1994, p. 22) developed a program, known as 'Family Involvement with Care', which includes the types of activities that family members undertake with nurses to participate in the care of ill loved ones. These include group activities and some aspects of physical and psychosocial care. This involvement with patient care may help create a close relationship with the patient, as well as build rapport with nurses.

Qualitative studies of lay-family member

Over the past three decades, several research studies have addressed the importance of ill patients having family members at their bedside in general wards. Many studies have used qualitative methods. In the United States of America, Congdon (1994) used qualitative grounded theory and conducted interviews with nurses to gather information on their experiences of discharging patients accompanied by family members within surgical wards. Interview data revealed that nurses' perceptions were that the discharge process went smoothly due to support from family members, though others reported feelings of uncertainty associated with the process because of inadequate communication with the health care team. However, some nurses surprisingly expressed that they were unaware of the impact hospitalisation has on family members of the patient during hospital admission. Also, other nurses were unsure of the involvement of

family members during the decision-making part of the discharge process. Nurses who had cared for these patients found that they often needed to coordinate with family members in relation to delivery of care.

Two ethnographic studies conducted by Carr and Fogarty (1999) examined the meaning of experiences of vigilance from the family's perspective while staying at the bedside of an ill loved one. A study of 16 family members who had stayed with a cognitively impaired relative for six to 24 hours was conducted in adult neurology and rehabilitation units. The researchers noted that the majority of ill loved ones had some degree of cognitive impairment and participants were described as a mixed group of undefined relatives. No information was provided about participant employment and family status at the time of their experience. However, results provided a rich description in terms of the development of themes. Findings revealed that family members were stressed by the fact that an important part of their experience involved being vigilant by being present with their hospitalised ill-loved one, and five themes related to the meaning of the experience were stated: 'commitment to care, emotional upheaval, dynamic nexus, transition, and resilience' (Carr & Fogarty 1999, p. 435). Such themes may assist health care staff in understanding family members' needs and contribute to the development of a strategy to fulfil patient needs during stays in general wards. Appreciating the perspectives of lay-family members' assists in the broader interpretation of how nurses might consider the needs of nurse-family members.

In an ethnographic study conducted in the United Kingdom, May, Ellis-Hill and Payne (2001) explored the relationship between family members of adult patients and health care staff in a rehabilitation ward. They addressed the important key relationship between family member and health care staff, centred on information exchange, gate-keeping and legitimacy considerations using a video recorder. The study provided a measure of the day to day interactions between family members and health care staff. The attitudes of nurses towards supporting family members may determine whether respect and trust develops between the different parties (Astedt-Kurki et al. 2001). A strength of the study was careful participant selection, including precise definitions of family member and type of relationship with the patient which may facilitate transferability to similar types of general wards. Morris and Thomas (2002) identified the importance of this type of study while providing rich descriptions of the role of relationships and negotiation with family members and health care professionals.

In an Australian study, Hancock et al. (2003) investigated the important aspects of nursing care as perceived by lay-family members who stayed during hospitalisation of their loved ones in five acute care hospitals (ten medical wards). The researcher used a questionnaire to collect quantitative and qualitative data and a total of 99 family members participated in the study. The family members described they were at times restricted by nurses in terms of degree of involvement in the care of their loved ones. Inclusion of family members in patient care was dependent on nurses, but may also have been related to family member choice. Although, the researchers acknowledged the study had some limitations in relation to participant selection, ethical concerns and setting, overall, the study provided insights to the importance of how nursing care is perceived by family members. Therefore, the role of family members in helping to improve the care of their ill loved one during hospitalisation in general wards is an important concern. Overall, study participants, data collection and analysis were accurately described. Although qualitative data was clearly presented, it would have been useful if some quotations from participants were included to support their findings.

In Denmark, Lindhardt, Bolmsjö and Hallberg (2006) used a descriptive phenomenological approach to investigate family members' lived experiences of caring for an adult loved one in medical and surgical wards. Eight family members who accompanied their loved ones agreed to participate in an interview, with study design informed by Husserl's phenomenological method. Research findings identified the phenomenon of being a relative in two main themes, 'history' and 'standing guard'. History is reflected in terms of the relationship and family member experience, a sense of responsibility to continue the journey of the relationship with care of their loved one. The researchers identified that 'standing guard' referred to the family member acting as an advocate for his or her loved one, similar to the Carr and Fogarty (1999) observation of 'vigilance' (Carr & Fogarty 1999). That is, he or she experiences a sense of responsibility to protect his or her loved one by watching over care provided by nurses and all health care staff. On some occasions family members participated in care of ill loved ones not only for support, but also to provide safety while assisting with their activities of daily living. However, it is unclear whether family member involvement with care was by choice or by a sense of obligation or expectation. Lindhardt, Bolmsjö and Hallberg (2006) concluded that during hospitalisation of an ill loved one, family members carry with them responsibilities, emotions and proficiencies which create certain expectations of health care staff and the health care system.

An Australian study by Higgins et al. (2007), using a descriptive qualitative approach and ethnographic data collection methods, was aimed at identifying the needs of family members of adult patients during hospitalisation in medical and surgical wards. A total of ten family members agreed to participate in interviews. The researcher noted that participants were a mixed group with regards to age, gender and type of relationship to the patient. Limited information was provided about participant employment and marital status at the time of their loved ones' hospitalisation. Through, detailed thematic analysis two main themes were revealed: 'being informed' and 'being there'.

Higgins et al. (2007, p. 213) introduced the term 'being informed' which referred to the need for family to be well informed by health care professionals. The authors emphasised that family member's experiences may be confusing and worrying due to the possibility of receiving inconsistent and conflicting information. Similar to the previous research, succinct information was identified as a primary need for family members, and the manner of how such information is delivered was cited as being equally important (Carr & Fogarty 1999; Lindhardt, Bolmsjö & Hallberg 2006).

In Denmark, a qualitative descriptive study was conducted by Lindhardt, Hallberg and Poulsen (2008) with nurses collaborating with family members of adult patients hospitalised in medical wards. Eight nurses caring for a patient accompanied by a family member were interviewed. Nurses assessing the collaboration between themselves and family members identified two major difficulties: 'relatives – a demanding resource and coincidental encounter – the collaboration' (Lindhardt, Hallberg & Poulsen 2008, p. 678). Many nurses reported feeling unprepared and unsure about the relationship established when a lay-family member accompanies an ill loved one, precisely during the time when care is provided. Such findings add weight to the need for further studies concerning the nurse, patient and family dynamic.

More recently, an ethnographic approach to involvement of family members in care of ill loved ones in two countries, Australia and Saudi Arabia, by Alshahrani (2016) aimed to explore the role of family members in the care of patients in medical settings. In her doctoral thesis, 22 family members in the Australia setting

and 52 family members in the Saudi Arabia setting were observed and interviewed. Four main domains emerged from the data: role ambiguity, involvement in care, nurse-relative relationship and safety. The thesis revealed that family members' role was at times ambiguous, which poses a challenge to nurses especially in the extent of family members' involvement in patient care. Alshahrani (2016) recommended that family members' involvement be negotiated during an ill loved ones' admission, to provide clarity and consistency with patient care involvement. Previous studies have focused on the domain of family members' involvement in patient care in a critical care setting (Fateel & O'Neill 2015) and in a community setting (Pickard, Jacobs & Kirk 2003). An interesting exploration of the cultural meaning and context of family members' experience was reported. The doctoral thesis presents rich information about the methods and data gathered. In addition, there was accurate description of results as evidenced by illustrations of the findings. To provide a balanced assessment of the literature, quantitative studies on the issue of nurses and family relationships are next considered.

Quantitative studies of lay-family member

From a quantitative research perspective, most empirical studies have focused on the presence, involvement and needs of family members during their ill loved ones' general care. An early study using descriptive design conducted by Molter (1979) focused on needs of family members of ill loved ones in two teaching hospitals in the United States of America. For the study, 40 family members of hospitalised adult patients were interviewed using a structured interview format. During interviews, each family member identified the importance of their presence during hospitalisation of their ill-loved one and indicated that recognition of their own needs was imperative. Molter (1979) established the first instrument for needs assessment known as Critical Care Family Needs Inventory (CCFNI), which has been described in many papers published worldwide (Bandari et al. 2015; Brysiewicz & Chipps 2017). Molter (1979) used Likert scales to identify 45 needs of family members when their ill loved one is admitted to hospital. Five of these were rated as the most significant needs of family members in a hospital facility:

- Feel there is hope,
- Feel that hospital personnel care about the patient,
- Be called at home about changes in the condition of the patient,
- Know the prognosis, and
- Receive information about the patient at least once a day.

In Finland, a pilot study by Laitinen (1992) used a family member participation scale to measure quality of care provided to their loved one. Seven family member responses were positive with regards to being present with their loved one in the hospital, however the study indicated limited involvement in terms of whether family members should or should not be asked to participate in care delivery. Despite this assertion the researcher stated that family members were involved in up to 18 activities of daily living, including emotional support, the provision of which often occurred more than three times in a week. Although Laitinen (1992) investigated a small sample which may not be generalisable to larger populations, it is suggested that appropriate methods provided valid findings. The use of appropriate statistical analysis, assessment of interrater reliability and identification of Cronbach's alpha were helpful in establishing study

rigor and in providing detailed reports of family member's needs when their ill-loved one was hospitalised in a general ward.

A cross-sectional study design by Cho and Kim (2006) was performed to examine the needs of family members' presence alongside an ill loved one in non-critical wards in Korean hospitals. Of 3,203 patients surveyed, 87% identified the need for presence of family members during hospitalisation. The researchers emphasised there was an increase in presence of family members in hospital settings during the period of 1997 to 2006. However, this increase may be due to an increase in elderly population or an increase in the proportion of patient admissions during that time, both of which indicate the need for support from family members. Therefore, with an increased number of patients needing family members, such considerations are an essential aspect of general ward management to provide high level patient care. Overall, the article reflects an accurate study with a well-structured approach to data gathering.

A quantitative study conducted in Brazil by Pena and Diogo (2009) led to identification of different family member activities within two medical wards of hospitalised elderly patients. Thirty family members were recruited and interviewed using face to face interview tools. This adapted instrument recorded daily activities performed by family members which were categorised as 'always, never and whenever necessary' (Pena & Diogo 2009, p. 353). The results of the study showed that family members consider themselves active participants in care provided to their ill loved ones. The most predominant activity was delivering emotional support, which scored 96.7%, as compared to other activities of daily living. However, results from this data may not be generalisable to other patient populations, for example younger adults. Furthermore, data showed that, while there is great involvement of family members in providing emotional support, physical support, such as changing body position, dressing and hygiene, were also delivered under the guidance of nurses.

In a cross-sectional study conducted in Israel, Auslander (2011) explored the extent of inpatient care provided by family members for patients hospitalised in general care. Of 1,076 adult patients admitted to general wards, more than 69% had family members present at their bedside for an average of eight hours a day. In addition, she highlighted that 12% of patients were aged below 45 years of age which represents younger aged patients. This population group may not need as much direct assistance from families compared to older patients making it somewhat difficult to determine the relevance of findings to other populations. Auslander (2011, p. 208) stressed that during hospitalisation of an ill loved one, family members get involved in a number of common tasks, such as 'monitoring, communication and accompanying, support and comforting…'. However, most family members have no formal training and rely to a great degree on what they learn from listening and observing health care staff. Therefore, it is clear from both qualitative and quantitative measures that in some instances and cultures, family members are an essential part of patient-centred care. Health care staff, especially nurses, are encouraged to identify the support that family members need to assist in provision of appropriate care.

Since the 20th century, admission of adult patients accompanied by family members to acute care hospitals has been a phenomenon of study with regards to the role of nurses. Nurses are aware of the importance of family members, such as a source of information and background. On a daily basis, nurses observe family members assisting their ill loved one with physical care and psychological support. Nurses identified that without external support, family members may face difficulty dealing with caring responsibilities, especially

in relation to the more technical aspects of care. Involvement of family members in patient care, with the assistance of nurses, has been acknowledged as an essential component in related literature (Fink 1995).

As populations age it is likely that a significant increase in the number of family members accompanying ill loved ones within general care wards will occur. The presence of family member during the ill loved one's admission is now considered to make a significant contribution to improvement of quality of care. At the same time, nurses increasingly face challenges in creating new relationships in daily practice. The experience of nurses managing a patient has been explored through the efforts of many nursing researchers over the last 20 years. Miracle (2006) stressed that the needs of family members must be made clear to nurses to meet patient needs and improve care delivered. Moreover, many studies have focused on experiences and perceptions nurses have of family members of ill loved ones during hospitalisation in general ward settings.

In Australia, Hancock et al. (2003) were among the first researchers to investigate the nursing needs of adult patients accompanied by relatives. Ninety nurses completed a survey, known as 'Caregiving Activities Survey', in ten medical wards across five public hospitals (Hancock et al. 2003, p. 507). Hancock et al. (2003, p. 510) used the 'Caregiving Activity Scale' to measure responses, which were constructed of four parts: psychosocial care, physical care, doctors' orders and discharge planning. Some nurses commented that time management limited them in terms of providing adequate nursing care, especially in the area of psychosocial care.

In the hospital setting, various cultures are considered as having an influence on lay-family member needs. In some cultures, it is expected that family presence plays a vital role in terms of communication with the healthcare professional and for a certain level of support to ill loved ones. The term culture is defined as, 'the attitudes and behaviour characteristic of a particular social group' (Oxford Dictionaries 2018). For example, in Israel, a majority of participants reported that they were with their ill relatives nearly every day (Auslander 2011). This was similar to a study conducted in Saudi Arabia where it was a normal practice to have a family member or carer with the patient most of the time; however, this may not be common across cultures, such as in Australia (Alshahrani 2016). In developing countries, such as Korea and Brazil, it was reported that family member presence and involvement were necessary during an ill loved one's hospitalisation (Cho & Kim 2006; Pena & Diogo 2009). However, it is crucial to not assume cultural norms, but to discuss these among the family group.

The perception of nurses

The experiences of nurses caring for a patient whose family member is a nurse is an interesting topic that has surprisingly only been discussed in the form of personal reflections (Olivet & Harris 1991). No literature was found that identifies formal qualitative study into the interactions of nurses and nurse-family members. As indicated, only a few personal reflection articles describe being a nurse where a family member with an ill loved one is also a nurse. While some nurses are unconcerned about the presence of nurse-family members when providing care to their ill-loved ones, others may consider such circumstances very stressful and overwhelming experiences. One nurse described her experiences with her head nurse, saying, '…Jane: Oh, I'm so frustrated with Mr Brown's daughter and I don't know what to do. Head nurse: You mean the daughter who is a nurse? ...' (Olivet & Harris 1991, p. 248). In another reflective article, Spear

(2002, p. 196), stated that during her mother's hospitalisation, her mother requested not to be turned because of pain, which she fully supports, but the nurses responded by saying, 'You are not being objective. You're a nurse. You know that your mother needs to be turned…'.

One of the few articles on this topic by Olivet and Harris (1991), titled 'Expectation versus realisation the family member who is a nurse', was based on a story, and the author discussed the experiences of nurses and nurse-family member concerns, relationships and specialised knowledge. Olivet and Harris (1991, p. 251) suggested eight strategies for nurses to be implemented during the stay of nurse-family members with their ill loved ones:

1. Assess the role of the nurse-family member,
2. Assess the knowledge of the nurse-family member related to the patient's present illness and treatment plans,
3. Assess the role of stress being experienced by the nurse-family member,
4. Assess the emotional responses of the patient and all significant others,
5. Provide explanations and preparations for all procedures and treatments to the patient and all family members including the nurse-family member,
6. Provide support and encouragement to the nurse-family member,
7. Seek to establish an alliance among staff, patient, nurse-family member, and other family members, and
8. Provide a consistent, high quality of patient care so that no changes are necessary when the family member is a nurse.

Another narrative on personal experiences by Wilson and Ardoin (2013), entitled 'When professional and personal worlds meet: nurse as daughter', was based on two nurse-family members' experiences during the hospital journey with their loved ones. Wilson and Ardoin (2013, p. 196) offered the following recommendations to nurses caring for a patient whose family member is a nurse:

- Prepare for the nurse-family member's visit; this person knows quality health care and is usually the spokesperson,
- Identify the nurse-family member as a member of the team and allow his or her input,
- Recognise the emotional connection for the nurse-family member, and
- Listen respectfully to the nurse-family member and provide information accordingly.

While nurses may offer support for the physical and emotional needs of their clients, they also try to fulfil the various needs of nurse-family members throughout the duration of their loved ones' time in hospital. Detailed information, the ability to be engaged in care, expectations from staff and role boundaries may serve as general needs for nurse-family members maximise to delivery of care for ill-loved ones. As always, nurses are in a unique position to provide an appropriate plan of care to patients and family members, regardless of professional background. However, nurses appear divided on whether nurse-family members should be supported in the same way as others (Olivet & Harris 1991; Wilson & Ardoin 2013). In this respect, Study 3 is unique for its investigation of experiences of nurses with nurse-family members focused on non-critical areas, specifically, medical and surgical wards. This study provides greater understanding of the current experience of nurses and actors influencing these unique experiences.

Summary

The purpose of this chapter was to provide a review of the literature related to the experiences of nurses supporting lay-family members and nurse-family members when their ill loved ones have been admitted to general wards. Although nurses face significant challenges and compliments with support of nurse-family members, they may also feel pressured and strained, leading to avoidance of such encounters. The review was divided into two parts: an overview of the existing literature related to family members with loved ones in general wards, such as the medical and surgical areas, an overview of the literature on nurses' viewpoints regarding supporting lay-family members, and a review of the literature on the views of nurses with regards to providing support to nurse-family members. Caring for a patient whose family member is a nurse may add complexity to the care provided and support needs for the family. Highlighted in the chapter was the growing body of literature in the form of qualitative and quantitative studies on the role of nurses supporting family members, specifically in general ward areas. In respect of the nurse-family member only a few personal accounts have shed light on the nurse's perspective with ill loved ones hospitalised in general wards. These papers are not constructed from research and indeed there is no research to date that has investigated the context using a qualitative study. The qualitative methodology used to undertake this study is presented in the next chapter.

Chapter Three: Research Methodology

Introduction

This chapter outlines the methodology used in Study 3, providing an overview of the chosen qualitative method of enquiry and research design. There are two main phenomenology schools of thought: descriptive and interpretive (hermeneutic phenomenology). Study 3 used an interpretive hermeneutic phenomenological approach because of its potential to gain deep understanding of lived experience. In this chapter, the philosophical underpinnings of hermeneutic phenomenology are discussed, along with the van Manen approach to analysis. The work of van Manen was preferred for the structure and interpretation and for synthesising the data of this project.

Qualitative research

Qualitative research may take an interpretative or critical approach because it aims to define a concept and investigate a particular phenomenon of interest (Gerrish, Lathlean & Cormack 2015). A qualitative research study entails a non-experimental research design that uses rich and illustrative data to provide a deep description of the meaning of a phenomenon. This is particularly important when conducting social inquiry about individuals' experiences within their natural setting. Qualitative research is often used in fields such as nursing and social sciences. Mason (2002) emphasised that there is no common definition for qualitative research; however, a recent definition, from a nursing perspective suits the purpose of this research. Polit and Beck (2016, p. 741) define qualitative research as 'the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design'. In other words, it generates an understanding of an individual's experience using a specific research design. Therefore, qualitative research offers a humanistic approach to understand the experiences, perceptions and opinions from the unique perspective of the research participant.

Qualitative research allows the researcher to gain knowledge of the phenomena from nurse participant perspectives of their experiences in the clinical setting. As Polit and Beck (2016) highlight, qualitative approaches such as phenomenology are concerned with understanding the meaning of the lived experience through the eyes of the interviewee. Qualitative method was considered more suitable for this study than quantitative method because the study question involves a uniquely human interaction between two or more people in the life-world. While there are many different qualitative methodologies, such as, ethnography grounded theory and critical theory, phenomenology was selected for use in this case. Thus, the methodology aims to allow the researcher to describe and understand human experiences of a phenomenon (Polit & Beck 2016). Using a specific qualitative research design not only requires an understanding of the nature of the study, but also the type of research questions considered appropriate. Developing a research question that has a phenomenological character involves two steps: 'finding a phenomenon of interest and formulating an initial life-world evoking question' (Holloway 2005, p. 107). Exploring the essence of how nurses deal with adult patients whose family members are nurses in a general ward and what it meant to them reflects a concern of the life-world. To achieve this, it was important to use an open question, in keeping with a phenomenological approach, that provides nurses enough freedom to verbalise their experiences by asking the research question, 'What are the experiences of

nurses caring for an adult patient whose family members are nurses in a general ward?' In this form the question is considered suitable to employ a phenomenological design approach.

Phenomenology

Phenomenological research explores human experiences. These experiences are examined by either descriptive or interpretive methods using data collected from participants who have lived a certain experience. Phenomenological design was considered the appropriate method for this study because it allowed the researcher to explore the phenomenon of supporting a nurse-family member by collecting descriptive data based on nurses' experiences. The aim was to provide detailed information on the nature of the meaning of individual daily experiences and describe and reflect on them (Gerrish, Lathlean & Cormack 2015). This design allowed nurses, via in-depth interview, to share meaning from their own experiences of caring with adult patients whose family members are nurses. Borbasi and Jackson (2012, p. 257) indicated that the purpose of phenomenology design is 'to understand and attribute meaning to the phenomenon of interest'. Holloway (2005) stated that such designs have two advantages: firstly, it is an ideal design for human experience from the perspective of qualitative research, and secondly, it is considered to be a method of systematic, critical and rigorous examination of the phenomenon. The term phenomenon was defined by Gerrish, Lathlean and Cormack (2015, p. 587) as 'an occurrence, circumstance, experience or fact that is perceptible to the senses'. Phenomenological researchers seek to understand the importance of an experience by asking questions such as what is the essence of the participants' experience and what does it mean?

Phenomenology is both 'a philosophy of knowledge and qualitative research approach' (Østergaard, Dahlin & Hugo 2008, p. 94). The philosophy of phenomenology was advanced by contemporary philosophers Husserl and Heidegger and is often generally divided into two main approaches: descriptive and interpretive (Polit & Beck 2016). Annells (2007) emphasised that phenomenological research does not proceed with a formulaic or direct approach; rather researchers are required to familiarise themselves with a range of phenomenological approaches to be able to outline the philosophical assumptions in their work. While both descriptive and interpretive approaches begin by using the term 'life-world', which involves collecting information from individual daily experience as a starting point, different processes are used in the analytic method (Gerrish, Lathlean & Cormack 2015, p. 215). For example, descriptive approaches may use a process of 'bracketing' where one isolates their understanding of meaning from previous experiences, while the interpretive approach uses a 'sensitising' process to describe the experience (Gerrish, Lathlean & Cormack 2015, p. 215). In other words, descriptive phenomenology allows the researcher to describe lived experiences in a literal way free of outside interpretation, essentially a 'pure' description of an individual's experience. In contrast, interpretive phenomenology requires the researcher to seek out and interpret meaning of individual experience, emphasising individual subjectivity. Laverty (2003) mentioned that, although there is similarity between descriptive and interpretive approaches in some features, both types are clearly from different research traditions. Therefore, the researcher benefits from understanding how to choose either descriptive or interpretive phenomenological research to best appreciate how an individual might perceive an event.

Descriptive phenomenology, attributed to Edmund Husserl, concentrates on individuals' descriptions of experiences (Polit & Beck 2016). His philosophy is more centred on an epistemological approach where knowledge and development of knowledge is central to the relationship between the investigator and person being researched. If the investigator is unable to 'deny' or place into abeyance any prior knowledge, any pre-judgement which was identified and was unable to detach the researcher from the world of investigation may skew or alter the final interpretation. This approach was inconsistent with the current study because of its transcendental nature, an approach that was not thought to help the researcher to understand the deeper meaning of nurses' experiences. Secondly, the difficulty in ensuring an approach to bracket the perspective of the novice researcher was important to consider.

While perhaps not any less difficult in application, it was decided that an interpretative phenomenological approach, attributed to Martin Heidegger (1962) and known as 'hermeneutical phenomenology' would provide a suitable vehicle to interpret the meaning of experiences (Polit & Beck 2016, p. 472). This hermeneutic phenomenological design was appropriate for the current study because of its potential to lead to pre-understanding and encourage the researcher to consider a range of possible interpretations based on the meaning and being of lived experience. The design gave nurses an opportunity to explore their own experiences and allow the investigator to be 'in' the world of investigation. In line with the above, the researcher considered Heidegger's phenomenological paradigm to be an appropriate approach in this study because it allowed rigorous, critical, and systematic investigation of the phenomena. In the next section, the Heideggerian phenomenological approach is discussed in more detail.

Heideggerian phenomenology

This section considers Heideggerian phenomenology and hermeneutics, an approach that explores the concept of knowledge and nature of the true essence of phenomena. Heidegger's philosophical position is an ontological approach where great value is placed on the nature of reality, meaning and being. He initiated the concept of 'Dasein' a German word that means 'being-there' (Horrigan-Kelly, Millar & Dowling 2016, p. 1). So important is the concept of Dasein to interpretive phenomenology and hermeneutics that Heidegger (1962, p62) writes '…Being and the structure of Being lie beyond every entity and every possible character which an entity may possess'. The centrality of this concept in Heidegger's phenomenology encourages consideration of 'what it is to be' as this then provides an opportunity to explore and be open to differences in interpreting a being's experiences of their life-world. This version of phenomenology was adapted and reformed from Husserl's approaches and developed into hermeneutic phenomenology, also known as interpretive phenomenology. Unlike Husserlian approaches to phenomenology, Heidegger employed the concept of describing and interpreting the meaning of life experience in a hermeneutic process. Polit and Beck (2016, p. 472) described hermeneutics as the 'art and philosophy of interpreting the meaning of an object, for example text.' van Manen (1990) emphasised that human existence in the reality 'of being' was unavoidable hermeneutically in Heidegger's approach. Currently, Heidegger's foundation to hermeneutics is widely used by health care researchers, particularly in nursing research, where patients are the centre of care and nurses are often providers of care.

This foundation encouraged the investigator to understand the world of nurses to obtain a range of insights to the experiences of nurses. Laverty (2003) also describes that using a hermeneutic process offers a way to develop understanding and allow interpretation of the meaning of a phenomenon, an approach that

characterises the Heideggerian method. Interpretation is an essential step towards the process of understanding.

The hermeneutic process

When listening to participants' stories, it is important to recognise their Dasein, which Heidegger (1962, p63) notes has a 'historical' aspect, that is to not judge but to let the conversation flow and then interpret the meaning of these dialogues by using the hermeneutic circle. The concept of the hermeneutic circle developed further by Gadamer, is 'a methodologic and interpretive process in which to reach understanding, there is continual movement between the parts and the whole of the text that are being analysed' (Polit & Beck 2016, p. 730). Generally, the process of data interpretation is a systematic process which occurs in a circular or spiral fashion redressing and reframing the text, known as the spiral of interpretation. This process of constant engagement helps the researcher's understanding of the natural experience of individuals, rather than moving 'in and out' or between the text (Motahari 2008).

In this study, an interpretive process was used to build understanding about nurses' experiences by moving between the experiences of each nurse and seeing the phenomena of nurses as a whole story. van Manen (1997) supports the idea that understanding the concept of the phenomenon depends on the individual text and understanding individual text depends on associating it with the whole. This shows that the process of interpretation contains the investigator's own pre- understanding in a very positive way into the text known as 'fusion of horizons' (Laverty 2003). Fusion of horizons describes a process of illustration for understanding that occurs between investigator and the phenomenon. In other words, when the investigator understands the interview transcript in such a way that they also are also aware of how that interpretation includes their own background and influences, a greater degree of transparency and structure result. Horrigan-Kelly, Millar and Dowling (2016) highlight a diversity of interpretive research methods available to uncover the meaning of human interaction, and van Manen's method is one of these. This structured and tried approach, along with the fact that van Manen writes in a way that is suited to researchers new to phenomenological approaches, helped justify the choice of van Manen's method to analyse and synthesise the data in this study.

Van Manen approach

Van Manen's approach is one of the most efficient forms of qualitative analysis when conducting phenomenological research. According to Polit and Beck (2016), the approach originates from the second school of phenomenology, also known as the Utrecht school. It aligns with Heideggerian phenomenology, which focuses on the description and interpretation of individual experience. In other words, van Manen's approach is used to help the researcher 'grasp the essential meaning' of the experience being studied (van Manen 1990, p. 77). van Manen (1997) considered that an investigator needs to be immersed in the phenomenon to achieve an understanding of participants' experiences within the life-world. He also designed the method to be used as a human science research approach which would essentially be kept in mind while the current study was explored. For interpretive phenomenological research, van Manen (1990, p. 30) recommends six methodical steps to assist the research process:

1. Turning to a phenomenon which seriously interests us and commits us to the world.
2. Investigating experience as we live it rather than as we conceptualise it.

3. Reflecting on the essential themes which characterise the phenomenon.
4. Describing the phenomenon through the art of writing and rewriting.
5. Maintaining a strong and oriented pedagogical relation to the phenomenon.
6. Balancing the research context by considering parts and whole.

The six steps offer a concrete approach useful in undertaking an interpretive phenomenology based on human lived experience. These steps provide an outline for the methods used in this study in terms of nature of the phenomenon through the life-world of people. Although these components are broadly described, they are useful to guide the flow of research when exploring the phenomenon being studied. van Manen (1997) stressed that the framework of these components was not rigid and that researchers should allow some flexibility in the research steps.

Summary

The qualitative research paradigm and philosophical aspects of research designs were discussed in this chapter. The research design and rationale for choosing the method of enquiry, hermeneutic phenomenology, were explained. Study 3 was guided by this design because it is an approach that describes how a phenomenon can be understood by individuals. Additionally, van Manen's approach was described, and the six steps of undertaking phenomenological research and data interpretation were outlined. With this in mind, this approach proposed to combine the power of story with the unfiltered lens of hermeneutic process to gain insight into the life-world of nurses who have cared for adult patients whose family members are nurses. The next chapter describes the methods used in this project.

Chapter Four: Methods

Introduction

In this chapter, methods used to undertake the study are described and discussed. It describes how the hermeneutic method and steps for gathering and analysing data informed by van Manen were used to answer the research question. The aim of hermeneutic phenomenological method is to gain a deeper understanding of experiences, and this often involves respondents sharing personal stories. Ethical concerns, study setting, data collection procedures, how rigour was maintained throughout and analysis technique used to reflect on the transcripts is also presented. The aim of the study was to provide a rich narrative of nurses' experiences in caring for a patient in a general ward who has a family member who is a nurse. Nurses often have a wealth of unique information to share within clinical and academic contexts, and an understanding of these experiences may assist in preparing current and prospective nurses to understand more clearly what it is like to work with nurse-family members. This knowledge may assist continuing development of nurses and may also be utilised to enhance clinical practice within the hospital setting.

Restatement of research question

For the purposes of Study 3, the phenomenon of interest was the experience of nurses when caring for adult patients who have a family member who is a nurse within a general ward. The research question presented for this research was as follows: What are the experiences of nurses caring for adult patients in a general ward who have a family member who is a nurse? Although nurses have been experiencing this phenomenon for many years, there appears to be a significant gap in research with no published studies identified regarding this issue.

Description of the study setting

The study was conducted at the Adelaide Nursing School, The University of Adelaide. The University of Adelaide is the third oldest university in Australia. It maintains a world-leading research reputation and is a member of eight research intensive universities nationwide. The Adelaide Nursing School is one of five schools within the Faculty of Health and Medical Sciences that offers clinically focused and evidence-based research to undergraduate and postgraduate nursing degrees.

Participants

Study participants were Registered Nurses working in non-critical care areas and who were completing postgraduate studies. For consistency, participants are referred to as nurses. It was assumed all nurses were able to speak and understand English as this is a requirement for registration with The Australian Health Practitioner Regulation Agency (2015). Domestic and international born and educated nurses need to comply with levels of English language suggested in the International English Language Testing System (IELTS). This IELTS requirement mandates a minimum overall score of 7 and a minimum score of 7 in each of the four components (listening, reading, writing and speaking). Essentially, each participant was fluent in English. Lastly, although no nurse was known to the researcher prior to data collection, nurses were

accessible as study participants as they were studying a range of post graduate specialities in the same school as the researcher.

Inclusion and exclusion criteria

Inclusion criteria for Study 3 were as follows: nurses employed at an acute care hospital in a general ward who had experienced caring for an adult patient who had a family member who was a nurse within the prior 24 months. Nurses were excluded from the study if they worked exclusively in critical care areas, for example emergency department and intensive care units. Nurses from critical care areas were excluded because of different foci in nursing care, potential for family involvement, potential for higher levels of stress and anxiety and in acknowledgement of some previously reported studies.

Recruitment strategies

An email invitation including an information sheet and consent form was sent to all postgraduate nursing students, initially through the postgraduate program coordinator. The research student's supervisors, who also work in the Adelaide Nursing School, were not involved in the recruitment process, only the student conducting the project had contact with nurses. The research supervisors only had access to de-identified data. Participants nominated a time that was convenient for them for the interview to take place. This was clarified via email and phone calls to nurses. The number of participants may be considered small, but the researchers noted that data saturation was reached through interviews with five participants, with no new themes emerging. The themes that emerged provided rich descriptions of the phenomenon under investigation.

Ethical issues

Ethical approval for Study 3 was granted by the University of Adelaide Human Research Ethics Committee (H-2017-038), and the study was authorised to commence on 31 March 2017 (Appendix I). Therefore, Study 3 was conducted according to the requirements of the National Statement on Ethical Conduct in Human Research (2007) and involved low risk for research participants. Nurses were given a participant information sheet (Appendix II) that outlined the research project. The sheet included, but was not limited to, information about the aims, benefits and potential risks of the study. It also highlighted potential length of interview as 45 to 60 minutes, which may have proven potentially time consuming for nurses. However, it was thought unlikely that interviews would result in discomfort. In the event that a nurse became upset because of their participation in the research project, the research team were able to arrange for counselling or other appropriate support. Any counselling or support was to be provided by an individual from the University Counselling Service, not a member of the research team. This counselling would have been provided free of charge, but was not necessary.

Informed consent was obtained prior to commencing interviews using a consent form (Appendix III). Holloway (2005) stresses that consent forms provide comprehensive information and be clearly signed by the participant after they have been made aware of the nature of the study and voluntarily agree to take part. To ensure that participants were fully informed of what they were agreeing to before interview commencement, a witness signature was required by the researcher. There was no direct benefit to participants of being involved in the study. However, information collected during interviews was intended

to increase the understanding of nurses' experiences of caring/supporting nurse-family members and possibly improve support for nurse-family members. There were no costs or monetary benefits for participants in this research project.

Privacy and confidentiality of participant data

Interview narrative data, without identification of participant, was saved on a password protected computer file to a confidential staff server and submitted as required to the Adelaide Nursing School with the final project documentation. Participants were offered the opportunity to review their transcripts if so desired. No participant elected to change any of their comments. Data files were stored in a non-identifiable form and aspects of interviews where personal identifiers were used were permanently removed. Pseudonyms were used when referring to participants. The research may be published in a peer reviewed journal and presented at conferences. The information gathered will be stored confidentially for 12 months.

Data collection

Recruitment and data collection occurred over a six month period. Data were collected using a one to one interview that lasted for 45 to 60 minutes per interview. Interviews were held at the Adelaide Health and Medical Sciences Building in meeting rooms at times convenient to participants. Interviews were not conducted in the participants' workplaces to ensure anonymity. Prior to interviews, the researcher confirmed that participants had read the information sheet and consent form, which they then signed. In addition, it was agreed between the investigator and participants that the transcript would be sent to them to ensure credibility of the recorded conversation. Interviews were digitally recorded. As this was the first qualitative study conducted by the primary researcher, his previous experience in conducting face-to-face interviews was limited, but the resulting transcript data collected related well to the research question posed.

To elicit information about experiences of nurses in general wards caring for a patient who had a family member who is a nurse, the following question was asked to commence the interview: 'Can you tell me about your experience of caring/supporting nurse-family members who have adult relatives in your ward?' The researcher listened to participants' verbal responses, observed their non-verbal communication and wrote brief field notes for later reference. Throughout, the researcher indicate agreement when needed, and verbal signals that indicated interest, such as nods, to support the flow of communication with the interviewee. Using this method of communication, a collaborative conversation and mutual understanding was generated between the researcher and interviewees. Additionally, further questions were used as prompts to keep the conversation flowing:

- Can you tell me a little more about that?
- What do you mean by…? (paraphrasing)
- What happened next?
- How did that make you feel?

The researcher ended the interview by thanking the participant for their time and assuring them about data confidentiality. A transcript of the interview was emailed to participants for review prior to the analysis stage to check for ratification.

Data analysis and management

In qualitative research, data collection and analysis are two related phases during the research process. In a hermeneutic phenomenological study, description of how the data has been interpreted helps provide an in-depth understanding of the participant experience. While there are several approaches to analysing phenomenological data, data from Study 3 was analysed using the six steps of van Manen's method, describing nurses' experiences of dealing with nurse-family members who have adult relatives in general wards. Data were managed, classified and sorted using manual and intuitive computer system.

When conducting the interview, the researcher wrote brief notes to help focus on the story being told. Following the interview, recordings were reviewed to provide additional insight and to document the information while it was still easily recalled. Interview recordings were transcribed and then read and re-read to get a sense of the nurses' experiences. Then, to ensure an accurate record of each transcript, the investigator requested the interviewee to check for accuracy, additions and corrections so these issues could be resolved before data was analysed. Interview transcripts were thematically analysed following van Manen's approach.

Demonstration of rigour

As mentioned above, the phenomenology method aims to investigate the nature of lived experience of phenomena. When conducting a study using an interpretative approach, such as hermeneutic phenomenology, it is important to establish a high standard of quality and rigour. Gerrish, Lathlean and Cormack (2015, p. 588) define rigour as 'the strength of a research design in terms of adherence to procedures, accuracy and consistency'. To establish the determinants of rigour, qualitative researchers use standards of criteria to maintain a feasible objective during the study. Objectivity is described as 'a neutral and unbiased stance' (Holloway 2005, p. 294). While a number of studies have used different criteria to establish rigour in qualitative research, this study will focus on Lincoln and Guba's use of four components in interpretive inquiry (Lincoln & Guba 1985). These are the terms of: (a) credibility, (b) transferability, (c) dependability and (d) confirmability. Figure 2 was created by recording the activities that occurred at each section of the study process. Description of each criteria outline on particular examples of methods used in this study as follows.

Credibility

Credibility is defined as a 'criterion for evaluating trustworthiness in qualitative studies, referring to confidence in the truth of the data; analogous to internal validity in quantitative research' (Polit & Beck 2016, p. 724). This component allows the investigator to recognise the experiences of the interviewee, which can be established by navigating and grouping similarities among participants. Lincoln and Guba (1985) suggested that establishing credibility involves member checking or returning to the interviewee to check if the themes and analyses of their experiences are correct. In Study 3, member checking includes some supervisors rechecking the themes and subthemes based on the recordings and transcripts. In

addition, participants were given the opportunity to read their transcripts for accuracy, and additions and corrections could be made because of their feedback via email communication. Another strategy used involved piloting the interview with supervisors.

Applicability

Applicability, also known as transferability, has been described by Polit and Beck (2016, p. 726) as 'the extent to which qualitative findings can be transferred to other settings or groups; analogous to generalizability'. In other words, it entails transferring results of qualitative findings from one group to another for the reader to judge applicability of interpretations (Koch 2006; Lincoln & Guba 1985). In Study 3, the study population, together with demographic description and setting of the study, were used to enhance transferability. In this study, transferability was achieved by collecting data from a specific group of participants which were nurses and a specific work setting which was a general ward.

Dependability

Dependability is defined as 'a criterion for evaluating trustworthiness in qualitative studies, referring to the stability of data over time and over conditions; analogous to reliability in quantitative research' (Polit & Beck 2016, p. 726). Lincoln and Guba (1985) referred to dependability in place of reliability as a criterion for rigour. Dependability can be established by providing a detailed description of the research project in terms of purpose, participant selection, and specifics about the method used to collect data, length of data collection and how data was transformed, analysed and interpreted. This enables potential investigators to replicate the study within the same context, methods, participants and findings. Dependability in this study was addressed by offering a clear explanation of the study's aim, describing the selection process, describing how data were collected and describing analysis and interpretation of data used. Another strategy used involved seeking a second researcher with expertise in qualitative analysis to assist by reading and coding de-identified transcripts.

Neutrality

Neutrality, also known as confirmability, is considered in reference to the concept of objectivity in quantitative research. When dependability, credibility and transferability have been established, confirmability occurs (Lincoln & Guba 1985). Polit and Beck (2016, p. 723) described confirmability as 'a criterion for trustworthiness in a qualitative inquiry, referring to the objectivity or neutrality of the data and interpretations.' Lincoln and Guba (1985) emphasised that, while there are several methods which may establish confirmability of qualitative inquiry, personal reflection is one method often used by investigators. Personal reflection, reflexivity or self-reflection of one's own preconceptions, biases and preferences should be applied during the course of a research project (Gerrish, Lathlean & Cormack 2015). For example, this may include, but is not limited to, the investigator's notes regarding feelings and insights to participant's responses and nonverbal language of participants. The reflexivity process is discussed in detail in the following section. Another common strategy used by researchers is developing an audit trail of the research process, as recommended by Koch (2006).

Building on Koch's work, Polit and Beck (2016, p. 720) defined audit trail as 'the systematic documentation of material that allows an independent auditor of a qualitative study to draw conclusions about trustworthiness'. Consequently, it is the role of the researcher to establish trustworthiness of these judgements by offering an audit trail of the research process. In this study, the researcher achieved an audit trail by keeping record of data collected and analysis process to demonstrate confirmability.

Some qualitative studies, mainly using phenomenological design, depend on the 'phenomenological nod' to reflect trustworthiness of participants' stories and gain recognition of credibility. It is a recognition of participants' experiences that the reader resonates with the phenomenon. In addition, it occurs to the degree that main findings are authenticated by other researchers. The term 'phenomenological nod' is described 'as a way of indicating that a good phenomenological description is something that we can nod to, recognizing it as an experience that we have had or could have had' (van Manen 1990, p. 27). In other words, it is a process that researchers and readers go through to show they have experience in their area of practice. This is similar to how Van der Zalm and Bergum (2000, p. 212) refer to the 'phenomenological nod', as stated 'yes, that is an experience I could have'. In the process of inquiry in which the participant living the experience is the focus, the nod confirms that readers have had similar previous experiences. Therefore, a good phenomenological description is achieved by a critical process of substantiation of a phenomenon which in turn includes thoughtful reaction to the findings.

Reflexivity

When conducting qualitative research using a hermeneutic phenomenological approach, reflexivity is considered important in demonstrating the degree of rigour. Gerrish, Lathlean and Cormack (2015, p. 588) defined reflexivity as a process 'whereby the researcher reflects continuously on how their own actions, values and perceptions impact upon the research setting and affect data collection and analysis'. In other words, the reflexivity process offers the researcher an opportunity to acknowledge their position on the phenomena under investigation by identifying his/her previous experience and recognising this may influence interpretation of the phenomena during data collection and analysis stages. However, Finlay (2008, p. 29) noted that 'past knowledge is both restricted and used to interrogate the meanings that come to be, in order for the researcher to be more fully open to the research encounter'.

To be as reflective as possible to the study, the researcher acknowledges their practice within the study context. In this case, the researcher had completed a Bachelor degree in nursing and worked as a registered nurse for over 15 years in an acute care hospital. He had cared for many patients whose family member were nurses, from which he developed an interest in investigating the experiences of nurses caring for adult patients whose family members are nurses. In developing the portfolio of research for this topic, Study 1, which involved a qualitative systematic review, provided detailed information to increase the knowledge base in the field of professional practice. This professional and research experience informed the purpose of examining nurses' experiences in general wards. However, during data collection (interview process), the researcher remained aware of how previous knowledge and experience might influence critical examination of participant experiences. This also applied during stages of thematic analysis where some decisions were made by engaging the researcher's own perspectives into the process.

Summary

To explore the experiences of nurses caring for adult patients whose family members are nurses within a general ward, a qualitative interpretive methodology informed by hermeneutic phenomenological study design was chosen. This chapter presented a detailed overview of the research design and process undertaken in conducting this research. The types of participants, how participants were recruited and how the information sheet was presented to research participants were discussed, and an overview of how the face-to-face interviews were conducted was provided.

Ethical considerations and the process of gaining ethical approval from the University of Adelaide Ethics Committee for the research were also described. Demonstration of rigour was achieved by presenting issues of credibility, transferability, dependability and confirmability. This chapter discussed data collection and analysis which facilitated development of the findings and discussion chapters. In the next chapter, study findings are explained, and themes of study findings are presented using relevant and appropriate direct quotations.

Chapter Five: Analysis And Findings

Introduction

This chapter of the hermeneutic phenomenological study describes findings and the data analysis process used to address study objectives. The purpose of this chapter is to provide a rich description of the lived experiences of nurses caring for adult patients whose family member is a nurse. The prime objectives of the study were to explore the experiences and challenges that nurses face, the dynamics of their relationships with patients, impact of their experience and professional practice when caring for adult patients who have a family member who is a nurse. The main study question guiding interviews was: 'What are the experiences of nurses in general wards who are caring for adult patients who have a family member who is a nurse?' Findings from face-to-face interviews with five nurses are presented in this chapter. This chapter centres on themes developed from participant stories that underline the experiences of nurses caring for patients with a nurse-family member. Each theme is outlined and discussed, with quotes from transcripts used to highlight and support each sub-theme.

Van Manen's approach to phenomenological analysis was used to analyse data in this study. All transcripts were read several times to gain a sense of 'meaning' and to identify the main themes (van Manen 1990, p. 93). The researcher screened each participant's transcript and listened to recordings, while being mindful of the research question. Illustrative and important statements relating directly to the study were extracted from participants' transcripts, which were then collected and presented in table format. Reading and re-reading participants' statements and highlighting key words revealed meaningful themes. These illustrations were grouped together and were later identified as a sub-theme. Sub-themes that related to each other were then convened to create a main theme, by looking at transcripts as a whole and capturing the meaning that aligned with the phenomenon under investigation. Van Manen designated themes as 'categorical statement[s]' to understand and capture the structure of phenomenon (van Manen 1990, p. 79). Therefore, the main themes help shed light on the experiences of nurses in general wards caring for adult patients with a nurse-family member. The process of analysis undertaken by the researcher is presented in Appendix IV.

Main themes

Important quotes were grouped into twelve sub-themes. The twelve sub-themes were shaped and further merged into six main themes that became the basis of reported findings. The six main themes were: 'acting like a nurse', 'being careful', 'being scrutinised', 'sharing knowledge', 'holding my own' and 'avoiding conflict', as shown below (Table 1).

Table 17: Main Themes and Subthemes

Main Themes	Sub-themes
Acting like a nurse	Identifying as a nurse
	Process of identifying role
Being careful	Being on guard
	Can be combative
	Rising conflict
Being scrutinised	N/A
Sharing knowledge	Recognising their knowledge
	Enabling rapport
Holding my own	Being comfortable with practice
Avoiding conflict	Being diligent with patient care

First Main Theme: Acting like a nurse (Oh, that's fine. I'm a nurse too)

The main theme 'acting like a nurse' signified the experiences of participants while caring for patients who have a family member who is a nurse. It included descriptions by participants' who stated that nurse-family members are either directly or indirectly recognised. This theme consisted of two subthemes: 'identifying as a nurse' and 'process of identifying role'.

Sub-theme One: Identifying as a nurse

The way in which participants identified nurse-family members is described in this subtheme. Participants felt it was easy to recognise the nursing knowledge of nurse-family members by the level of communication the family member used. Some participants described the phenomenon of talking to a nurse-family member, which illustrated their subjective identification:

> *'**When she talks, you could pick up that she knows her medical (sic). She uses medical jargons, nursing jargons, and all that**. She mentioned about how long she was working in the rehab.'P1*

And:

'You've got somebody who sits there quiet, doesn't speak, don't get involved, doesn't tell you who they are. They might introduce the wife or the partner or the sister, the brother because ***sometimes they'll go all the way through that level of nursing care for that particular moment****. It might be the end that you find out, or it might be just somebody passed and say, I know that lady. I'm sure she's a nurse.' P4*

Alternatively, objective identification of a nurse-family member may happen by:

'They'll just tell you, you know, ***That's my daughter. She's a nurse. Or they'll tell you, I'm a nurse****.' P3*

Sub-theme Two: Process of identifying role

It can be difficult for participants to uncover a nurse-family members' identity. Some participants described feeling stressed upon discovering that a family member is a nurse. Recognising that a family member has nursing knowledge made some nurses feel pressured when providing care. As one participant stated:

*'****I could easily pick up then that she worked in either carer, but I know that she doesn't work in the hospital, carer, or EN, or RN****. Anyways, she came to us.* ***As soon as we settled her mum, straight away she told us****. I think I was just explaining to her what I am going to do, like, Okay. She's settled now. I'm just going to get the doctors to come in and review her, la, la, la, la (sic).* ***Then, she's like, Oh, that's fine. I'm a nurse too. I'm an RN. This is more intense.****' P1*

Other participants' discovery of the nurse-family member's identity was relatively objective and easy by the recognition of the family member's uniform.

*'****She was dressed in uniform so clearly she is a nurse****. I just said, Hi. How are you?* ***She mentioned that she's going for a late shift****. I continued on doing my stuff, left them, leave them (sic). I started the chemotherapy treatment with my other colleague double checking the things. It all went well and then continue with my other duties.' P2*

Although this was common among participants, it is obvious that the process of identifying a nurse-family member may be either objective or subjective, as perceived by nurses. Participants had the clear impression that nurse-family members were identified either by the way the family members asked questions due to them 'acting' like nurses.

*'****They either ask enough questions that you know that they're a nurse, because they ask you and they speak like a nurse, and they'll act like a nurse****.' P3*

Therefore, acting like a nurse, in whatever way, is integral to the concept of nursing identity, as verified by participants.

Second Main Theme: Being careful (There's no point arguing with them / On guard)

The second theme, 'being careful', describes interactions between nurses and nurse-family members as challenging situations. Having learned that a family member is a nurse, participants stated that they then

need to give them careful attention, particularly during high pressure events, when they feel like they are being watched by nurse-family members. This has the potential to create conflict between nurses and nurse-family members. The three subthemes: 'being on guard', 'can be combative' and 'rising conflict' represented the essence of this main theme.

Subtheme One: Being on guard

The subtheme 'being on guard', for a majority of participants, supported development of the main theme. Participants felt the need to be extra careful due to the knowledge of nurse-family members, as described in the following events:

> *'**Immediately you're on the, that back foot of being careful, extra careful of everything you do because their daughter's a nurse and the daughter probably knows everything about nursing, so you're immediately put on guard**.'P3*

At times, this may lead to extra effort, as explained below:

> *'**I find a lot more, you put a lot more by the end of the day you're really tired because you're making sure**. I work in really busy wards, so there is a lot to make sure that you get done, and **you make sure you're very, very thorough**.' P3*

One participant emphasised that they were cautious when providing care to avoid mistakes that may easily be pointed out by the nurse-family member:

> *'Actually, because her father has already mentioned to me before she arrived in the hospital, I would, Okay. I know that, so what when she comes in, whenever, at least, **I would be cautious**. They can pick up, for me. **I was just a bit cautious because we're humans too…..we can make mistakes. I'm sure that if, at that point, if I've done a mistake, they could easily pick it up, and that I would be in trouble.** Yeah.'P1*

Another participant stated there is a need to be extra careful with information provided, making sure it is in line with rules:

> *'Yeah. **I think it gives you that heightened awareness of every single activity, every single intervention**, **you are choosing your words carefully and making sure that what you are telling them is actually to the letter, to the book**. We are telling exactly as it is because, especially to work in the nursing profession, we know that many people. Even though they might not work in that particular area, **they do have that base knowledge anyway**.'P4*

Others mentioned having to carry out frequent 'hand hygiene' as a result of being watched:

> *'What happened because when the daughter left, I was able to insert the cannula. I gave her the infusion but unfortunately, during lunchtime she came back. The infusion was still going on so I have to be there for her mother **and I remember I was just doing hand hygiene almost all the time like over and over again because at the back of my***

mind she's also nurse at the same hospital. She is watching me. *I need to do my hand hygiene and I just gelled my hand over and over again that day.' P2*

And:

*'**It did definitely add stress** because you then, when somebody says, Watch what you're doing, **you start going back over what you've done to think, Well, have I said something? Have I not gone through all the checks when I'm giving medication,** something as simple as that. Have I done something? **Have I not explained something?** Have I, even after washing me hands, have I not put a bit of gel on me hands at the end of the bed? **It's just something I'm being picked up on.**' P4*

Sub-theme Two: Can be combative

The second sub-theme, 'can be combative', is related to participants' knowledge and skill being questioned by nurse-family members. Several participants indicated that family members with nursing backgrounds can be combative, for example:

*'**So it sometimes can go either way. You can get them as a mediator or they can be off guard straightaway** because they are a nurse and their mum needs to be taken care of the best. I don't like ward very much, but it can be, **you hope that they're a nice person because it can be very combative.**' P3*

Another participant supported this by saying:

*'Yeah, from them because **they could question your ability. They could question your competence**. That was just what I was thinking. Yeah. They can see by asking if you know or you do not know. **Sometimes they will test you, as well**.' P1*

Furthermore, a participant commented that she felt intimidated when questioned and that this may have had some bearing on the experience:

*'My patient was having a chat with her niece and it was fine. But when I was doing the dressing, I changed everything and when I was removing my gloves already and **this niece just asked me a question. Did you change the bung (sic)? I just felt intimidated.** I was like, "Oh. Why are you asking me that question?" But that was at the back of my head. Instead I just told her, Yes, I did, and I showed her the old bung (sic) which I took from her aunt.' P2*

Sub-theme Three: Rising conflict

When exploring participants' experiences, some spoke of conflict between the nurse-family member and themselves. This conflict is explored in this sub-theme. One participant spoke about trying to avoid arguments and calm down:

*'**She come and we have little bit argument. Still I respect her, but I say, "You have to understand that we look after her, but we can't stay with her because we have a lot of responsibility". She wasn't happy like with my reply and my attitude. Still I tried***

> ***to respect her, I said, "Look, you understand. If you want, you can come and look after your sister. But I can't stay with her." Yeah, I communicate with her then I have to call one of my supervisor.*** *Yeah, and when she come I explain to her and she said, I'm right, because I can't spend time. And I said, please could you explain to her. She won't listen from me. Because she thought I don't like her sister or I don't like her as personality to look after her sister. Yeah, that's what happened. And* ***at the end I didn't argue with her****, I said, okay, I will do my best. And I keep doing my work. Because I think I lost like my temper a little bit, but still I try to calm down, and just I say, okay, I'll do this. I'll do my best. Yeah, we talk to my colleague and I said to her, look.* ***Because I know she will start argue with her, it will be big fight****.' P5*

Another also commented:

> *'So you can get nurses that are very...* ***You can get already combative nurses****, and they're looking after family members' combative daughters or, you know, nurse-family members****, there can be a real difference in opinions to what's right*** *because, obviously as nurses what we'd like to think what we've learned is the best, or what we learned is the best thing or the best way and sometimes you can get those difference of opinions as well. So yeah,* ***you can get lots of fights. Well not fights, but they can be nurses can be sometimes very abrasive and abrupt.*** *And if you got very abrasive and abrupt towards two people you can have two people being abrasive and abrupt. And not everyone gets along with family members.' P3*

Emerging from nurse descriptions was a sense of being careful due to the delicate situation as the family member is a nurse. These nurses were on guard and were challenged on care provided to the patient by the family member who possessed similar professional knowledge. On reflection, participants were concerned about the way nursing care was delivered. A critical reflection was made of their experiences, and one participant echoed this sentiment:

> 'So, reflective, oh my goodness, did I do enough for this person?' P3

Consequently, the theme of being careful was pivotal to the experience of the nurses.

Third Main Theme: Being scrutinised (We are being scrutinised)

The third theme, 'being scrutinised', explores experiences of nurses when performing an intervention on a patient in the presence of a nurse-family member. It includes the experience of feeling worried while delivering care. Participants expressed feeling nervous about being assessed by family members who are also nurses. Such experiences made participants feel scared, worried, and frustrated when providing care. One participant described feeling scrutinised, as follows:

> *'When the relatives are nurses, I think, I know definitely I've done everything. I know the call bell is right to the side of them. I know I've explained every detail about everything. I think you're definitely more aware.* ***You're more heightened and more aware. Even though you may not be, you feel like you're being scrutinised.*** *I think that's probably more in our head, more than it is in theirs.' P4*

One participant was still building her confidence in her nursing skills, and she therefore felt particularly nervous about a nurse-family member picking up on her mistakes, she expressed it this way:

> *'I was so nervous because **I was just too scared to make mistakes because I know that she knows the hospital protocols. If I did a mistake, she would pick it up** right there and then. I was still building my confidence that time.' P2*

Another participant said that knowing that the nurse-family member had knowledge of the health system worried her:

> *'**The only thing that was actually worried me at that point was, because she knows the system**. I was just worried that she will just insist us for her father to stay because, he's not well.' P1*

The theme of being scrutinised was evident in all nurses' experiences. Naturally, the context of an error in nursing care determines the extent of the nurse's assumption of being judged. Participants described how nurse-family members judged their performance, which led to them feeling uncomfortable with treating the patient:

> 'Yes, maybe we are sometimes, but I think sometimes it's the way we feel as nurses, that oh, we're being scrutinised.' P4

Fourth Main Theme: Sharing knowledge (You speak how we talk to colleagues)

The fourth theme, 'sharing knowledge', signifies the experiences of participants when caring for patients whose family members are nurses. Participants described their ability to acknowledge nurse-family members' medical knowledge. This was the initial step taken by participants to try and build a relationship with the nurse-family member and enhance the care provided. This theme is characterised by two sub-themes: 'recognising their knowledge' and 'enabling rapport.'

Sub-theme One: Recognising their knowledge

The way in which participants recognised nurse-family members' knowledge was described in this subtheme. Participants found themselves in a position where they possessed similar knowledge to that of the nurse-family member. For example, one participant described:

> *'I work in cardiology, so if you've got relatives that have specialist knowledge in cardiology, then **the language change**. You use different, you use exactly, **you speak how we talk to colleagues in the same profession**. We speak how we talk to doctor because we're used to them. When you're talking about troponin levels, and when you're talking about ECG changes, and when you're using certain cardiac terminology, if they work in that profession, they know exactly what you're talking about. If you say to somebody, and they don't know what it is, you then have to go into detail and say and simplify. If they work in that profession, **they know exactly what you're talking about**.' P4*

One of the most important ways in which participants connected with nurse-family members was through interactive sharing ofinformation:

> *'Because it was his first time to have the treatment, and I have printed out the protocol from eviQ on the chemo drugs that he will be receiving, he told me, that's fine. I already have them and I already looked at them. I read them through the site, which* ***makes me feel they both are aware of what is going on and what treatment he's having and the wife as well as the patient is comfortable of having the drug and I felt comfortable as well of giving it to them*** *because* ***I know that they both understand what I'm doing and what he's receiving*** *and that because they are matured nurses probably, they know the hospital protocols and everything that it will just be smooth treatment.' P2*

Sub-theme Two: Enablingrapport

Occasionally participants discussed nurse-family members having a rapport with nurses being beneficial during hospitalisation of the relative. The participants agreed that support and assistance of nurse-family members was helpful regarding some aspects of care. The following extract exemplifies this:

> *'I work two earlies, really. Then, the next day she came back, as I said. For her to come at 8:00 in the morning, get her dad up, and put him in a shower, help him dress up, pack his belongings, making sure that everything is all good. Actually, we did not have to organise an ambulance because she was quite happy to take her dad on her private vehicle. She even. I think at that day, she even brought his own wheelchair. To me, it is just like for me not to worry.* ***For me not to worry about the patient for his ADLs (sic) and all that. It's quite helpful****.' P1*

This was echoed by other participants:

> *'In their investigations, you make sure to liaise with the patient because usually they're recording back to their person [nurse-family member] - they're family member, their daughter in this case, of exactly what's happening. And sometimes* ***you're able to establish a rapport with them because they're medically understanding, so sometimes they can help be a mediator.****' P3*

Briefly, the theme of sharing knowledge explored the relationship between nurses and the nurse-family member. As both speak the same language and understand each other, this may lead to them having good rapport. This unique communication was enhanced by the state of comfort that nurses found during delivery of care, which may have resulted, in part, from the care provided:

> *'You want to work with them because, as a family member, you try to empower them with the choices to help make their mum better.* ***So you want to engage in a collaborative approach because a lot of the time the nurse knows what's best,*** *even though it's their daughter. They may know what's best, and they maybe want to take care of mum. She wanted to take care of her mum.' P3*

Sharing knowledge is, therefore, an important aspect that nurses experienced in the provision of care.

Fifth Main Theme: Holding my own (I can hold my own)

The fifth theme, 'holding my own', describes how participants' previous experiences of dealing with nurse-family members gave them confidence in their nursing abilities. This subsequently put them in a position where they felt in control and could work effectively. This theme is explained further in the following sub-theme and quotes.

Sub-theme One: Being comfortable with practice

Participants with a lot of experience caring for patients who have a family member who is a nurse felt more competent and confident. This experience is captured by the following participants:

> *'**A lot more experience now so I can hold my own. I don't feel like I'm questioning my own, myself as much, or questioning my own practice. I can hold my own and I'm confident enough to just be and a very collaborative approach.** Sometimes if you've got a family member who's a nurse, you don't want to put your opinion on them.' P3*

And

> *'Also letting me just feel more confident because she's a grad (sic) so she's into the hospital protocols and the standards, which is good, but because probably she's a grad (sic) and **I'm a senior nurse and it just makes me feel more confident of what I'm doing.**' P2*

Another participant expressed the comfort they felt due to the support of the nurse-family member as this increased the quality of care and level of information provided:

> *'I've sort of been in a situation where **I've felt supported and I felt comfortable because the actual relative is so happy with the care, and they're actually talking on the same level. It's almost like having another colleague at the side of you.**' P4*

Nurses demonstrated a feeling of comfort and support to the nurse-family member, evidenced in the theme 'holding my own'. The most important part of delivering good patient care was being confident in clinical practice:

> ***'I'm confident enough to just be.' P3***

Therefore, the theme of 'holding my own' is significant to the experience of nurses while providing patient care.

Sixth Main Theme: Avoiding conflict (I just don't want to create tension)

The sixth theme, 'avoiding conflict', describes how participants exert extra effort trying to understand their patients' conditions and in management of their care to avoid conflict between them and the nurse-family member. This theme consisted of one sub-theme described below.

Sub-theme One: Being diligent with patient care

When acknowledging that having a nurse-family member may create tension during the process of caring for the patient, participants also emphasised the importance of being diligent, familiar, and aware of the patients' condition and care. Two examples are described in the following quotations:

> *'**You just got to be really diligent and patient, and understanding because it can go either way**.' P3*

And:

> *'Actually, what I do if I know that their family members are say they've got medical backgrounds and all that, **I would really familiarise myself more with patient.** I know, as well, I should do that with every patient anyway, but **I just don't want to create tension**.' P1*

The final theme of 'avoiding conflict' was demonstrated by nurses in one way or another by being diligent with patient care. In addition, nurses tend to be more familiar with the patient's condition due to knowing that a family member has a nursing background:

> ***'I just don't want to create tension.'** P1*

Therefore, avoiding conflict is a desirable ability for nurses to have in clinical practice when encountering a nurse-family member.

Summary

The hermeneutic phenomenological approach was used to explore the lived experiences of nurses caring for adult patients who have a family member who is a nurse. Interestingly, this is the first known research study with the specific objective of exploring this nursing challenge. A total of five nurses were interviewed and their answers generated rich and descriptive data that illustrated their lived experiences. As transcripts were analysed using the van Manen approach, the text informs the sub-themes and sub-themes inform the main themes. From the hermeneutic phenomenological perspective, to reach a reliable approach transcripts were read and re-read until the researcher reached a common understanding of the data and process of analysis. Although results cannot be generalised, Study 3 offers insights into the experiences of nurses working in clinical practice, particularly in general wards. All nurses had a unique story, but common experiences and opinions were present across participants. Six main themes were identified: 'acting like a nurse', 'being careful', 'being scrutinised', 'sharing knowledge', 'holding my own', and 'avoiding conflict'. In this study, nurses noted that presence of a nurse-family member with their hospitalised loved one is not uncommon in general wards and may make daily care challenging. Pressure, tension, stress and nervousness are shared answers of nurses when discovering that a family member is a nurse. However, some participants felt in control and could work effectively during nurse-family members' presence. The following chapter provides a discussion of the main themes described in this chapter. This is followed by highlighting implications of the study, alongside limitations and recommendations for further studies.

Chapter Six: Discussion

Introduction

The previous chapters presented the lived experiences of nurses caring for adult patients with a nurse-family member using a hermeneutic phenomenological approach. Presentation of data has been described and incorporated into van Manen's method. However, nurses did not comment about the support they would like during this delicate situation. Based on the themes and sub-themes described in Chapter five, the lived experience of nursing staff is a richly complex and meaningful experience. This final chapter discusses the significance of main findings and outlines relationships between main themes. This is followed by discussion of study limitations, recommendations for further investigation and clinical implications.

Summary of studypurpose

The experience of managing care for a patient who has a nurse-family member is different to that of caring for other patients. There may be different expectations from those caring for the patient and the nurse who is also the family member. The systematic review (Study 1) highlighted the importance of exploring the experience of staff when dealing with health care professionals who are family members and explored how these experiences can affect quality of patient care (Sabyani et al. 2017). The aim of Study 3 was to gain an understanding of the experiences of nurses working in general wards who care for adult patients whose family members are nurses, and answer the research question, 'What are the experiences of nurses in general wards caring for adult patients whose family members are nurses?' This question was examined using qualitative research (Study 3), which contributed to the research portfolio. The study was conducted at the Adelaide Nursing School at the University of Adelaide in South Australia. The narrative data in this study may be used within the hospital system to provide information to health care professionals and policy makers about dealing with nurse-family members in acute care wards.

Significance of mainfindings

Study findings highlight the experiences of nurses caring for patients with nurse-family members in general wards. Six themes were identified through analysis of interviews with nurses. These themes are 'acting like a nurse', 'being careful', 'being scrutinised', 'sharing knowledge', 'holding my own' and 'avoiding conflict'. To illustrate how the themes can be considered as interrelated aspects of a whole of experience, Figure 2, demonstrates the range of experiences a nurse may have at this time. The uppermost theme of acting like a nurse leads nurses to respond to the nurse-family member by either being more open and sharing knowledge or adopting a more closed response of being careful. From there the impacts of holding my own or managing feelings of scrutiny are directed to one key aim, to avoid conflict. From that point those experiences influence how a nurse may respond to future instances of caring for patients with nurse family members. The intricacies of these relationships are discussed below.

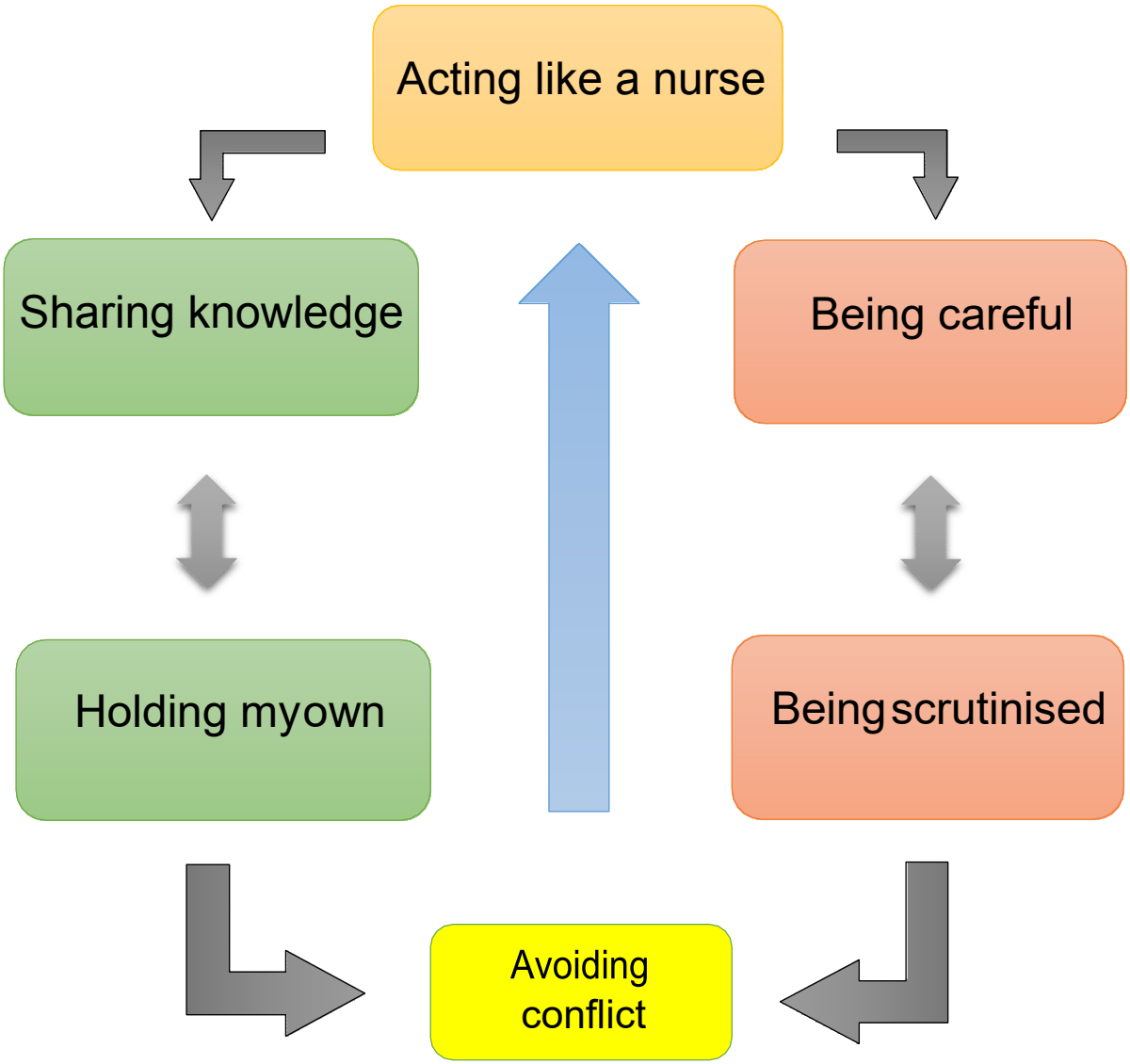

Figure 11: Model depicting nurses' experiences with nurse-family members.

Acting like a nurse (Oh, that's fine. I'm a nurse too)

The experience of nurses' encounters with family members who are nurses included the description of 'acting like a nurse' in daily practice. Although nurse-family members do not always identify themselves as a nurse, interviews with nurses show that they behave like a nurse during encounters with nursing staff. These encounters may present challenges not encountered with non-nurse-family members. Findings of this study highlighted a number of ways in which nurses identify family members who are nurses on a general ward, using both subjective and objective identification. It is essential to understand the different description of each because it may impact on nurse delivery of care and their emotional state. The presence of family members with their ill loved ones has become common in general wards, as patients may rely on them for help in communicating and interacting with health care professionals (Alshahrani 2016;

Linnarsson, Bubini & Perseius 2010). This study revealed that nurses can identify nurse-family members indirectly based on the manner of their communication and interaction with them. The language used by the family member may indicate that the family member is a nurse, for example through their use of use of medical and nursing jargon.

Previous Australian studies have shown how nurse-family members utilise hospital language during their ill loved ones' admission due to their specialised knowledge and professional role (Ledwidge 2010; Sabyani et al. 2017). On the other hand, nurses reported that they sometimes identify nurse-family members directly by self-disclosure or by the fact that they are a colleague, peer, or are known to the nurses by their ill relative or directly themselves. A recent review reported that nurse-family members were sensitive about revealing or not revealing their identity to health care professionals (Sabyani et al. 2017). In some cases, discovering that a family member was a nurse was unexpected, leaving nurses caring for the patient feeling very unprepared for the situation.

Despite all nurses participating in interviews having more than one experience of caring for a patient with a family member who is a nurse in a general ward setting, all felt some level of stress in the situation when delivering patient care. Nurses may also face additional challenges in this situation that they do not encounter with other 'lay' family members; however, scant attention has been given in the literature to possible solutions to this concern, such as disclosure of identity by nurse-family members (Ledwidge 2010). Whilst knowing that the family member understands nursing language and has a professional role within the health care system was considered critical in providing care, it may also make nurses feel uncomfortable and unable to provide the best care. However, based on findings of this study, it is worth questioning whether nurse's level of comfort and confidence increases with experience in nursing practice.

Being careful (There's no point arguing with them / On guard)

Nurses mentioned the importance of 'being careful', both verbally and clinically, about individual communication and interactions with family members who are nurses. This is due to nurse-family members' specialised knowledge, which causes nurses to be on guard during delivery of care. This study's findings showed that nurses put extra effort into being aware of every intervention initiated in the presence of the nurse-family member. The experience can be combative, especially when nurses are challenged by the nurse-family member. Experiences, such as not having enough knowledge of the patient's condition, may result in nurses being uncomfortable in encounters when nurse-family members make enquiries. As a result, nurses may feel intimidated, which may result in conflict between staff and the nurse-family member. At the same time, what was unique about the findings was that the nurse 'is extra careful', 'is a bit cautious' and 'conducts lots of reflection' when having an encounter with a nurse-family member while providing patient care. Although there is a need to further explore the meaning of being careful, these findings can be useful to nurses caring for lay-family members in adult settings. In everyday practice, the context of being careful with family members of hospitalised patients is experienced by nurses (Alshahrani 2016). Reflecting on these findings, it would be interesting to determine if the concept of being careful depends on whether or not the nurse-family member is physically present during the intervention.

Being scrutinised (We are being scrutinised)

As interviews revealed, participants described being scrutinised while caring for patients whose family members are nurses. The link between being scrutinised and being careful is clear. While some nurses deal carefully with patients' medical problems, others may feel worried, nervous and frustrated because of nurse-family members' comments. This study's findings revealed that nurses feel worried about being judged in the care they deliver. Further, in the case of an error in nursing care, nurses assume that nurse-family members may harshly judge them and report them. While nursing knowledge may enable nurse-family members to help their ill loved ones receive the best care, it may negatively affect their relationship with nurses.

The literature confirmed that nurse-family members use their specialised knowledge to judge patient care (Ledwidge 2010; Sabyani et al. 2017; Salmond 2011). In general, lay-family members watch out for their ill loved ones in the hospital as unofficial agents of care provided to them, and they often critique hospital staff. In a recent study by Alshahrani (2016), nurses expressed an uncomfortable feeling of being judged by lay-family members during inadequate care. However, based on the findings of this study, it is worth asking nurses what type of support (e.g. from manager, colleagues and counsellors) they receive in the case of scrutiny of unintentional mistakes while caring for patients regardless of family members' profession.

Sharing knowledge (You speak how we talk to colleagues)

One of the most significant concepts that nurses encounter with nurse-family members is knowledge sharing. In hospital, when a family member of an ill loved one has the title of 'nurse', nursing staff expect that this individual possesses specialised knowledge. Participants expressed that information shared with nurse-family members plays a significant role in understanding how to care for their ill loved ones because both speak the same language. The experience of sharing knowledge with a nurse-family member, particularly when the nurse-family member had the same profession or colleagues, also contributed to a feeling of support. It provided the double benefit of promoting pre-existing knowledge in the area of care and enabling a rapport between nurses and nurse-family members. Family members' nursing knowledge makes them different to lay-family members. Therefore, the level of information and support obtained from them may be different because of the nurse-family member's ability to understand the health care system and deliver appropriate care. Additionally, in this study nurses highlighted ability to establish a rapport with nurse-family members to improve care provided to the patient.

Within general wards, nursing staff often view family members as a good resource for both social and physical support related to the patient's wellbeing (Alshahrani 2016; Higgins et al. 2007; Lindhardt, Bolmsjö & Hallberg 2006; Lindhardt, Hallberg & Poulsen 2008; Lindhardt, Nyberg & Hallberg 2008; Linnarsson, Bubini & Perseius 2010; Pena & Diogo 2009). However, when a family member is a nurse, the resource level is different because he or she is medically aware of what is involved in the ill loved one's care. One participant pointed out that the nurse-family member is considered to be a valuable and helpful resource as a 'mediator'. Therefore, this suggests that understanding, comforting, and supporting are important elements in sharing professional knowledge for both groups. The question of whether nurses can expect

nurse-family members to be involved in the level of care that can be provided during the admission period should be explored.

Holding my own (I can hold my own)

In interviews, nurses referred to the theme of 'holding my own' during interactions with nurse-family members' during the ill loved ones' care. The association between sharing knowledge and holding my own is a product collaboration. Through sharing information with nurse-family members about care, staff may feel confident, supported, and comforted by nurse-family members. Participants pointed out that more frequent interactions with the nurse-family member leads to increased confidence in care delivered. Further, they emphasised that the nursing knowledge of the family member made them feel more supported because they had a colleague by their side. A similar study confirmed this study's result that nurse-family members collaborate with nurses by acting as a helpful resource to make nurses feel more comfortable (Salmond 2011). The fact that nursing staff are comfortable with this practice indicates that some nurse-family members are perceived to have appropriate knowledge and skill to further improve quality of patient care. However, according to Alshahrani (2016) nurses felt uncomfortable in the presence of a lay-family member because they were concerned about the patient's privacy being violated and/or care being manipulated. Another study reasoned that some nurses' lack of knowledge and skills may contribute to their feeling of being uncomfortable dealing with lay-family members (Namasivayam, Orb & Connor 2005). Therefore, when patients' family members are nurses, nurses can take advantage of their knowledge to provide effective care. The depth of nurses' comfort or discomfort in the presence of a nurse-family member affects care delivered to the patient and should be studied further.

Avoiding conflict (I just don't want to create tension)

Avoiding conflict is the final concept among experiences of nurses managing patients with nurse-family members. An inner battle was evident in this study as nurses tried to understand the uniqueness of being on the other side and preventing tension that may cause potential conflict. This presumptive thinking may either increase tension or lead to an avoidance of conflict when providing care. Kreitner (2010, p. 373) defined conflict as 'a process in which one party perceives that its interests are being opposed or negatively affected by another party'. In the hospital setting, nurse and family member conflict can be a predominant issue. Lindhardt, Hallberg and Poulsen (2008) stated that family members were ideally considered a resource, but also as a challenge, so occasionally nurses avoid them. This study revealed that nurses avoid conflict by being diligent and patient with care provided as well as by familiarising themselves with the patient's condition. This includes finding out beforehand about the professional role and clinical skills the nurse-family member possesses.

When conflict arises with a nurse-family member, nurses may deal with the situation differently than with a family member from the general public. In this situation, the nurse-family member plays two different roles that may exacerbate or end the conflict (Carlsson et al. 2016; Cicchelli & McLeod 2012; Giles & Hall 2014; Giles & Williamson 2015; Ledwidge 2010; Sabyani et al. 2017; Salmond 2011). Nurses need to understand that the methods used to avoid potential conflict between staff and nursing family members may not be in the best interests of patients.

However, conflict in general wards between lay-family members and nursing staff is considered a natural phenomenon (Alshahrani 2016; Bridgman & Carr 1997;Eggenberger & Nelms 2007; Higgins et al. 2007; Lindhardt, Bolmsjö & Hallberg 2006; Namasivayam, Orb & Connor 2005). Therefore, nurses may encounter challenges with nurse-family members in managing their ill loved ones' care. The questions of whether avoiding conflict makes a difference to the comfort level of nurses and whether their comfort level makes a difference to patient care outcomes in general needs to be explored. The following sections provide limitations of the research, recommendations for further research, and implications for practice.

Limitations of thestudy

Study 3 was conducted as a part of a portfolio of research with the aim of obtaining narrative data to understand the experiences of five nurses working in general wards and caring for adult patients with a nurse-family member. In drawing conclusions, this study considered the following limitations:

- The targeted group in this study consisted of nurses currently working in general wards and completing postgraduate studies with the Adelaide Nursing School. The findings may not be generalisable and applicable beyond this group.
- During interviews, nurses were able to identify constructive experiences they had with nurse-family members, but there may be limitations due to their recall of specific information.
- Evidently, no previous study has investigated nurse's experience of dealing with a nurse-family member within general wards. This limited the identification of similarities and dissimilarities between different studies in the literature.

Directions for furtherresearch

While Study 3 generated some important findings, the limitations of this study can be a starting point for further research. The following areas are recommended for further research:

- Future studies may include a survey exploring prevalence of nurses' experience in encountering nurse-family members during an ill loved one's admission to an acute care hospital.
- Qualitative study of patient experiences of having a nurse-family member may be useful in adding comprehensive knowledge to the study.
- Further research is needed to explore ways of increasing nurse readiness in facing a nurse-family member within the hospital setting.
- As the experience of encountering nurse-family members occurs within the health care setting, having other health care professionals, such as medical officers, as participants in the study may be useful to obtain a broader picture of this phenomenon.
- A comparison study between family member groups (lay-family members and health care professional family members) to examine differences between support of patients' family members and improvement in the quality of patient care is needed.

Implications for Practice

This present study suggests that nurses experience challenges when caring for a patient whose family member is a nurse. While hospital policies address the issue of supporting lay-family members, there is no clear information on managing nurse-family members along with their ill loved ones. Nurses must deal with a delicate situation where family members are in double roles because they are both family members and nurses. Therefore, this may affect the nurse's provision of care not only professionally, but also personally. This section highlights the practice implications for Study 3.

The findings revealed a level of tension when nurses manage lay-family members, but there may be even more pressure when the family member is a nurse. All participants were very careful with their interactions with the nurse-family member, and some even avoided nurse-family members. Avoiding interactions with family members regardless of their professional identity may not be the best solution to manage the situation. At the same time, it may be impossible to disregard nurse-family members' existing knowledge, especially when their identity in the nursing profession has been revealed. It would be beneficial for nurses, when faced with unique family members, to keep in mind that all situations are different. The hospital administration may offer a relief strategy for nurses to help them cope emotionally with stress. A potential intervention might include creating a free stress zone for nurses to express their emotions and share their thoughts. Another intervention would be to provide a support resource to nurses on how to deal with nurse-family members in the case of conflict. Conflict resolution is usually accomplished using problem-solving tools, such as involving the manager and other health care professional teams, including social worker and counsellors.

Study findings showed that nurses experience a unique situation when discovering a patient's family member is a nurse. Caring for patients with nurse-family members requires different approaches that nurses need to consider to manage and support nurse-family members in caring for their ill loved ones. Due to nurse-family members' specialised knowledge, nurses are encouraged to conduct free dialogue with nurse-family members in relation to care provided and knowledge sharing to build a rapport with nurse-family members. For example, adhering to a practice of introducing oneself to the family at the beginning of a shift. This dialogue may include expectations nurse-family members of nurses and level of participation and level of control nurse-family members have over their ill loved ones' care. Discussing these unique concepts would help nurses manage patient care and provide the support that nurse-family members need. Nurses will also be able to improve their level of communication and avoid conflict. Further, policy makers should consider implementing strategies through educational support to enhance trust and confidence among staff in clinical practice.

Summary

This was the first study to explore the experience of managing care for a patient who has a nurse-family member. Chapter six provided a summary of the study purpose and study context and restated the research question. It also discussed study findings and significance of main findings in the context of current literature. In this chapter, six themes were interpreted based on interview findings: first, nurses revealed how they identified nurse-family members in a general ward using both subjective and objective identification. Second, they described their experience of 'being extra careful', 'being a bit cautious' and 'conducting lots of reflection' when having an encounter with a nurse-family member alongside an ill loved one. Third, participants revealed they felt worried about being judged by nurse-family members for the care they delivered. Fourth, participants stated that information shared with nurse-family members played a key role in their understanding of the care provided. Fifth, nurses pointed out more frequent experiences when dealing with nurse-family members leads to confidence in care delivered. Lastly, participants stated that conflicts with nurse-family members can be avoided by being diligent and patient with the care provided. These findings were compared to currently available literature.

Limitations and recommendations were also addressed in this chapter. Despite the limitations, this study offers a rich description of the lived experiences of nurses in the area of general wards and contributes to developing the portfolio of research on the subject. The major findings of this study indicate a need for further research on the importance of the study's direction. This study has major implications for overall hospital support and provision of care to family members who are nurses in general wards.

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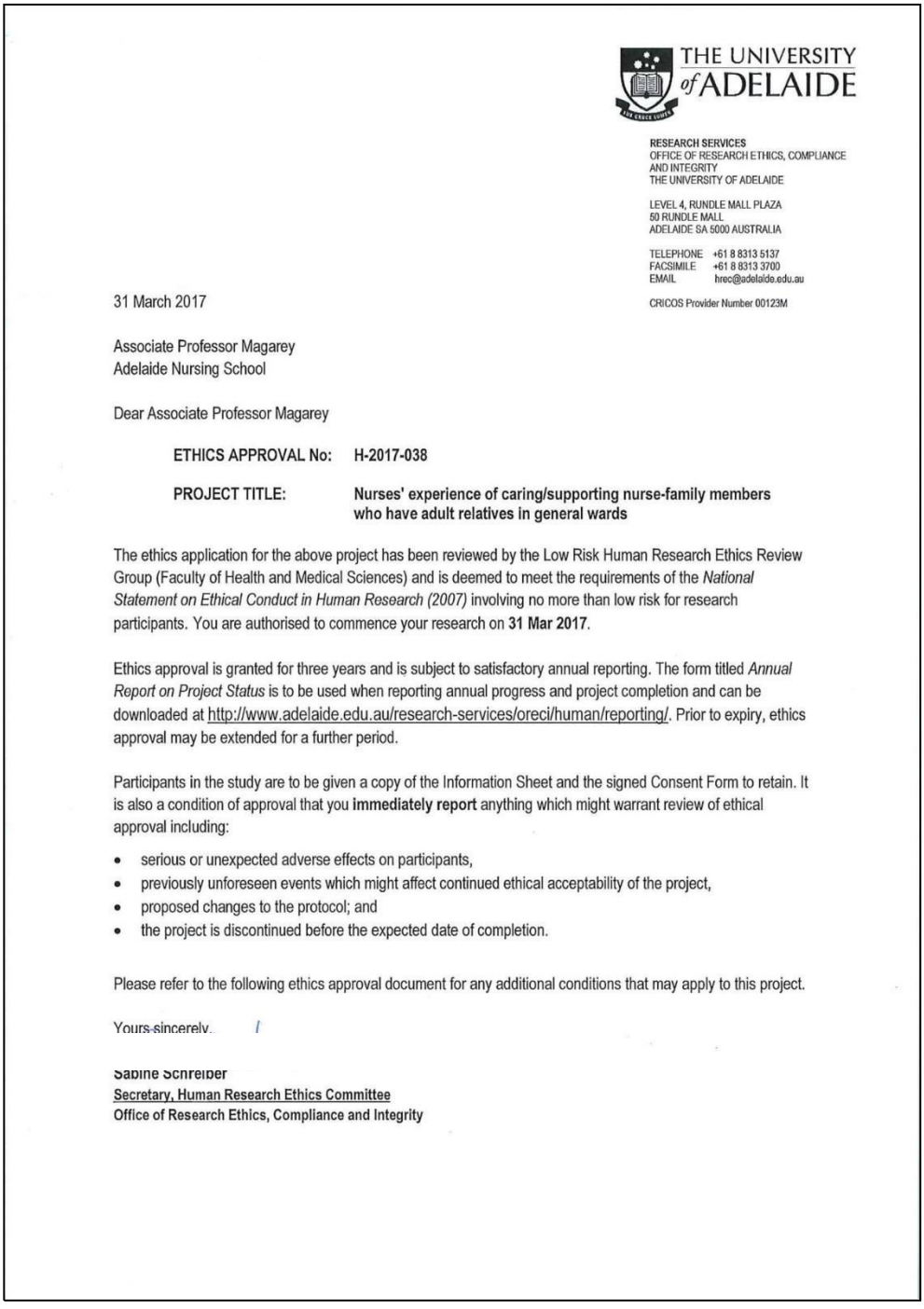
Appendix List

Appendix I



THE UNIVERSITY of ADELAIDE

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31 March 2017

Associate Professor Magarey
Adelaide Nursing School

Dear Associate Professor Magarey

ETHICS APPROVAL No: **H-2017-038**

PROJECT TITLE: **Nurses' experience of caring/supporting nurse-family members who have adult relatives in general wards**

The ethics application for the above project has been reviewed by the Low Risk Human Research Ethics Review Group (Faculty of Health and Medical Sciences) and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* involving no more than low risk for research participants. You are authorised to commence your research on **31 Mar 2017**.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled *Annual Report on Project Status* is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the Information Sheet and the signed Consent Form to retain. It is also a condition of approval that you **immediately report** anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol; and
- the project is discontinued before the expected date of completion.

Please refer to the following ethics approval document for any additional conditions that may apply to this project.

Yours sincerely

Sabine Schreiber
Secretary, Human Research Ethics Committee
Office of Research Ethics, Compliance and Integrity

Appendix II

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Nurses' experiences of caring/supporting nurse-family members who have adult relatives in general wards.

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2017-038
PRINCIPAL INVESTIGATOR: Assoc. Prof. Judy Magarey
STUDENT RESEARCHER: Hussamaldeen Sabyani
STUDENT'S DEGREE: Doctor of Nursing

Dear Participant,
You are invited to participate in the research project described below.

What is the project about?
When a nurse cares for an adult patient whose family member is also a nurse, the circumstances may be different than those faced when caring for a patient without a nurse in his or her immediate family. Nurses may have different experiences when supporting a nurse-family member, because of their inside knowledge. This issue will be examined with a face-to-face interview, which will contribute to a portfolio of study for a Doctor of Nursing degree.

Who is undertaking the project?
This project is being conducted by Hussamaldeen Sabyani. This research will form the basis for the degree of Doctor of Nursing at the University of Adelaide under the supervision of Assoc. Prof. Judy Magarey, Dr. Rick Wiechula, Dr. Frank Donnelly.

Why am I being invited to participate?
You are being invited to participate because:

- You are a Registered Nurse employed at an acute care hospital in a non-critical care area
- And, in the last two years you have cared for an adult patient in a general ward whose relative is also a nurse.

What will I be asked to do?
If you decide to take part in the research project, you will be invited to an interview. The information collected by the research team about participants will be non-identifiable. The interviews will provide nurses with the opportunity to describe their experiences of caring/supporting nurse-family members who have adult relatives in general wards. The location for the interview will be at the Adelaide Nursing School meeting room at a most convenient time.

How much time will the project take?
The interviews will last approximately 45 to 60 minutes and will be digitally recorded and transcribed using Audacity software. The location for the interview will be in an Adelaide Health and Medical Sciences Building meeting room at a time convenient for you. There are no costs associated with participating in this research project, nor will you be paid.

Are there any risks associated with participating in this project?
If you feel uncomfortable as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Only the research student conducting the project will interview the participants. The other researchers will only have access to de-identified data. Your participation will not be known by any of your lecturers in your program of studies. Your anonymity will be maintained at all times and pseudonyms will be used. No information which may identify you as an individual will be published or presented.

What are the benefits of the research project?
There is no direct benefit to you for your participation, however the information collected from the interview may increase the understanding about nurses' experiences of caring/supporting nurse-family members and improve support for nurse-family members.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study up to the submission of the thesis.

What will happen to my information?
The information gathered will be stored confidentially for a minimum of 5 years. Summary data without identification of any individual participant will be saved on a password protected computer file in a confidential staff server and submitted as required to the Adelaide Nursing School with the final project documentation. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. Participants will have the option of reviewing their interview transcripts. The personal information that the research team collect and use is basic demographic information and some questions about your views concerning your experience of caring/supporting nurse-family members who have adult relatives in general wards.

Who do I contact if I have questions about the project?
If you want any further information concerning this project. Please contact Hussamaldeen, telephone: 8313 0428 Also, you may contact Assoc. Prof. Magarey telephone: 83136055 or email: judy.magarey@adelaide.edu.au

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2017-038). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding a concern or complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8 8313 6028
Email: hrec@adelaide.edu.au
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
If you decide to participate, please email the researcher, alternatively you may call him on telephone number: 8313 0428. The researcher will organise a time with you to conduct the interview. Consent will be obtained prior to commencing the interview.

Yours sincerely,
Hussamaldeen Sabyani

Appendix III

THE UNIVERSITY of ADELAIDE

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	**Nurses' experiences of caring/supporting nurse-family members who have adult relatives in general wards.**
Ethics Approval Number:	**H-2017-038**

2. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

3. Although I understand the purpose of the research project it has also been explained that involvement may not be of any benefit to me.

4. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

5. I understand that I am free to withdraw from the project at any time and that this will not affect my study at the University now or in the future.

6. I agree to the interview being audio recorded. Yes ☐ No ☐

7. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research to _____

(print name of participant) and in my opinion she/he understood the explanation.

Signature: _____ Position: _____ Date: _____

2013_consent_form_for_participation_by_University_students.docx

Appendix IV

Illustration	Sub-Theme	Theme
When she talks, you could pick up that she knows her medical. **She uses medical jargons, nursing jargons**, and all that. She mentioned about how long she was working in the rehab. P1	Identifying as a nurse	Acting like a nurse
They either ask enough questions that you know that they're a nurse, because they ask you and they speak like a nurse.' P3		
You've got somebody who sits there quiet, doesn't speak, don't get involved, doesn't tell you who they are. They might introduce the wife or the partner or the sister, the brother because sometimes they'll go all the way through that level of nursing care for that particular moment. It might be the end that you find out, or it might be just somebody passed and say, I know that lady. I'm sure she's a nurse.P4		
'They'll just tell you, you know, That's my daughter. She's a nurse. Or they'll tell you, I'm a nurse.' P3		
I could easily pick up then that she worked in either carer, but I know that she doesn't work in the hospital, carer, or EN, or RN. Anyways, she came to us. As soon as we settled her mom, straight away she told us. I think I was just explaining to her what I am going to do, like, Okay. She's settled now. I'm just going to get the doctors to come in and review her, la, la, la, la. Then, she's like, Oh, that's fine. **I'm a nurse too. I'm an RN**. This **is more intense**. P1	Process of identifying role	
She was dressed in uniform so clearly she is a nurse. I just said, Hi. How are you? She mentioned that she's going for a late shift. I continued on doing my stuff, left them, leave them. I started the chemotherapy treatment with my other colleague double checking the things. It all went well and then continue with my other duties. P2		

Illustration	Sub-Theme	Theme
Immediately you're on the, that back foot of **being careful**, extra careful of everything you do because their daughter's a nurse and the daughter probably knows everything about nursing, so you're immediately put on guard. P3	Being on guard	Being careful
'I find a lot more, you put a lot more by the end of the day you're really tired because you're making sure. I work in really busy wards, so there is a lot to make sure that you get done, and you make sure you're very, very thorough.' P3		
'Actually, because her father has already mentioned to me before she arrived in the hospital, I would, Okay. I know that, so what when she comes in, whenever, at least, **I would be cautious**. They can pick up, for me. I was just a bit cautious because we're humans too. We're not, we can make mistakes. I'm sure that if, at that point, if I've done a mistake, they could easily pick it up, and that I would be in trouble. Yeah.' P1		
'Yeah. I think it gives you that heightened awareness of every single activity, every single intervention, you are choosing your words carefully and making sure that what you are telling them is actually to the letter, to the book. We are telling exactly as it is because, especially to work in the nursing profession, we know that many people. Even though they might not work in that particular area, they do have that base knowledge anyway.' P4		
What happened because when the daughter left, I was able to insert the cannula. I gave her the infusion but unfortunately, during lunchtime she came back. The infusion was still going on so I have to be there for her mother and I remember I was just doing hand hygiene almost all the time like over and over again because at the back of my mind she's also nurse at the same hospital. **She is watching me**. I need to do my hand hygiene and I just gelled my hand over and over again that day. The infusion was still going on so I have to be there for her mother and I remember I was just doing hand hygiene almost all the time like over and over again because at the back of my mind she's also nurse at the same hospital. She's watching me. I need to do my hand hygiene and I just gelled my hand over and over again that day.' P2		
It did definitely add stress because you then, when somebody says, Watch what you're doing, you start going back over what you've done to think, Well, have I said something? Have I not gone through all them checks when I'm giving medication, something as simple as that. Have I done something? Have I not explained something? Have I, even after washing me hands, have I not put a bit of gel on me hands at the end of the bed? It's just something I'm being picked up. P4		
'So it sometimes can go either way. You can get them as a mediator or they can be off guard straightaway because they are a nurse and their mom needs to be taken care of the best. I don't like ward very much, but it can be, you hope that they're a nice person because **it can be very combative.** P3	Can be combative	
you can be very self-critical, probably a little more self-critical. So, reflective, oh my goodness, did I do enough for this person? So lots of reflection, self-criticism. P3		
'Yeah, from them because they **could question your ability**. They could question your competence. That was just what I was thinking. Yeah. They can see by asking if you know or you do not know. Sometimes they will test you, as well.' P1		
My patient was having a chat with her niece and it was fine. But when I was doing the dressing, I changed everything and when I was removing my gloves already and this niece just asked me a question. Did you change the bung? I just felt intimidated. I was like, Oh.		

Why are you asking me that question? But that was at the back of my head. Instead I just told her, Yes, I did, and I showed her the old bung which I took from her aunt. P2		
Yeah, I communicate with her then I have to call one of my supervisor. Yeah, and when she come I explain to her and she said, I'm right, because I can't spend time. And I said, please could you explain to her. She won't listen from me. Because she thought I don't like her sister or I don't like her as personality to look after her sister. Yeah, that's what happened. And at the end I didn't argue with her, I said, Okay, I will do my best. And I keep doing my work. Because I think I lost like my temper a little bit, but still I try to calm down, and just I say, Okay, **I'll do this. I'll do my best**. Yeah, we talk to my colleague and I said to her, Look. Because I know she will start argue with her, it will be big fight.P5	Rising conflict	
So you can get nurses that are very. you can get already combative nurses, and they're looking after family members combative daughters or, you know, nurse family members, there can be a real difference in opinions to what's right because, obviously as nurses what we'd like to think what we've learned is the best, or what we learned is the best thing or the best way and sometimes you can get those difference of opinions as well. So yeah, you can get lots of fights. Well not fights, but they can be nurses can be sometimes very abrasive and abrupt. And if you got very abrasive and abrupt towards two people you can have two people being abrasive and abrupt. And not everyone gets along with family members. P3		

Illustration	**Sub-Theme**	**Theme**
When the relatives are nurses, I think, I know definitely I've done everything. I know the call bell is right to the side of them. I know I've explained every detail about everything. I think you're definitely more aware. You're more heightened and more aware. Even though you may not be, you feel like you're being scrutinised. I think that's probably more in our head, more than it is in theirs. Yes, maybe we are sometimes, but I think sometimes it's the way we feel as nurses, that oh, we're **being scrutinised**. P4	Nil	Being scrutinised
I was so nervous because I was just too scared to make mistakes because I know that she knows the hospital protocols. If I did a mistake, she would pick it up right there and then. I was still building my confidence that time. P2		
The only thing that was **actually worried** me at that point was, **because she knows the system. I was just worried that she will just insist us for her father to stay because, He's not well.** P1		

Illustration	**Sub-Theme**	**Theme**
I work in cardiology, so if you've got relatives that have specialist knowledge in cardiology, then the language change. You use different, you use exactly, You speak how we talk to colleagues in the same profession. We speak how we talk to doctor because we're used to them. When you're talking about troponin levels, and when you're talking about ECT changes, and when you're using certain cardiac terminology, if they work in that profession, they know exactly what you're talking about. If you say to somebody, and they don't know what it is, you then have to go into detail and say and simplify. If they work in that profession, they **know exactly what** you're talking about. P4	Recognising their knowledge	Sharing knowledge
because it was his first time to have the treatment, and I have printed out the protocol from eviQ on the chemo drugs that he will be receiving, he told me, That's fine. I already have them and I already looked at them. I read them through the site, which makes me feel they both are aware of what is going on and what treatment he's having and the wife as well as the patient is comfortable of having the drug and I felt comfortable as well of giving it to them because I know that they both understand what I'm doing and what he's receiving and that because they are matured nurses probably, they know the hospital protocols and everything that it will just be smooth treatment. P2		
'I work two earlies, really. Then, the next day she came back, as I said. For her to come at 8:00 in the morning, get her dad up, and put him in a shower, help him dressed up, pack his belongings, making sure that everything is all good. Actually, we did not have to organise an ambulance because she was quite happy to take her dad on her private vehicle. She even. I think at that day, she even brought his own wheelchair. To me, it is just like for me not to worry. For me not to worry about the patient for his ADL's and all that. **It's quite helpful.**' P1	Enabling rapport	
'In their investigations, you make sure to liaise with the patient because usually they're recording back to their person [nurse-family member] - they're family member, their daughter in this case, of exactly what's happening.. And sometimes you're able to establish a rapport with them because they're medically understanding, so sometimes they can help be a mediator.' P3		

Illustration	Sub-Theme	Theme
A lot more experience now so I can hold my own. I don't feel like I'm questioning my own, myself as much, or questioning my own practise. I can hold my own and I'm confident enough to just be and **a very collaborative approach**. Sometimes if you've got a family member who's a nurse, you don't want to put your opinion on them. You want to work with them because, as a family member, you try to empower them with the choices to help make their mom better. So you want to engage in a **collaborative approach** because a lot of the time the nurse knows what's best, even though it's their daughter. They may know what's best, and they maybe want to take care of mom. She wanted to take care of her mom. P3	Being comfortable with practice	Holding my own
Also letting me just feel more confident because she's a grad so she's into the hospital protocols and the standards, which is good, but because probably she's a grad and I'm a senior nurse and it just makes me feel more confident of what I'm doing. P2		
I've sort of been in a situation where **I've felt supported** and I felt comfortable because the actual relative is so happy with the care, and they're actually talking on the same level. It's almost like having another colleague at the side of you. P4		

Illustration	Sub-Theme	Theme
'You just got to be really **diligent and patient**, and **understanding** because it can go either way. You do not want to put them off guard and you want them to think that their mom's had **a good experience**, because they are a nurse as well So they may be scared and vulnerable as well, and they're trying to be the daughter. They're trying to be a daughter, they're trying to be a nurse, but they're still trying to be daughter at the same time so they may be going through their own emotional cycle of their parent, their mom being in hospital.'. P3	Being diligent with patient care	Avoiding conflict
Actually, what I do if I know that their family members are say they've got medical backgrounds and all that, I would really familiarise myself more with patient. I know, as well, I should do that with every patient anyway, but I just don't want to create tension. P1		

SECTION 5: CONCLUSION

RESEARCH PORTFOLIO CONCLUSION

TABLE OF CONTENTS

RESEARCH PORTFOLIO CONCLUSION

This is the final chapter of the research project presented in this portfolio of research about when a patient's family member is a nurse. The chapter summarises findings of the research portfolio across the three studies conducted in this project. It discusses the findings of each study and reviews the significance of these findings. The implications of this research portfolio for practice and future research directions are outlined. Figure 1 provides a map of the three studies presented in this research portfolio.

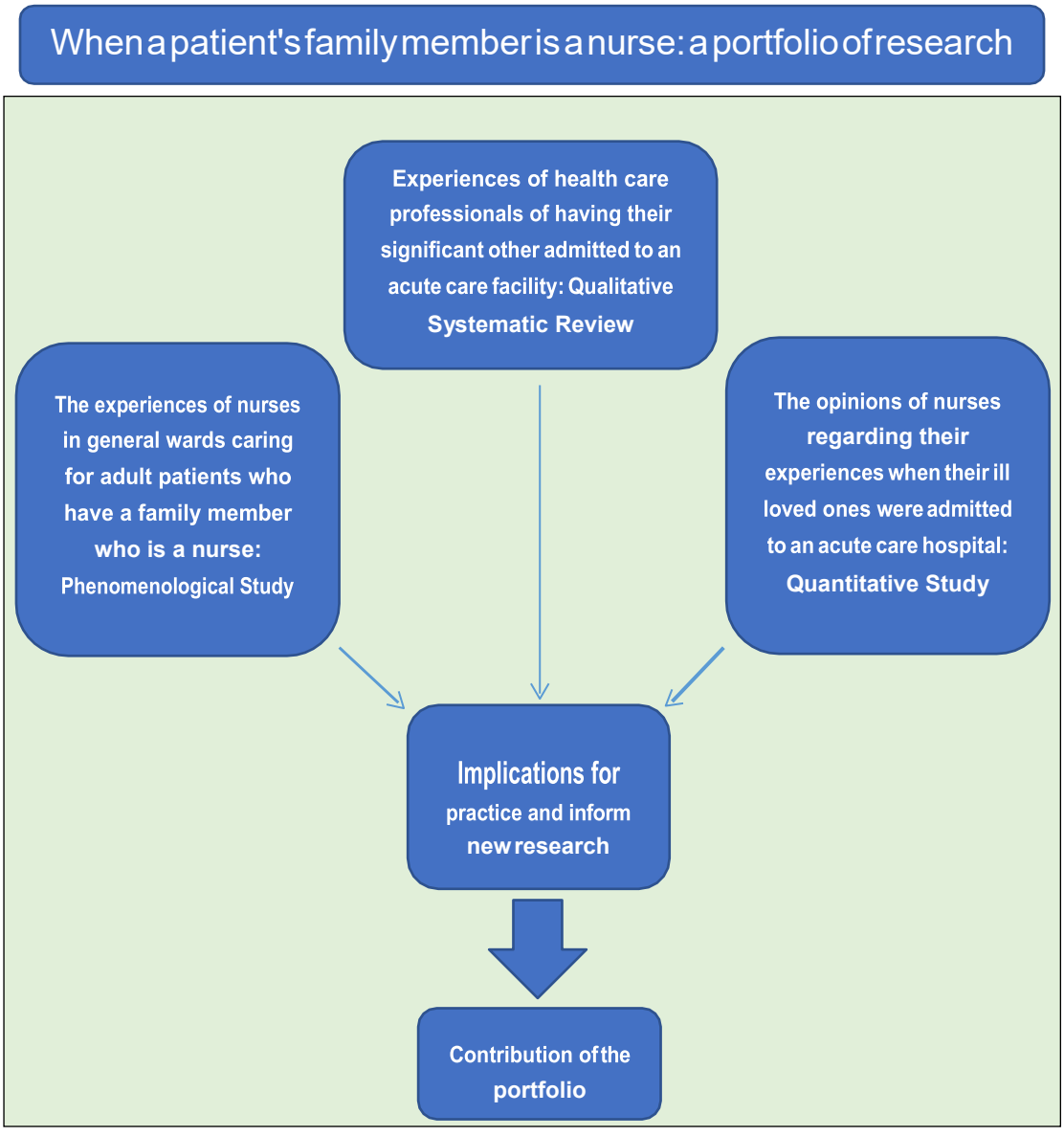

Figure 12:Map of the three studies presented in this research portfolio.

The portfolio provided the researcher and his supervisors the opportunity to not only understand the lived experiences of nurse-family members, but also their feeling of being unique as compared to lay family members. As little has been written about nurse-family members who experience hospital admission of an ill loved one, the findings presented in this portfolio extend current knowledge available regarding these experiences. In addition, this thesis provides knowledge of how nursing staff feel when caring for a patient whose family member is a nurse. Narration of nurse-family members' experiences offers an opportunity

to learn of their perspectives regarding advantages and disadvantages of having a family member admitted to a hospital and the ability to utilise their experience to inform future practice. While some nurses face challenges when dealing with nurse-family members, others understand this phenomena as a way of ensuring that these family members are unique and their needs are supported. To investigate nurses' perceptions about their experiences, an evaluation of the current evidence base was needed. In particular, evidence based methods are needed in clinical practice to enhance patient outcomes and education of future nurses. Consequently, a systematic review of qualitative evidence (Study 1) was conducted.

Study 1

A qualitative synthesis of literature was completed to identify current available evidence about the experiences of health care professionals when their significant others have been admitted to an acute care hospital. The outcome of the review showed moderate quality in the current study. While most studies stated their philosophical framework and situated the research culturally or theoretically, some were generally limited related to researcher influence on the research and vice-versa. However, the review addressed current knowledge and extended information of the previous literature. Specifically, the review acknowledged that being a health care professional as a significant other is a comprehensive and difficult experience, with connecting issues that are influenced primarily by expert knowledge and professional role. Several factors influence this experience, including privileged knowledge, unavoidable dilemmas as a consequence of dual identity, the need to act as a protector, inevitable family expectations, and intense impact of the experience.

Study 1 adds to our knowledge

Findings of Study 1 add further understanding to current knowledge about the experiences of health care professionals when their significant others have been admitted to an acute care hospital, and about the quality of available evidence (see chapter 6). Main findings of Study 1 were:

- Compared to lay family members, health professionals possess additional knowledge and understanding that alter their perceptions and expectations and the expectations others have of them.
- Good communication by staff with health care professionals as significant others about their expectations and needs is a logical step in reducing the impact on these individuals when a loved one is acutely ill.

Study 2

A cross sectional study was used to examine nurses' experiences when their ill loved ones were admitted to acute care hospitals. In this study, a post-positivist approach to the frequency of nurses' understanding of the individual experiences when their relatives are hospitalised. The descriptive study addressed gap (surveying frequency) that occur when a nurse-family member has an ill loved one hospitalised and health care provided (see chapter 4). Particularly, Study 2 identified that differences in the setting and experiences of nurse-family members, and their similarity in terms of their information and approaches toward care provided, played a key role in the experience of nurse-family members' communication.

What Study 2 adds to our knowledge

The findings of the cross sectional study expand understanding and add new knowledge to current evidence about nurse-family members perceptions of the experience. These findings are summarised below:

- Given nurses' knowledge and professional role, nurse-family members are in a unique position as compared to general public family members.
- Nurses' knowledge, satisfaction with care, ability to evaluate care, different expectations, self-impact and relationship with staff were the six issues identified by nurses while staying with their ill loved ones in the hospital.

Study 3

This hermeneutic phenomenological study was undertaken to provide evidence to address the recommendation in the qualitative systematic review. It used a qualitative approach to the interpretation of nurses' experiences when caring for patients with nurse-family members. The study reported current information to extend the knowledge of previous literature (see chapter 6). Specifically, the study identified that nurses face a significant challenge when they learn that a family member is a nurse. In addition, it highlighted the differences in background and experiences of nurses which may impact on the management of patient care. While there were factors that had a positive effect on nurses' practices, such as sharing knowledge with a nurse-family member, others had negative effects, including being scrutinised by the nurse-family member. Study 3 highlighted that nurses essentially learned from their encounters with nurse-family members.

What Study 3 adds to our knowledge

The results of the hermeneutic phenomenological study enhanced our baseline knowledge and added new information to the previous studies about nurses experiencing challenges when caring for a patient whose family member is a nurse. Findings were:

- Nurses confirmed that the experience of managing care for a patient who has a nurse-family member is different to that of caring for other patients.
- Nurses perceived that when knowing that a family member has a nursing background, they may either increase tension or lead to an avoidance of conflict when providing patient care.

Implications for clinical practice

The findings of this research have implications for clinical practice regarding the presence of nurse family member when a relative is admitted to an acute care hospital. While these findings extend our knowledge from the perspective of nurse family members and nursing staff who interact with them, the recommendation of this portfolio of research imply thorough understanding of the participants' experiences. This section highlights clinical practice implications for Studies 1, 2, 3.

- The knowledge that a nurse-family member possesses can be advantageous because they may have a deeper and more detailed understanding of the patient's history and condition, but this

must not be assumed. It is essential that nursing staff not assume that all nurse-family members desire the same level of information provided to lay-family members. Because of their nursing knowledge, nurse-family members want to be treated like a nurse by health care professionals to gain information about their loved ones' care. (Study 1, 2)

- Nursing staff should understand and acknowledge that nurse-family members judge the quality of nursing care provided and maintain a high standard of care. However, any involvement in care must be under the health care professionals' consultation and based on hospital policy. Another intervention would be to provide a support resource to nurses on how to deal with nurse-family members in case of conflict. (Study 2, 3)
- Nursing staff need to understand that nurse-family members may experience stress and anxiety which may be different to that of lay-family members and provide support. The hospital administration may offer a relief strategy for nurses to help them cope emotionally with stress. One potential intervention might include creating a stress zone for nurses to express their emotions and share their thoughts. (Study 2, 3)
- When dealing with a nurse-family member, nursing staff should be aware that the knowledge the nurse-family member possesses may amplify the impact of the situation. Health care administrators must be cognisant that nursing staff need to be able to use all information and resources available, not only to improve the quality of care, but also to provide sufficient support to all family members. Nurses are encouraged to conduct free dialogue with nurse-family members in relation to care provided to ill loved ones and knowledge sharing to build a rapport with nurse-family members. For example, adhering to a practice of introducing oneself to the family at the beginning of a shift. Further, policy makers should consider implementing strategies through educational support to enhance trust and confidence among staff in clinical practice. (Study 1, 2,3)

Implications for research

The findings of this portfolio of research show that nurse-family members' experiences during the admission of ill loved ones are common in hospital settings. In order to increase the knowledge base about these experiences there is need for future research in this context. Consequently, future studies are suggested as follows:

- In this portfolio of research, it is noted that most of participants were female. Further research exploring the experiences of male nurses in this context will promote a knowledge base from a gender viewpoint using a qualitative approach.
- In the future, a larger sample size may be considered. Studies 2 and 3 selected nurses only from South Australian hospitals. Therefore, expanding the survey to other locations in Australia will improve the generalisability of this portfolio of research and capture nurses' in-depth experiences.
- Future studies could particularly examine the country setting where nurses are much more likely to have a relative admitted to their hospital. In addition, further research could include comparisons of experiences and needs of nurses working in private hospitals where the system may be different to that in public hospitals.

- In Study 1, nurse-family members reported the impact of the phenomenon on their professional practice. Therefore, further research is needed to explore how the experiences may influence professional practice. For this purpose, the use of focus group methods may particularly be important.
- Also, researching the experiences of patients whose family members are nurses may be of value. An interview study of patient experiences of having a nurse-family member would be helpful by adding comprehensive knowledge to this area of study.
- A comparative study between family member groups (lay-family members and nurse-family members) to examine the differences between support of patient family members and improvement in the quality of patient care is needed.

CONTRIBUTION OF THE PORTFOLIO

The previous section outlined how this portfolio of research contributes to the academic considerations when it comes to examining nurses who are also family members of an ill patient. What becomes clear is that, in analysing the findings of the research in this portfolio and how it relates to the previous knowledge in the literature, the phenomenon of a nurse who is also a family member of an acutely ill patient is a recurring theme. This portfolio of research offers significant knowledge about when a patient's family member is also a practising nurse, and this portfolio aims to make a distinct contribution to the clinical practice in these cases. The goal of this contribution is not only to share new knowledge but also to gain feedback.

More importantly, the policy makers may consider to translate the evidence from this research and apply it to the relevant people in the acute care hospital. This will require collaboration and support from health care professionals, nurse-family members, clinical managers, and hospital directors. In the early stages of the candidature period, the researcher and the supervisors discussed the types of work production carried out. The researcher used four methods to share the three series of studies from this portfolio. These were: publication, conference presentation, Three Minute Thesis (3MT) and a portfolio fact sheet.

Publication

Supervisors usually encourage research candidates to publish their work, especially those completing doctoral research, as these in-depth studies may be able to contribute significantly to clinical practice. Publication in journals is not an easy task, and it can be challenging for a new research candidate, specifically with writing style. Manuscript writing requires collaboration with supervisors to be clear on the goal and shape of the work. However, one of the many rewards for researchers is to receive positive reviews and comments. Also, the benefits in publishing the research are immense as it allows researchers to identify areas that require attention.

Study one in this portfolio of research has been published at the JBI Database of Systematic Reviews and Implementation Reports. The title of the publication is ‘Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review’. (Appendix II) Furthermore, the researchers will work on further publications for study two and three that are in progress.

Conference presentation

Research conference is a formal academic work and is considered an important core component of research communication. Most, if not all, research candidates are encouraged to submit an abstract of their work during their candidature. The modes of presentation in conferences may differ, such as oral and/or poster presentations. The findings from this portfolio of research have been presented at a range of conferences in South Australia.

Study one has been presented as a poster at the 10th Annual Florey Postgraduate Research Conference 2016. The title of the poster is 'How healthcare professionals experience having a 'significant other' admitted to an acute care facility: A qualitative systematic review'. (Appendix III)

Also, it was presented as an oral presentation at the 2017 South Australian Nurses and Midwives Research Symposium. The title of the presentation is 'Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review'.

Study two has been presented as a poster at the 12th Annual Florey Postgraduate Research Conference 2018. The title of the poster is 'A survey of how nurses respond when their loved ones are admitted to an acute care hospital'. (Appendix IV)

Study three has been presented as an electronic poster at the Adelaide Nursing School, Research Conversazione 2018. The title of the poster is '"Oh, that's fine. I'm a nurse too": The experiences of nursing staff when caring for patients whose family members are nurses'. (Appendix V)

Three Minute Thesis (3MT) competition

3MT is competition that offers postgraduate students a distinctive opportunity to present their research to a non-specialist audience across the faculty within the university. Together with other universities nationally, the University of Adelaide hosts the 3MT during the middle of the school year. With the support of the supervisors, the researcher prepares a single PowerPoint slide which is limited to a three-minute presentation.

The researcher who participated during the 2017 3MT competition presented their research entitled, 'Who am I? Brother or Nurse'. It was presented with the Faculty of Health & Medical Sciences at the University of Adelaide. (Appendix VI)

The researcher noted that

"As a Higher Degree Research candidate, pushing the boundaries of the thesis is achieved by participating in the 3MT competition."

Portfolio fact sheet

A Portfolio Fact Sheet offers scientific information to the healthcare professionals, particularly nurses, about when a patient is admitted to an acute care hospital and their family member is a nurse. It is a two-page document listing important information about the experiences of nurse-family members. It was produced by the researcher and the supervisors for the purpose of this portfolio of research. The title of the fact sheet is 'Portfolio Fact Sheet: When a patient's family member is a nurse.' The fact sheet includes diagrams, definitions, objectives, key considerations, current evidence, suggestions for practice (evidence to practice and reasoning), references and project staff. The details of the fact sheet are depicted in Appendix VII.

CONCLUDING NOTES

This portfolio of research examined the experience of the family member who is a nurse. The challenge at the beginning of this portfolio was to research the experiences of nurse-family members with a view to increase the body of knowledge in adult acute care settings. This portfolio indicates the importance of the ability for nurses to describe and articulate their opinions and their practice; it emphasises the importance of nurse-family members' needs within acute care hospital settings. The significance and complexity of nurse-family members' experiences, demonstrated in this portfolio, warrants further investigation, discussion and debate. The knowledge about nurse-family members must be refined into useable forms to support families regardless of their professional identity within the hospital setting.

There is a need to facilitate transformation of the body of knowledge to clinical practice. Indeed, there is no better way to inform health policy makers and administration than to apply evidence based practice efforts via clinical policy. Hospital policies are necessary because it is easier for hospitals to create guidelines based on good clinical practice than to manage persons on case by case basis. Clinical knowledge of the health care system gives staff the ability to ask and answer queries and explain complex procedures. Within the relationship between families and health care professionals, sharing this knowledge is beneficial.

Portfolio Appendix

Portfolio Appendix I

THE UNIVERSITY of ADELAIDE

This is to certify that

Hussamaldeen Sabyani

has been awarded the

Adelaide Graduate Award

for employability skills development
through extra-curricular activities

25 October 2018

Professor Philippa Levy
Pro Vice-Chancellor (Student Learning)

Date

2018 Adelaide Graduate Award at the National Wine Centre

Hussamaldeen Sabyani and Professor Philippa Levy, Pro Vice Chancellor (Student Learning).

SYSTEMATIC REVIEW PROTOCOL

Healthcare professionals' experiences of having a significant other admitted into an acute care facility: a qualitative systematic review protocol

Hussamaldeen Sabyani[1,2,3] · Richard Wiechula[1,2] · Judy Magarey[1] · Frank Donnelly[1]

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Review question/objective: The objective of this review is to synthesize the qualitative evidence regarding the life experiences of healthcare professionals when their significant others are admitted to an acute-care hospital. Specifically, the review will address the following research question: what are the experiences of healthcare professionals as significant others to hospitalized loved ones in an acute-care facility?

Keywords Acute care; experiences; healthcare professionals; nurse-family member; significant others

Background

Being in a hospital can be an unpleasant experience for both patients and their families. Traditionally, families often provide care for their loved ones for the duration of their illnesses. A family might include a wife, husband and children; each of these individuals could potentially be a significant other. A significant other is identified as an individual who is important in someone's life.[1,2] They are often individuals who have significant input into their loved one's treatment plan.[3] In existing literature, the terms friend, spouse, partner, relative and significant other are used interchangeably. For the sake of consistency, the term "significant other" will be used primarily throughout this protocol.

In an acute-care hospital, patient care is not only provided by healthcare professionals, but also by patients' significant others. Mills and Aubeeluck describe significant others as assuming the role of informal carers.[4] This may involve providing both physical and psychological support such as providing assistance with bathing and feeding as well as being emotionally supportive. The need for a significant other's presence alongside a loved one is well documented in literature.[5] Therefore, healthcare professionals not only are responsible for providing care for the patients but also need to understand the emotional state of their significant others.

When a healthcare professional's significant other is admitted to an acute-care hospital, the context is quite different. Having a healthcare professional as a family member can impact on the delivery of care to an ill loved one.[6–8] The study by Salmond used a qualitative approach using open-ended, focused exploratory interviews to bring to light what a nurse-family member of an ill loved one experienced.[6] This experience was described as being different to that of the general public. Issues of role conflict and the burden of expectations were highlighted. Another study by Chen *et al.* using in-depth, semi-structured telephone interviews clarified the challenge physician-family members face when a significant other becomes ill.[9] The researchers specifically explored the experiences of physicians when their significant others were ill. In particular, they explained that when a patient has a physician-family member, the patient's care becomes unique.[9] Fromme *et al.* reported that having a physician-family member was considered as a "good thing" due to the physician's greater familiarity with the current healthcare system as compared with other family members.[10] What is more, the physician may be an expert in a relevant area of practice or hold strong views about what care should be provided. Commonly, most physicians are involved in their ill family member's care.[11]

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There is no conflict of interest in this project.

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Schofield explained that being both a nurse and a family member to a loved one, who has been admitted to a hospital, potentially offers additional assistance to staff.[12] For instance, the nurse may personally know the staff members they are dealing with, enhancing communication. Scarff and Lippmann highlighted that healthcare professionals exert greater influence on their relative's care because they believe that they are more concerned about the patient's wellbeing than the healthcare staff in charge.[11] Other researchers propose that a nurse-family member does not experience the same emotional distress as other relatives due to their increased awareness of the hospital environment.[7] Although nurses' familiarity within the clinical setting may be helpful, their professional knowledge may also increase their stress, and they may fear that the worst situation will happen.[4,13,14]

Often, a healthcare professional who is a significant other is more familiar and knowledgeable about their loved one's health conditions compared with others. For example, they may have increased information about their loved one's medications, medical history and desired form of care. As healthcare professionals, nurses understand how these details can impact on the quality of patient care and influence decision making.[4,7] Fromme *et al.* emphasized that having a physician-family member may provide relief to other family members, provided they are knowledgeable and truthful. When a healthcare professional's loved one is admitted to a different hospital, their need for information would logically be the same or greater compared with other significant others. They may have relevant professional knowledge but not local knowledge about the specific organization.[6,15]

Alternately, the healthcare professionals may not be versed in the relevant medical areas. This situation may significantly heighten anxiety because the healthcare professionals' families or colleagues may have unrealistic expectations regarding prognosis or patient outcomes. Olivet and Harris stressed that healthcare professionals and other family members place expectations on nurses who have ill loved ones.[7] A healthcare professional who is a significant other may experience pressure concerning his or her roles and responsibilities, including being an expert on the field, being a significant other and being part of the decision making process. These roles and responsibilities may lead a healthcare professional into having two conflicting identities: a professional identity and a personal identity. It is likely that multiple factors affect healthcare professionals as significant others when they are caring for loved ones. In almost every study, expectations, conflicting roles and communication are important factors highlighted in the current literature.[6–8,14,16]

Having a significant other who is a healthcare professional in a relevant clinical area is a special experience for both the staff member and the family members. However, the healthcare system places its own needs, concerns and expectations on healthcare professionals that may limit their ability to care for their loved ones. Increased awareness of these circumstances may help healthcare professionals to make better judgments regarding patient care and the support and care for relatives who are health professionals. Although there have been some investigations into this issue,[10,17–19] many have primarily been concerned with family members in the critical-care setting. One qualitative systematic review has been identified that addressed this issue; however, studies were restricted to nurse-family members only whose relatives were critically ill.[16] Therefore, this systematic review will have a broader focus: the experience of healthcare professionals as significant others and the factors influencing the unique experiences in any acute-care setting. A synthesis of the qualitative studies regarding the life experiences of healthcare professionals whose significant others have been hospitalized in the acute-care sector will increase our understanding of this issue. The aim of this systematic review is to better inform healthcare professionals, administrators and policy makers about dealing with health professionals as significant others to patients within the acute-care sector.

Inclusion criteria

Types of participants

The review will consider studies that include registered nurses and physicians who have reported their experience as a significant other when a relative has been admitted to an acute-care facility.

Phenomena of interest

The review will consider all studies that explore the experience of healthcare professionals when a significant other has been admitted into an acute-care facility.

Context
The review will consider research conducted in any acute-care setting.

Types of studies
The review will consider all qualitative studies that have examined the phenomena of interest including, but not limited to, research designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

Search strategy

The search strategy aims to find both published and unpublished studies. A three-step search strategy will be utilized in this review. An initial search of PubMed and CINAHL will be undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second search, using all identified keywords and index terms, will then be undertaken across all included databases. Third, the reference list of all identified reports and articles will be searched for additional studies. Only studies published in English will be considered for inclusion in this review. There will be no date restriction.

The databases to be searched will include PubMed, CINAHL, PsycINFO and Embase.

The search for unpublished studies will include Google Scholar, ProQuest Dissertations and Theses. Initial keywords to be used will be (Text word and MeSh terms):

1. Healthcare professional, health personnel, professional-family relations, nurse, nurse-family member, physician and doctors
2. Significant other, family, spouses, partner, loved one, family relations, extended family, immediate family, close relative, family member, family presence, wife, husband, mother and father
3. Life experiences, experience, personal experience, role expectation and dual role
4. Acute care, critical care and intensive care.

Assessment of methodological quality

Qualitative papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix I). Any disagreements that arise between the reviewers will be resolved through discussion or with a third reviewer.

Data extraction

Qualitative data will be extracted from papers included in the review using the standardized data extraction tool from JBI-QARI (Appendix II). The data extracted will include specific details about the interventions, populations, study methods and outcomes of significance to the review question and specific objectives.

Data synthesis

Qualitative research findings will, where possible, be pooled using JBI-QARI. This process will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings rated according to their quality, and categorizing these findings on the basis of similarity in meaning. These categories are then subjected to a meta-synthesis to produce a single comprehensive set of synthesized findings that can be used as a basis for evidence-based practice.

Acknowledgements

The review will be part of a research project to fulfil the requirement of a doctoral degree.

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Appendix I: QARI appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐ Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

_____

_____

_____

Appendix II: QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____

Journal _____ Record Number _____

Study Description

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete Yes ☐ No ☐

Findings	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete Yes ☐ No ☐

Experiences of healthcare professionals of having their significant other admitted to an acute care facility: a qualitative systematic review

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EXECUTIVE SUMMARY

Background
Most healthcare professionals at some time will experience having a significant other admitted to an acute care hospital. The knowledge and understanding that these individuals possess because of their professional practice can potentially alter this experience. Expectations of staff and other family members (FMs) can potentially increase the burden on these health professionals. All FMs of patients should have their needs and expectations considered; however, this review specifically addresses what may be unique for healthcare professionals.

Objectives
To synthesize the qualitative evidence on the experiences of healthcare professionals when their significant others are admitted to an acute care hospital.

Inclusion criteria
Types of participants
The current review considered studies reporting the experiences of healthcare professionals, specifically registered nurses (RNs) and physicians.

Phenomena of interest
The experiences of RNs and physicians when a significant other is admitted to an acute care facility.

Types of studies
Qualitative studies that have examined the phenomenon of interest including, but not limited to, designs such as phenomenology and grounded theory.

Search strategy
The search strategy aimed to find both published and unpublished studies with no date restrictions. Only studies published in English were considered for inclusion in this review.

Methodological quality
Qualitative papers selected for retrieval were assessed using the standardized critical appraisal instrument from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI).

Data extraction
Data were extracted from the seven included papers using the standardized data extraction tool from JBI-QARI.

Data synthesis
The data were synthesized using the JBI approach to meta-synthesis by meta-aggregation using the JBI-QARI software and methods.

Results
Seven studies of moderate quality were included in the review. Forty findings were extracted and aggregated to create 10 categories, from which five synthesized findings were derived:

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There is no conflict of interest in this project.

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- Privileged knowledge
- Unavoidable dilemmas as a consequence of dual identity
- Being a protector is imperative
- Family expectations are inevitable
- The intense impact of the experience

Conclusion

In contrast to "lay" FMs, health professionals possess additional knowledge and understanding that alter their perceptions and expectations, and the expectations others have of them. This knowledge and understanding can be an advantage in navigating a complex health system but may also result in an additional burden such as role conflict.

Keywords Acute care; experiences; healthcare professionals; nurse-family member; significant others

JBI Database System Rev Implement Rep 2017; 15(5):1409–1439.

ConQual summary of findings

Systematic review title: Experiences of healthcare professionals of having their significant other admitted to an acute care facility.
Population: Registered nurses and physicians who reported their experiences as a significant other when a relative was admitted to an acute care facility.
Phenomena of interest: The experiences of healthcare professionals when a significant other was admitted to an acute care facility.
Context: Research conducted in any acute care setting.

Synthesized finding	Type of research	Dependability	Credibility	ConQual score	Comments
Privileged knowledge	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Exploratory approach • Hermeneutic phenomenology	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Unavoidable dilemma as a consequence of dual identity	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Hermeneutic phenomenology • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Being a protector is imperative	• Phenomenography • Descriptive approach • Descriptive interpretive approach • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Family expectations are inevitable	• Descriptive approach • Descriptive interpretive approach • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings
Intense impact from the experience	• Exploratory approach • Hermeneutic phenomenology • Grounded theory	Remains at the level*	Downgrade one level**	Moderate	* Remains at the level due to 4 yes responses ** Downgraded one level due to mix unequivocal/credible findings

Background

Being in a hospital can be an unpleasant experience for both patients and their families. Families often provide support and care for their significant others for the duration of their illnesses. "Significant other" is identified as an individual who is important in someone's life.[1,2] This could be a relative or a close friend. These are often individuals who have input into their significant other's treatment plan.[3] The terms friend, spouse, partner, relative and significant other are used interchangeably in the existing literature. For the purpose of consistency, the term "significant other" will be used primarily throughout this background.

In an acute care hospital, patient care is not only provided by healthcare professionals but also by patients' significant others. Mills and Aubeeluck[4] describe significant others as assuming the role of informal carers. This may involve providing both physical and psychological support such as assistance with bathing and feeding as well as emotional support. The need for a significant other's presence alongside a loved one is well documented in the literature.[5]

When a healthcare professional's significant other is admitted to an acute care hospital, the context is quite different. Having a healthcare professional as a family member (FM) can impact on the delivery of care to an ill person.[6-8] The study by Salmond[6] used a qualitative approach with open-ended, focused exploratory interviews to examine this experience. This experience was described as being different to that of the general public. Issues of role conflict and the burden of expectation were highlighted. Another study by Chen *et al.*,[9] using in-depth, semi-structured telephone interviews, clarified the challenge physician-FMs face when a significant other becomes ill. In particular, they explained that when a patient had a physician-FM, there was the possibility of competing professional and personal expectations.[9] Fromme *et al.*[10] reported that having a physician-FM was considered as a "good thing" due to the physician's greater familiarity with the current healthcare system as compared to other FMs. Additionally, the physician may be an expert in a relevant area of practice or hold strong views about what care should be provided. Commonly, most physicians are involved in their ill FMs care both personally but also sometimes professionally.[11]

Schofield[12] explained that being a nurse and an FM to a significant other who has been admitted to a hospital potentially offers additional assistance to staff. For instance, the nurse-FM may personally know the staff that they are dealing with, enhancing communication. Scarff and Lippmann[11] highlighted that healthcare professionals exert greater influence on their relative's care because they believe that they are more concerned about the patient's wellbeing than the healthcare staff in charge. Other researchers propose that a nurse-FM does not experience the same emotional distress as other relatives due to their increased awareness of the hospital environment.[7] Although nurses' familiarity within the clinical setting may be helpful, their professional knowledge may also increase their stress, and they may fear that the worst situation will happen.[4,13,14]

Often, a healthcare professional-FM is more familiar and knowledgeable about their significant other's health conditions compared to others. For example, they may have increased information about their significant other's medications, medical history and desired form of care. As healthcare professionals, nurses understand the importance of how those details can impact on the quality of patient care and influence decision making.[4,7] Fromme *et al.*[10] emphasized that having a physician-FM may provide relief to other FMs, provided that they are knowledgeable and truthful. When a healthcare professional's significant other is admitted to a different hospital, their need for information would logically be the same or greater compared to other significant others. They may have relevant professional knowledge but not local knowledge about the specific organization.[6,15]

Alternately, the healthcare professionals may not be versed in the relevant medical area. This situation may significantly heighten anxiety because the healthcare professionals' families or colleagues may have unrealistic expectations regarding prognosis or patient outcomes. Olivet and Harris[7] stressed that healthcare staff and other FMs place expectations on nurse-FMs. A healthcare professional-FM may experience pressure concerning his or her roles and responsibilities, including being an expert in the field, being a significant other and being part of the decision making process. These roles and responsibilities may trap a healthcare professional into having two conflicting identities: a

professional identity and personal identity. In almost every study, expectations, conflicting roles and communication are important factors highlighted in the current literature.[6-8,14,16]

Having a healthcare professional-FM in a relevant clinical area is a special experience for both the staff member and other FMs. However, the healthcare system places its own needs, concerns and expectations on healthcare professionals that may limit their ability to care for their significant others. Increased awareness of these circumstances may help staff to make better judgments regarding patient care and the support and care for relatives who are health professionals. Although there have been some investigations into this issue,[10,17-19] many have primarily been concerned with FMs in the critical care setting. One qualitative systematic review has been identified that in part addressed this issue; however, studies were restricted to nurse-FMs whose relatives were critically ill.[16] This systematic review has a broader focus: the experience of healthcare professional-FMs in any acute care setting. Providing a synthesis of the qualitative studies regarding the experiences of healthcare professionals whose significant others have been hospitalized in the acute care sector will increase our understanding of this issue. The outcome of this systematic review will be to better inform healthcare professional staff, administrators and policy makers about dealing with health professional-FMs within the acute care sector. This review was conducted according to an *a priori* published protocol.[20]

Objectives

The objective of this review was to synthesize qualitative evidence regarding the experiences of healthcare professionals when their significant others are admitted to an acute care hospital. Specifically, the review addresses the following research question: what are the experiences of healthcare professionals when their significant others are admitted to an acute care hospital?

Inclusion criteria

Types of participants

The current review considered studies that include registered nurses (RNs) and physicians who had reported their experience when a significant other had been admitted to an acute care facility.

Phenomena of interest

The current review considered studies that explored the experience of RNs and physicians when a significant other had been admitted to an acute care facility.

Context

The review considered research conducted in any acute care facility. Acute care facility related to services occurring within an acute care hospital, i.e. a hospital that offers treatment care for acute disease or trauma services such as the acute care, critical care, intensive care and emergency departments.

Types of studies

The current review considered qualitative studies that had examined the phenomena of interest including, but not limited to, research designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

Search strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was utilized in this review. An initial search of PubMed and CINAHL was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Third, the reference list of all identified reports and articles was searched for additional studies. Only studies published in English were considered for inclusion in this review. There were no date restrictions. The databases searched included PubMed, CINAHL, PsycINFO and Embase. The search for unpublished studies included Google Scholar, ProQuest Dissertations and Theses and Trove. Databases were searched between February 1 and 5, 2016, and dates for searching are shown in search strategy in Appendix I.

Method of the review

Qualitative papers selected for retrieval were assessed by two independent reviewers for methodological validity prior to inclusion in the review using the standardized critical appraisal instrument from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI).[21] Any disagreements that arose between the reviewers were

resolved through discussion or with a third reviewer. Each article was assessed using all criteria. There was no minimum number of criteria deemed essential.

Data extraction

Qualitative data were extracted from papers included in the review using the standardized data extraction tool from (JBI-QARI).[21] The data extracted included specific details about the phenomena of interest, participants, study methodology and methods that described the experiences pertinent to the review question and specific objectives. The data were extracted by the principal author to an electronic document and checked by a second author prior to entering into JBI-QARI as a single entry.

Data synthesis

Qualitative research findings were pooled using JBI-QARI software and methods. This involved the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings rated according to their quality, and categorizing these findings on the basis of similarity in meaning. These categories were then subjected to a meta-synthesis to produce a single comprehensive set of synthesized findings that could be used as a basis for evidence-based practice. Furthermore, the ConQual approach was used to summarize the findings based on the level of dependability and credibility.[22]

Results

Description of included studies

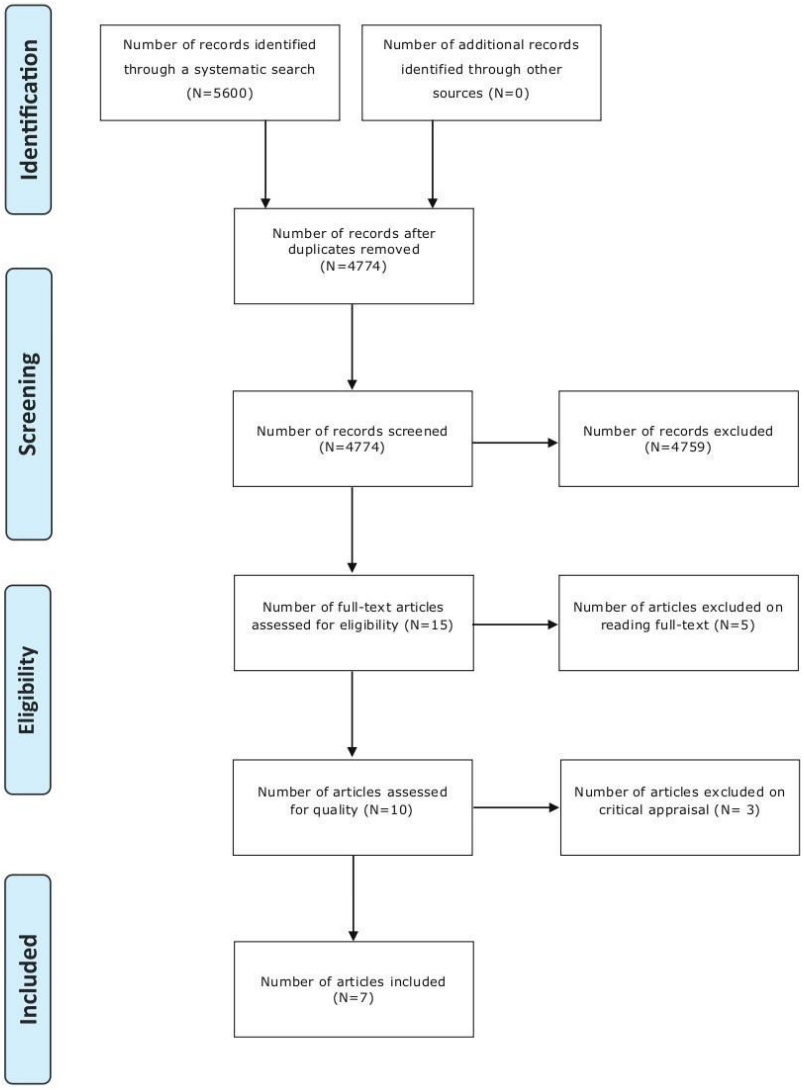
The systematic search identified 5600 records. Duplicate records were removed, and the 4774 remaining records were screened based on title and abstracts. A total of 4759 records were excluded, and 15 articles were selected for retrieval. After a full-text review, a further five articles were excluded. A total of 10 articles were subjected to quality assessment, and three additional articles (comprising one study) were excluded. A total of seven studies were included in the results of the review.[4,6,13,23-26] The study search is presented in Figure 1.

Characteristics of included studies

The included studies were conducted over a 10-year period in five countries: three in Australia,[23-25] and one each in Sweden,[26] New Zealand,[13] the United Kingdom[4] and the United States of America.[6] The earliest included studies were published in 2006,[4] and the latest in 2016.[26] The studies used a variety of methodologies. Three used phenomenographic and hermeneutic phenomenological approaches using semi-structured interviews.[4,13,26] However, the other four studies used descriptive,[23,24] exploratory[25] and ground theory[6] approaches. In six of the seven studies, participants were RNs.[4,6,13,23-25] One study[26] did recruit a variety of healthcare professionals. This study was included as the majority of participants were RNs and all but one of the illustrations provided were specifically attributed to RNs.[26] Six studies detailed the nature of the relationship with the healthcare professional which included spouses, parents, children, siblings, nieces, in-laws and grandparents.[6,13,23-26] One study did not state the relationship with the healthcare professional.[4] Almost all of the healthcare professionals had experienced having their ill FM admitted to their own facility.[6,13,23,24,26] Two studies did not state this condition.[4,25] A total of six studies reported the reasons behind admission or the diagnoses of ill FMs, which were varied with the most common being cancer, heart disease, stroke and infection.[4,6,13,24-26] Two of the studies were theses,[13,24] and five studies were published articles.[4,6,23,25,26] Three studies were set in a single hospital,[13,24,25] two were multi-hospital studies[6,26] and two did not report the specific details of their settings, but the described experiences indicate that they occurred in an acute care setting.[4,23] The characteristics of included studies are presented in Appendix II.

Methodological quality

Ten articles representing eight studies were appraised for quality.[4,6,8,13-15,23-26] One study, reported in three articles, was excluded.[8,14,15] The researchers did not report the process undertaken to analyze the data that was provided as "professional commentary" based on the data from a single case study. Furthermore, much of the commentary was about issues raised by the case rather than a discussion of and reference to the case. The list of articles excluded and the rationales for exclusion are provided in Appendix III. All studies were strong in the critical appraisal questions related to congruity between the research methodology and the research question, the research methodology and the



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097.

Figure 1: Flowchart of the study inclusion process

Table 1: Methodological quality of included studies

Reference	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	10/10 Y response
Carlsson *et al.*[26]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10
Giles and Williamson[23]	Y	Y	Y	Y	Y	N	UC	Y	Y	Y	8/10
Ledwidge[24]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10
Lines *et al.*[25]	Y	Y	Y	Y	Y	UC	UC	Y	Y	Y	8/10
McNamara[13]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10
Mills and Aubeeluck[4]	UC	Y	Y	Y	Y	N	N	Y	Y	Y	7/10
Salmond[6]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/10

N, no; UC, unclear; Y, yes.

methods used to collect the data, the representation and analysis of data and the interpretation of results. In addition, the questions addressing adequate representation of participants' voices, evidence of ethical approval and the conclusion drawn from the analyses were strongly represented. Half of the included studies stated their philosophical framework and situated the research culturally or theoretically. The weakest reporting among all studies was related to question 7 that addressed the influence of the researcher on the research and vice versa. Only two studies clearly stated this influence because they were based on a research thesis.[13,24] There were no disagreements between the reviewers regarding the critical appraisal. The results from the appraisal are presented in Table 1.

Results of meta-synthesis of qualitative research findings

Forty findings were extracted and aggregated to create 10 categories and five synthesized findings. Of the 40 total findings, 18 were rated unequivocal (U) and 22 rated credible (C). The extracted findings with illustrations are listed in Appendix IV. The five synthesized findings were then rated using the ConQual approach in line with Munn *et al.*'s[22] description and all were graded as "moderate." The synthesized findings and categories follow below and are found in Table 2. Findings are graded as U or C.

Synthesized finding 1: Privileged knowledge

The first synthesized finding relates to the privileged knowledge that healthcare professionals have as a result of their practice. Healthcare professionals recognize this knowledge of healthcare practices and more broadly the healthcare system as being fundamental to the experience of having an FM admitted to an acute care facility. Findings indicate that this knowledge brings some benefits in a better understanding of what is happening to their relative and also a need to have this acknowledged by the staff. In addition, the knowledge from being a health professional results in a heightened sense of judgment about the care being provided to their relative. Two categories were generated from eight findings (three U and five C), which contributed to this synthesized finding.

Category 1: Having expert knowledge is central to the experience when a loved one is ill.

Five findings were grouped into this category. Healthcare professionals acknowledged the importance of the knowledge they bring from their practice. They recognized the importance themselves but also wanted staff to acknowledge this. Importantly, they also recognized that their knowledge might not be complete particularly in settings in which they had no experience as a clinician. These findings were extracted from four studies.[13,23,25,26]

Finding 1: The informed bystander: benefits perceived to be related to their professional experience were knowing the healthcare system and how to navigate the system, possessing knowledge that facilitated their understanding of the patient's illness and the communication with staff about the patient's test results and medical state as well as about what plans were made for the patient (C).

Finding 2: Wanting acknowledgment of specialized knowledge: nurse-FMs believed that their specialized knowledge made them different to general public-FMs and wanted their knowledge acknowledged and respected by staff (U).
Finding 3: Wanting specialized communication: nurse-FMs highlighted the need for specialized communication that took into consideration previous knowledge and skills (U).
Finding 4: Specialized knowledge: nurse-parents found themselves in a unique position where they possessed not only an intimate knowledge of their child's personality, idiosyncrasies and medical history, but also considerable nursing knowledge and expertise. However, they were quick to acknowledge the limits of their knowledge, which was generally linked to their clinical specialty (C).
Finding 5: Knowing and not knowing: alongside knowing, not knowing also caused feelings of anxiety and stress. Not knowing what was happening while sitting in the waiting room and not having answers for relatives created feelings of frustration and powerlessness (C).

Category 2: Healthcare professionals as relatives use their specialist knowledge to judge the care provided.

This category represents some aspects of healthcare professionals as relatives who used their special knowledge to evaluate the care provided in terms of observing, detecting and protecting. In addition, they experienced frustration with the quality of care delivered. This category contains three findings extracted from three studies.[4,24,25]
Finding 6: Evaluating care: nurse-parents were aware of general standards of care expected in the hospital setting and often compared their child's care to the nursing care they would ordinarily provide (U).
Finding 7: Expertly observing, detecting and protecting: being vigilant served a number of purposes (C).
Finding 8: Disempowerment: all had experienced some dissatisfaction in the delivery of care and of the responses to their own needs (C).

Synthesized finding 2: Unavoidable dilemmas as a consequence of dual identity

Healthcare professionals experience the feeling of being trapped between their personal and professional identities.

The second synthesis contains 14 findings (seven U and seven C), and three categories fall under this synthesized finding. Healthcare professionals in the role of significant others experience the dilemma of dual identity (being a healthcare professional and a significant other). They are acutely aware of their two roles and are often conflicted in terms of which role they or others feel they should be undertaking. The decision of when or if to disclose their professional status to staff is a significant concern. Finally, they are confronted with personal and professional boundaries that bring pressure from within themselves and from others.

Category 3: Healthcare professionals as FMs experience role conflict moving between two identities.

Five findings were grouped into this category, which represented healthcare professionals as FMs recognizing the reality of having dual identities (professional versus personal roles). As a result, they experienced tension and conflict as they tried to reconcile their roles. These findings were extracted from five studies.[4,6,13,23,24]
Finding 9: Rather be treated as a lay son/daughter: staff would treat them differently and that they would be disadvantaged by disclosing their RN status so they preferred to be treated as a lay son or daughter rather than as an RN (U).
Finding 10: Feeling torn: the nurse as relative cannot simply switch off the nurse in her being. Inextricable connections mean that she cannot act as a detached FM (C).
Finding 11: Personal and professional boundaries: as a consequence of being a nurse and FM, they had to deal with the difficult issue of boundaries (C).
Finding 12: Emotion versus intellect: they stressed the importance of staff recognizing both the FMs-self and the nurse-self to provide effective care and support (U).
Finding 13: Resuming family roles: development of trust was pivotal to managing the challenge of resuming family roles (C).

Category 4: Healthcare professionals must consider whether or not to disclose their professional identity.

This category represents healthcare professionals as FMs considering whether or not to disclose their professional identity. Healthcare professionals recognized that disclosing their professional status could provide advantages for their loved ones but it might also additionally change expectations about their role as a relative. This category contains four findings that were extracted from two studies.[23,24]

Finding 14: Dual role conflicts: nurse-FMs experienced a conflict between wanting to hide and wanting to reveal their RN status (C).
Finding 15: Disclosure unnecessary: participants did not generally want or expect to take over the nursing of their parent. They expected the hospital staff to nurse their parent (U).
Finding 16: Disclosing to be treated as a peer/colleague: advised staff of RN status to be recognized as a peer/colleague (C).
Finding 17: Disclosing to get action: the need to advise staff of their RN status to gain added power to intervene in a way that was as influential as possible and resulted in getting their parent the care and attention they needed (C).

Category 5: Healthcare professionals are confronted by personal/professional boundaries.

Five findings were grouped into this category, which represents healthcare professionals as FMs' experiences of pressure in relation to their personal and professional boundaries. Findings indicated that healthcare professionals were confronted by the boundaries between the two roles as relative and healthcare professional. They identified that pressure to overstep this boundary could come from themselves or the expectation of others. These findings were extracted from three studies.[23,24,26]
Finding 18: The carer: the informants' descriptions focused on how they not only monitored the medical status of their loved ones and took over communication with ward staff as well as the coordination of care, but also that they were forced to take over much of the care, both in hospital and at home (C).
Finding 19: Stepping in on numerous occasions to ensure that their FMs received adequate nursing care, believing that their specialized knowledge and skills prevented significant deterioration in the patient's condition (U).
Finding 20: Expectations placed on self: nurse-FMs actively nursed both their own FM and other patients in the vicinity (U).
Finding 21: Staff expectations: nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general public-FM (U).
Finding 22: Filling in gaps: over-stepping boundaries and gender differences: overstepped the usual child-parent boundaries and this intruded on the parent's privacy and led to feeling uncomfortable (U).

Synthesized finding 3: Being a protector is imperative

The professional identity of healthcare professionals and their specialist knowledge makes it imperative that they take on the role of protector of their loved one.

The third synthesis contains six findings (two U and four C), and two categories fall under this synthesized finding. Healthcare professionals as significant others recognize that observing their ill loved one's condition and being a spokesperson for him or her to ensure that adequate care is delivered is unavoidable. They feel the need to query the in-depth details of the care provided and to contribute to the provision of care, when appropriate.

Category 6: The need to watch over their ill loved one is inescapable for healthcare professionals.

This category represented healthcare professionals as FMs' experiences being compelled to watch over the care provided to their ill loved one. They feel pressured or even distressed when keeping watch and monitoring their loved one's illness but recognized that there was no choice and this had to be done. Three findings extracted from three studies were aggregated from this category.[6,23,26]
Finding 23: The supervisor: this way of understanding was focused on monitoring the patient's medical status, test results and nursing care while staying in the background (C).
Finding 24: Keeping watch and advocating: nurse-FMs felt compelled to watch over and advocate for their FMs, fearful that care would deteriorate in their absence (U).
Finding 25: Surveillance and protection: vigilant observation was the key to surveillance and protection (U).

Category 7: Healthcare professionals are compelled to be an advocate for their ill loved one.

Category 7 focuses on healthcare professionals' experiences of being an advocate for their ill loved one's care. They stressed that advocating for the patient was their role because of their clinical experience and family relationship. This category contains three findings extracted from three studies.[6,24,26]
Finding 26: The advocate: the informants who understood being an FM of a hospitalized patient as being an advocate of the patient (C).
Finding 27: Being the fixer and fixing: intervene in the management of care (C).

Finding 28: Advocating for: advocacy occurred with or without collaboration; however, patient and family needs were best served when collaboration existed (C).

Synthesized finding 4: Family expectations are inevitable

Healthcare professionals struggle to meet the unavoidable high expectations of their FMs.

The fourth synthesis contains six findings (four U and two C), and one category falls under this synthesized finding. Healthcare professionals as significant others are seen to be under pressure to take the lead for the family when a loved one is acutely ill. They are required to know what is going on, be the support for the rest of the family even when this means not showing their true feelings.

Category 8: There is considerable pressure to be present for family when one is a healthcare professional.

This category shows how healthcare professionals, as FMs, perceived the role of being an FM of an ill loved one. They experienced pressure from FMs' expectations, including the ill loved ones, and took a leadership role in overseeing the quality of care. As a consequence, the healthcare professional, as an FM, was responsible for dealing with two relationships, their relationship with the family and their relationship with the staff, in order to facilitate and gain information. Six findings, which were extracted from three studies, were grouped in this category.[6,23,24]

Finding 29: Family member expectations: nurse-FMs also felt under considerable pressure from the patient and other FMs to play a particular role (U).

Finding 30: Leading and staying strong at any cost: being the eldest child was an important factor in relation to taking a leading role (C).

Finding 31: Being adept at hospital language: the RN-on-standby understood "hospital talk" and could interpret it for the family (C).

Finding 32: Keeping it real: providing reality grounding: at times, participants spoke up to correct the family's misguided ideas about the parent's prognosis or expectations of improvement, and this sometimes challenged FMs who were in denial or dramatically altered or shattered the family's hopes of the parent's recovery, and at times resulted in conflict between the participant and FMs (C).

Finding 33: Gaining information and seeking meaning: nurse-FMs intentionally built relationships to facilitate acquisition of detailed information and explanation of the meaning of this information (U).

Finding 34: Required to be "in-charge": outwardly, they wore a mask so that they appeared in control (U).

Synthesized finding 5: Intense impact on experience

The experience influences the healthcare professional's personal state and their clinical practice.

The fifth synthesis contains six findings (two U and four C), and two categories fall under this synthesized finding. Healthcare professionals, as significant others, feel that there is an additional impact on them personally because of their professional knowledge and understanding and that this is mainly negative. Conversely, there are some who feel that the experience of having a love one admitted to an acute care facility has a positive impact on their own practice.

Category 9: The impact on their personal wellbeing is amplified because of their professional identity.

This category provides evidence from healthcare professionals as FMs who experienced a negative impact and emotional imbalance in their personal life when an ill loved one was admitted in an acute care hospital. Many felt that this impact was greater because of their being a healthcare professional. The five findings allocated to this category were extracted from five studies.[4,6,13,23,25]

Finding 35: Personal impact of child's hospitalization: describing overall unpleasant experiences (C).

Finding 36: Specialized knowledge amplifying emotions: the impact of nurse-FMs specialized knowledge on their emotional state (C).

Finding 37: A nurse's nightmare describes unexpected intense emotions experienced by Intensive Care Unit (ICU) nurses when an FM is admitted, critically ill, to an ICU (C).

Finding 38: Heightened emotional turmoil: they pictured different scenarios of what might happen and what might go wrong as they dealt with the present and projected ahead to "what ifs" (C).

Finding 39: Quality of life: as a consequence of caring for their FM, they had experienced a negative impact on their quality of life (U).

Table 2: Meta-synthesis of findings

Finding	Category	Synthesized finding
The informed bystander: those benefits that they perceived to be related to their professional experience were knowing the healthcare system and how to navigate the system, possessing knowledge that facilitated their understanding of the patient's illness and the communication with staff about the patient's test results and medical state, as well as about what plans were made for the patient (P)	Having expert knowledge is central to the experience when a loved one is ill	*Privileged knowledge:* Healthcare professionals are able to use their privileged knowledge in the provision of care for ill family members and evaluate the care provided
Wanting acknowledgement of specialized knowledge: nurse-FMs believed their specialized knowledge made them different to general public-FMs, and wanted their knowledge acknowledged and respected by staff (U)		
Wanting specialized communication: nurse-FMs highlighted the need for specialized communication that took into consideration previous knowledge and skills (U)		
Specialized knowledge: nurse-parents found themselves in a unique position where they possessed not only an intimate knowledge of their child's personality, idiosyncrasies and medical history, but also considerable nursing knowledge and expertise. However, they were quick to acknowledge the limits of their knowledge, which was generally linked to their clinical specialty (P)		
Knowing and not knowing: alongside knowing, not knowing also caused feelings of anxiety and stress. Not knowing what was happening while sitting in the waiting room and not having answers for relatives created feelings of frustration and powerlessness (P)		
Evaluating care: nurse-parents were aware of general standards of care expected in the hospital setting and often compared their child's care to the nursing care they would ordinarily provide (U)	Healthcare professionals as relatives use their specialist knowledge to judge the care provided	
Expertly observing, detecting and protecting: being vigilant served a number of purposes (P)		
Disempowerment: all had experienced some dissatisfaction in the delivery of care and of the responses to their own needs (P)		

Table 2. (*Continued*)

Finding	Category	Synthesized finding
Rather be treated as a lay son/daughter: staff would treat them differently and that they would be disadvantaged by disclosing their RN status so they preferred to be treated as a lay son or daughter rather than as a RN (U)	Healthcare professionals as family members experience role conflict moving between two identities	*Unavoidable dilemma as a consequence of dual identity:* Healthcare professionals experience being trapped between personal and professional identities
Feeling torn: the nurse as relative cannot simply switch off the nurse in her being. Inextricable connections mean that she cannot act as a detached family member (P)		
Personal and professional boundaries: as a consequence of being a nurse and family member, they had to deal with the difficult issue of boundaries (P)		
Emotion vs intellect: they stressed the importance of staff recognizing both the FM-self and the nurse-self to provide effective care and support (U)		
Resuming family roles: development of trust was pivotal to managing the challenge of resuming family roles (P)		
Dual role conflicts: nurse-FMs experienced a conflict between wanting to hide and wanting to reveal their RN status (P)	Healthcare professionals must consider whether or not to disclose their professional identity	
Disclosure unnecessary: participants did not generally want or expect to take over the nursing of their parent. They expected the hospital staff to nurse their parent (U)		
Disclosing to be treated as a peer/colleague: advised staff of RN status to be recognized as a peer/colleague (P)		
Disclosing to get action: the need to advise staff of their RN status to gain added power to intervene in a way that was as influential as possible and resulted in getting their parent the care and attention they needed (P)		
The carer: the informants' descriptions focused on how they not only monitored the medical status of their loved ones and took over communication with ward staff as well as the coordination of care, but also that they were forced to take over much of the care, both in hospital and at home (P)	Healthcare professionals are confronted by personal/professional boundaries	
Stepping in on numerous occasions to ensure their FM received adequate nursing care, believing their specialized knowledge and skills prevented significant deterioration in the patient's condition (U)		
Expectations placed on self: nurse-FMs actively nursed both their own FM and other patients in the vicinity (U)		
Staff expectations: nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general public-FM (U)		
Filling in gaps: over-stepping boundaries and gender differences: overstepped the usual child-parent boundaries and this intruded on the parent's privacy and led to feeling uncomfortable (U)		

Table 2. (*Continued*)

Finding	Category	Synthesized finding
The supervisor: this way of understanding was focused on monitoring the patient's medical status, test results and nursing care while staying in the background (P)	The need to watch over their ill loved one is inescapable for healthcare professionals	*Being a protector is imperative:* The professional identity of healthcare professionals and their specialist knowledge make it imperative that they take on the role of protector of their loved one
Keeping watch and advocating: nurse-FMs felt compelled to watch over and advocate for their FM, fearful that care would deteriorate in their absence (U)		
Surveillance and protection: vigilant observation was the key to surveillance and protection (U)		
The advocate: the informants who understood being a family member of a hospitalized patient as being an advocate of the patient (P)	Healthcare professionals are compelled to be an advocate for their ill loved one	
Being the fixer and fixing: intervene in the management of care (P)		
Advocating for: advocacy occurred with or without collaboration; however, patient and family needs were best served when collaboration existed (P)		
Family member expectations: nurse-FMs also felt under considerable pressure from the patient and other family members to play a particular role (U)	There is considerable pressure to be present for family when one is a healthcare professional	*Family expectations are inevitable:* Healthcare professionals struggle to meet the uncomfortably high expectations from family members
Leading and staying strong at any cost: being the eldest child was an important factor in relation to taking a leading role (P)		
Being adept at hospital language: the RN-on-standby understood "hospital talk" and could interpret it for the family (P)		
Keeping it real: providing reality grounding: at times participants spoke up to correct the family's misguided ideas about the parent's prognosis or expectations of improvement and this sometimes challenged family members who were in denial, or dramatically altered or shattered the family's hopes of the parent's recovery, and at times resulted in conflict between the participant and family members (U)		
Gaining information and seeking meaning: nurse family members intentionally built relationships to facilitate acquisition of detailed information and explanation of the meaning of this information (U)		
Required to be "in-charge": outwardly they wore a mask so that they appeared in control (U)		

Table 2. (*Continued*)

Finding	Category	Synthesized finding
Personal impact of child's hospitalization: describing overall unpleasant experiences (P)	The impact on their personal being is amplified because of their professional identity	*Intense impact from the experience:* The experience influences the healthcare professional's clinical practice and personal state
Specialized knowledge amplifying emotions: the impact of nurse-FMs specialized knowledge on their emotional state (P)		
A nurse's nightmare describes unexpected intense emotions experienced by ICU nurses when a family member is admitted, critically ill, to an ICU (P)		
Heightened emotional turmoil: they pictured different scenarios of what might happen and what might go wrong as they dealt with the present and projected ahead to "what ifs" (P)		
Quality of life: as a consequence of caring for their family member, they had experienced a negative impact on their quality of life (U)		
Gaining deeper insight and new meaning: the insights have also provided their practice with new meaning (U)	The experiences of having an ill loved one can have a positive impact on their professional practice	

Category 10: The experiences of having an ill loved one can have a positive impact on their professional practice.

This category demonstrates the positive impact that healthcare professionals as FMs felt when they gained better insight through their experiences when an FM was admitted to the hospital. One finding, which was extracted from one study, was in this category.[13]
Finding 40: Gaining deeper insight and new meaning: the insights have also provided their practice with new meaning (U).

Discussion

The current review included seven studies exploring the experiences of health professionals when their significant others were acutely ill.[4,6,13,23-26] Meta-synthesis resulted in 40 findings that were grouped into 10 categories and resulted in the following synthesized findings: privileged knowledge, unavoidable dilemmas as a consequence of dual identity, being a protector is imperative, family expectations are inevitable, and intense impact from the experience. The discussion will detail how these synthesized findings relate to each other to comprehensively describe the experience. It is recognized that some aspects of the experience can be similar to FMs who are not health professionals but what is highlighted is the uniqueness of the experience when the FM of an acutely ill patient is a health professional.

For any individual, the experience of having a significant other with an acute illness can be an anxious or even a distressing experience. When that individual is a health professional, there is an added complexity to this experience. This complexity arises from the additional knowledge health professionals possess. This privileged knowledge is fundamental to this experience and gives the healthcare professional a different perspective of themselves and the part they play in the care that is being provided to their significant other. As a consequence, the health professional is drawn to consider that the dual identity of being a relative and a health professional brings an unavoidable dilemma. In addition, their privileged knowledge brings inevitable expectations from other

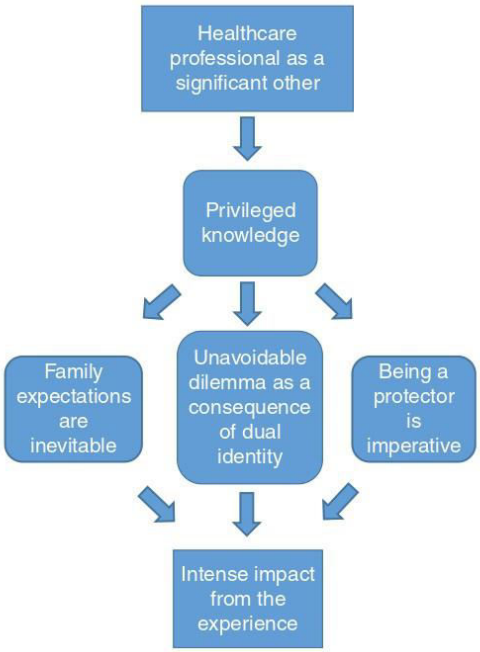


Figure 2: Model depicting the experiences of healthcare professionals as significant others to hospitalized loved ones in acute care settings and the impact from the experience

FMs but also their own expectations of using their knowledge to protect their loved one. Consequently, these experiences have an intense impact on the healthcare professionals both personally and potentially on their own practice. This interlinking of the synthesized findings of this review is presented in Figure 2 and represents the complexity of the phenomenon of a health professional with a significant other who is an acutely ill patient.

The first synthesized finding addresses how fundamental the privileged knowledge held by healthcare professionals was when an FM was an acutely ill patient. This knowledge related to both the clinical aspects of care and an understanding of the health system where that care was provided. The health professionals considered that this additional knowledge was central to their experiences when a loved one was ill. They believed that there were benefits of having that knowledge. They felt that they had a better understanding about their relatives' condition and that it was much easier to navigate the system and gain access to information that would not be available to a layperson. In addition, they wanted their specialized knowledge acknowledged by staff and that it should result in more in-depth explanation about what was happening. "We should be given more time for explanation because we need more depth and have more questions than most other people who would simply accept what was going on and the treatment offered."[23(p.8)] Other studies have reported that all FMs needed was to receive explicit information about their loved one.[5,17,27] The findings from this review indicate that health professionals felt they could understand more detailed information and therefore this should be given to them.[25,26] Health professionals also wanted recognition that depending on the circumstance, there might be limits to their knowledge particularly where the care did not relate to their own specialty.[25] Regardless of whether they had a specific specialist knowledge they still felt they were better equipped to evaluate the care being given in comparison to lay FMs.

In category two, the findings highlight that healthcare professionals used their clinical knowledge quite specifically to judge the care being provided to their ill loved ones. Healthcare professionals' possessing specialized knowledge resulted in certain expectations of the staff to provide a quality of care, but these needs were not often met. "You know the holes in the system, you know everything that could've gone wrong, did go wrong and I felt I just, I fought his corner constantly."[4(p.162)]

Given that the knowledge possessed by healthcare professionals is central to this experience, the following three synthesized findings address how having this knowledge relates to the expectations of both the healthcare professional and of others including FMs and the staff caring for their loved one.

The second synthesized finding (healthcare professionals experience being trapped between personal and professional identities) emphasizes that having a dual identity not only became blurred but also caused role conflict and identity confusion. Similarly, this finding is also identified in Giles and Hall[16] review that suggests that professional and personal roles can be extremely unclear. Three categories were synthesized to develop synthesized finding 2.

The findings highlight that healthcare professionals as FMs experienced tension between professional and personal roles that led to role conflict. The participants felt that they were torn between two identities. If they were seen by staff as being a healthcare professional, then they were not then being treated as a son or daughter. This could lead to a lack of emotional support by the staff. "Yet people forget that we are human too and when it is your family it is different, often you can't shut off as easily from the emotions as you do when you are at work."[23(p.9)] Traditionally, the FMs' role is supporting and comforting their ill loved one.[2,3,19] The healthcare professionals saw the need to return to that role but recognized they needed to deal with their professional role first. "They were there when I interacted with the physician requesting that care be changed. It made me feel safe. I could act like her mother for a while instead of the nurse in charge."[6(p.16)]

In category two, the findings identify the frustration occurring among healthcare professionals as FMs when making the decision whether or not to disclose their identity. They could see both advantages and disadvantages of disclosing their professional status. On the one hand, participants felt that if they did disclose their professional identity, they may be pressured to undertake more direct care of their relative.[24] However, on the other hand, disclosure could bring added authority and more power to influence the care of their ill loved one. "After 2 days of this it was time to let staff know. They even referred Mum to the stomal therapist. She ordered appropriate bags that didn't leak and Mum's legs were always elevated. Until they found out that I was an RN the staff had told my aunty that it was normal for stoma bags to leak."[24(p.116)]

In category three, the finding recognizes a challenge occurring among healthcare professionals as significant others in relation to personal and professional boundaries. The participants conveyed that they were acutely aware of personal and professional boundaries when an ill loved one was hospitalized. They needed to consider when to step in, step out or even over-step these boundaries. In some cases, they themselves felt compelled to take on the professional role to intervene on their relative's behalf or even on behalf of other patients.[23] On other occasions, they felt pressured by staff to undertake tasks that they felt would not be expected of a layperson FM. "Dad was a very, very private person and he would have hated me doing that . . . and it's just something that I think about now and again and I just wished I hadn't done it because he wouldn't have liked me doing it. I think she should have asked for one of the other nurses to come and help her not me."[24(p.156)]

In the third synthesized finding, the professional identity of healthcare professionals and their specialist knowledge make it imperative that they take on the role of protector of their loved one, being a protector is imperative. As expected, this finding is similar to the Giles and Hall[16] review that states that nurse-FMs act as a protector to their ill loved one. Two categories were synthesized to develop synthesis finding three.

In category one, the findings indicate that healthcare professionals cannot escape the obligation to watch over their ill-loved ones' care. "The weeks during his stay when his care was appalling were very difficult as I did not want to be over reacting but could not tolerate what was happening."[23(p.8)] The participants feel the need to oversee the quality of care provided because of their clinical expertise and their professional role.

In category two, the findings address that when an ill loved one is admitted to a hospital, healthcare professionals as FMs are bound to be an advocate. "I

came in in the morning. They told me he was unstable. I started asking questions, his blood gas, his pH was like 7.0. I was like 'what', he's going to code. You need to do this, you need to do that . . . I wasn't trying to manage the situation but I knew what needed to be done and I had to be sure everything was being done."[6(p.16)] Participants described the necessity to advocate for their ill-loved one using their clinical knowledge to interpret clinical information. In general, it can be expected that a layperson would act as an advocate for their ill relative but the healthcare professionals understood that their knowledge put them into a unique position that could not be avoided.

In the fourth synthesized finding, the uncomfortably high expectations of other FMs on healthcare professionals as FMs is always apparent, family expectations are inevitable. When an ill loved one is admitted, the family expects the relative who is a healthcare professional to take the lead and be the spokesperson for the family. Correspondingly, this finding is also acknowledged in the Giles and Hall[16] review that there are undeniable expectations on nurse-FMs by other FMs. One category was synthesized to develop synthesis finding four.

This category states that there is a considerable pressure faced by an FM who is a healthcare professional. When an ill loved one was hospitalized, participants expressed feelings of tension not only in becoming accountable for all parts of care but also dealing with other FMs' needs. They took the obligation to convey medical information to other FMs such as translating medical terminology, discussing the care provided and answering all questions relating to the loved ones' illness. Participants described themselves in the family as "in-charge" or "in control" in watching over the care delivered to their ill FM. "Oh my God, it was the scariest time of my life. But I couldn't, I wouldn't let them [family members] know how concerned I was. They looked to me for their hope and I did not want to diminish that."[6(p.14)]

In the fifth synthesized finding, intense impact from the experience, the healthcare professionals' clinical practice and personal state are fully influenced by their experience. Obviously, healthcare professionals as significant others experience an extreme impact on their personal and professional self due to their clinical expertise and professional identity. In our review, this synthesis was an important component of the participants' experience and was frequently described by the healthcare professionals, in contrast with the Giles and Hall[16] review where it was not noted. Two categories were synthesized to develop synthesis finding five.

The previous synthesized findings relate to various influences on health professionals when a loved one is hospitalized and the kinds of activities that result. The final synthesized findings are the perceptions about how this phenomenon impacts on the healthcare professional both personally and professionally. The findings of this review stressed that the personal impact on healthcare professionals as significant others was amplified because of their professional identity.[6,13,23] A qualitative systematic review described the experiences and the needs of [lay] FMs to critically ill patients in an acute care setting.[27] One of the major findings of that review was that FMs experienced emotional turmoil: a "roller coaster" of anxiety, distress and fear.[27] While it is logical that there will be a significant impact on healthcare professionals with an acutely ill loved one, it is their professional knowledge and identity that participants felt made the impact more intense. "At times it was like no matter what they said to me, I could not feel comfortable and confident that everything was going to work out. I kept thinking of the 'what ifs . . . ' and kept wishing I did not know anything so I could just go in there and sit by the bedside and just be supportive. Knowing made it much harder."[6(p.14)]

A novel finding was the impact for healthcare professionals as significant others on their own professional practice. Participants articulated that when having an ill FM admitted, their clinical practice made them more aware and provided a deeper insight into how FMs are treated. "I do a far better family handover . . .. I have a deeper understanding of relatives and it has changed my reaction to them quite a bit. It was a huge eye opener to me just . . . seeing the way things happened and seeing it from the other side . . .."[13(p.13)] They emphasized a significant change in their professional practice toward FMs of patients they were caring for because of their past experiences when a loved one was ill.

Limitations of the review

There are a number of potential limitations with this qualitative systematic review. It was decided that "significant other" was the term to be used for the review question and objectives. It was quickly

identified that there are many alternative terms such as "family member" or "relative" that are used in different ways in different studies. While alternative terms were included in the logic grid for the search of each database, it may be possible that additional terms could be used and as a result some studies may have been missed. Second, this review aimed to include studies of both RNs and physicians. The included studies had a high number of RN participants rather than physicians, and this should be considered when reviewing the findings. In addition, limitations relate to the restriction of the search strategy to English language studies only as there was no capacity for translation of other languages, and clearly the experience would not be limited to countries where English is the dominant language.

Conclusion

The qualitative systematic review produced a synthesis of a number of moderate-quality studies that explored the experiences of healthcare professionals as significant others to hospitalized loved ones in acute care settings. Compared to "lay" FMs, health professionals possess additional knowledge and understanding that alter their perceptions and expectations and the expectations others have of them. Good communication by staff with healthcare professionals as significant others about their expectations and needs is a logical step in reducing the impact on these individuals when a loved one is acutely ill.

Implications for practice

The current qualitative systematic review provides evidence in relation to the experience of healthcare professionals when a significant other is admitted in an acute care setting. The needs and expectations of all FMs should be considered by staff, but when the FM is a healthcare professional there are some additional considerations. The knowledge that a healthcare professional possesses can be advantageous because they may have a deeper and more detailed understanding of the patient's history and condition but this must not be assumed. Healthcare professionals may or may not want to disclose their professional identity to staff, and this should be respected. Depending on the context, relatives of any kind can play a role in providing some care to their loved one but when health professionals are involved, staff should be conscious of the boundaries between personal and professional care and ensure that care provided by the health professional FM is negotiated and appropriate. Finally, when dealing with an FM who is a healthcare professional staff should be aware that the knowledge that that person possesses may amplify the impact of the situation. These recommendations have been assessed based on the JBI grades of recommendation[21]: Grade A.

Implications for research

The current review identified that research has been particularly focused on the experience of nurses and in particular RNs. A broader population sample should be considered to include clinicians from other disciplines. It would also be useful to consider the experience of staff when dealing with healthcare professional FMs. It is noted that most of the participants of the included research were females. Further research exploring the experiences of male healthcare professionals in this situation will promote an understanding from a gender perspective. Finally, in this review, the participants from one study reported the impact of the phenomenon on their professional practice. Therefore, further research is needed to explore how the experiences may influence professional practice.

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Appendix I: Search strategy

Database	Search terms
PubMed February 2, 2016 Items 2015	(((((Health Personnel[mh] OR Professional-Family Relations[mh] OR Nursing[mh] OR Nurs*[tiab] OR Nurse Family member*[tiab] OR Physician*[tiab] OR Doctor*[tiab] OR Physician Family member*[tiab])) AND (Family[mh] OR Family Relations[mh] OR Caregiver[mh] OR Relative*[tiab] OR Partner*[tiab] OR Wife[tiab] OR wives[-tiab] OR Husband*[tiab] OR Family member*[tiab] OR Loved one[tiab] OR Mum[tiab] OR Father*[tiab] OR Sibling*[tiab] OR Significant other*[tiab])) AND (Attitude of Health Personnel[mh] OR Conflict[mh] OR Dual role*[tiab] OR Role conflict*[tiab] OR Conflict[tw] OR Experience*[tiab] OR Physician's role*[mh] OR Nursing role*[tiab])) AND (Acute illness*[tiab] OR Critical Care Nursing[mh] OR Critical illness[tiab] OR Acute care[tw] OR Critical care[tw] OR Intensive care[tw] OR Health care[tiab])) AND (ethnograph*[tw] OR interpretive study[tw] OR phenomenolog*[tiab] OR grounded theory[tiab] OR thematic analysis[tiab] OR focus group[tiab] OR hermeneutic*[tiab] OR qualitative research[mh:exp] OR qualitative study[tw] OR qualitative[tiab] OR interview[tw] OR lived experience[tw] OR narrative[tiab] OR mixed method[tw] OR interpretive synthesis[tw] OR meta synthesis[tw] OR key informant[tiab])
	[mh]= mesh heading, [tiab] = title and abstract, [tw] = txt word
Database	**Search terms**
Embase February 2, 2016 Items 1522	(nurse*:de,ab,ti OR physician*:de,ab,ti OR doctor*:de,ab,ti OR "physician family member":ab,ti OR "physician family members":ab,ti OR "nurse family member":ab,ti OR "nurse family members":ab,ti AND ("family"/exp OR caregivers:ab,ti OR relative*:de,ab,ti OR "family member":ab,ti OR "family members":ab,ti OR "loved one":ab,ti OR "significant other":de,ab,ti OR "significant others":de,ab,ti) AND ("conflict"/exp OR "psychological aspect"/exp OR "dual role":ab,ti OR "dual roles":ab,ti OR "role conflict":de,ab,ti OR conflict*:ab) AND ("acute illness":ab,ti OR "acute illnesses":ab,ti OR "intensive care":de,ab,ti OR "critical illness":de,ab,ti OR "critical illnessess":ab,ti OR "acute care":ab,ti OR "life threatening illness":ab OR "health care":ab) AND ("qualitative research":de,ab,ti OR "grounded theory":-de,ab,ti OR phenomenology:de,ab,ti OR ethnography:de,ab,ti OR "action research":-de,ab,ti OR "mixed methods":ab,ti OR narrative*:de,ab,ti OR experience*:ab,ti OR interview*:ab,ti OR "discourse analysis":ab,ti OR "focus group":ab,ti OR "focus groups":ab,ti OR descriptions:ab,ti OR opinions:ab,ti OR attitude:ab,ti OR attitudes:ab,ti OR descriptive:ab,ti)
	exp = explode, ab = abstract, ti = title, de = index term

Database	Search terms
CINAHL February 2, 2016 Items 1896	(MH Health Personnel OR MH Professional-Family Relations OR MM Professional-Family Relations OR MH Nurse* OR TI Nurse family member* OR AB Nurse family member* OR TI Physician* OR AB Physician* OR TI Doctor* OR AB Doctor* OR TI Physician family member* OR AB Physician family member*) AND (MH Family+ OR MH Family Relations OR TI Families OR AB Families OR TI Relative* OR AB Relative* OR TI Partner* OR AB Partner OR TI Wife* OR AB Wife* OR TI Husband OR AB Husband OR TI Family member* OR AB Family member* OR TI Loved one OR AB Loved one* OR TI Mum OR AB Mum OR TI Father* OR AB Father* OR TI Sibling* OR AB Sibling* OR TI Significant other* OR AB Significant other* OR MM Caregivers) AND (MH Attitude of Health Personnel OR MH Conflict OR TI Dual role* OR AB Dual Role* OR TI Role conflict* OR AB Role Conflict* OR TX Conflict* OR TI Experience* OR AB Experience* OR TI Physician's role* OR AB Physician's role* OR MH Nursing role) AND (MH Inpatients OR MH Critical Care Nursing OR TI Critical illness OR AB Critical illness OR AB Acute care OR TI Acute care OR TI Critical care OR AB Intensive care OR TI Acute illness* OR AB Acute illness* OR TI Critical condition OR AB Life-threatening illness OR TI Healthcare OR AB Healthcare) AND MH Qualitative studies+ OR TI Qualitative OR AB Qualitative OR MM life experience* OR TI experience* OR TI "Mixed-methods" OR AB "Mixed-Methods" OR TI "mixed methods" OR AB "mixed methods" OR TI narrative* OR AB narrative*OR TI interview* OR AB interview* OR TI "discourse analysis" OR AB "discourse analysis" OR TI "focus group*" OR AB "focus group*" OR TI descript* OR AB descript* OR TI opinion* OR AB opinion*OR TI attitude* OR AB attitude* OR TI phenomenol* OR AB phenomenol* OR TI ethnog* OR AB ethnog* OR TI "action research" OR AB "action research" OR TI "grounded theory" OR AB "grounded theory" OR AB "key informant")
	MH = main heading, TI = title, AB = abstract
Database	**Search terms**
Psych INFO February 2, 2016 Items 83	Medical Personnel.mp OR Nurse.mp OR Physicians.mp OR Doctor.ti OR Doctor.ab OR Doctors.ti OR Doctors.ab AND Family.mp OR Family members.mp OR Caregivers.mp OR Relative*.ti OR Relative*.ab OR Loved one.ti OR Loved one.ab OR Significant other.mp AND Health Personnel Attitude.mp OR professional identity.mp OR Conflict.mp OR Role conflicts.mp OR Life Experience.mp OR Role*.ti OR Role*.ab AND Intensive care.mp OR Chronic illness.mp OR Acute care.ab OR Acute care.ti OR Critical care.ab OR Critical care.ti OR Acute illness.ab OR Acute illness.ti OR Critical condition.ab OR Critical condition.ti OR Life-threatening illness.ab OR Healthcare.ti OR Healthcare.ab AND Qualitative.ti OR Qualitative.ab OR Qualitative Research.mp OR Phenomenology.mp OR Ethnography.mp OR Narrative.ti OR Narrative.ab
	mp = mapping Alias, ti = title, ab = abstract
Database	**Search terms**
Trove February 2, 2016 Items 84	(Nurse AND Family member AND Experience AND Health care)
Limited	Thesis

Appendix II: Characteristics of included studies

Study	Methodology	Method	Phenomena of interest	Participants	Family member who were patients	Family member admitted to participant's own facility	Reasons of admissions (diagnosis)
Carlsson, Carlsson (2016) Sweden[26]	Phenomenographic approach	Semi-structured interview	To describe how healthcare professionals understand the role of having a healthcare professional and family member of a patient admitted to a hospital	Healthcare professionals (registered nurse, physician, assistant nurse, midwife, social officer, occupational therapist, radiographer and biomedical technician)	Spouse/fiancé Daughter/son Mother Father-in-law/ grandmother/ granddaughter	Healthcare professionals' own workplace, as mentioned by participants	Cancer, stroke, frail elderly, gastroenterology/kidney, infection/ allergy, orthopedic/surgery/ gynecology and cardiology
Giles and Williamson (2015) Australia[23]	Descriptive approach	Online questionnaire	To understand and interpret the experiences of nurse-family members when a family member or loved one is hospitalized	Registered nurses	Spouse/partner Daughter Mother Sibling Niece Daughter-in-law granddaughter	Registered nurses' own workplace, as stated in the study	Not stated in the study
Ledwidge (2010) Australia[24]	Descriptive approach	Interviews and open-ended questions	To describe and interpret registered nurses' experiences as relatives during their parent's hospitalization	Registered nurses ages 40–65 y	Mother Father	Registered Nurses' own workplace, as stated in the study	Cancer, stroke, cardiology and infection
Lines, Mannix (2015) Australia[25]	Exploratory qualitative approach	Qualitative multiple case study design	To explore the experience of nurse-parents whose children were hospitalized	Registered Nurses Female	Children	Not stated in the study	Acute illness
McNamara (2007) New Zealand[13]	Hermeneutic phenomenology approach	Semi-structured interview	The meaning of the experience for intensive care unit nurses when a family member is critically ill	Registered nurse	Brother Sister Mother Father	Registered Nurses' own workplace, as stated in the study	Critically ill
Mills and Aubeeluck (2006) United Kingdom[4]	Hermeneutic phenomenology approach	Semi-structured interview	To explore the information needs, support systems available and the impact that this experience has upon the nurse's quality of life	Senior nurses	Not stated in the study	Not stated in the study	Life-threatening illness
Salmond (2011) United States of America[6]	Grounded theory	In-depth, open-ended and loosely structured interviews	To explore the experience of being a nurse family member of an adult relative hospitalized for a critical illness	Nurse	Wife Daughter Mother Grandmother Sister Niece Daughter-in-law	Nurses' own workplace, as stated in the study	Heart disease Cancer Trauma

Appendix III: Excluded studies

Fulbrook P, Allan D, Carroll S, Dawson D. On the receiving end: experiences of being a relative in critical care. Part 1. Nurs Crit Care.1999; 4 (3): 138-145.
Fulbrook P, Buckley P, Mills C, Smith G. On the receiving end: experiences of being a relative in critical care. Part 2. Nurs Crit Care.1999; 4 (4): 179-185.
Fulbrook P, Creasey J, Langford D, Manley K. On the receiving end: experiences of being a relative in critical care. Part 3. Nurs Crit Care.1999; 4 (5): 222-230.
Reason for exclusion: The studies did not use a rigorous qualitative design. The researchers did not report the process undertaken to analyze the data. Findings from these single case studies were presented as professional commentary.

Appendix IV: List of study findings with illustrations

Carlsson *et al.*[26]	
Finding 1	The informed bystander: those benefits that they perceived to be related to their professional experience were; knowing the healthcare system and how to navigate the system, possessing knowledge that facilitated their understanding of the patient's illness and the communication with staff about the patient's test results and medical state, as well as about what plans were made for the patient
Illustration	"What I appreciated very much – I asked lots of questions, it's important to me to know how it looks, how is the ECG? Is it an MI or only angina, or what is happening? … So, I phoned the Emergency Department direct and could talk to a nurse, and I said, 'It's me, Anna – we know one another, we work together every day – my Dad has just arrived in the ED, how is he?' It was really fine to get an immediate response. And she told me, 'The ECG looks like this and the test results are like that', and I don't think she would have told that to a general relative. But, she chose this track immediately, she chose to tell me about those very important medical findings, and then she asked, 'Do you want to talk to the doctor in charge?'"[26(p.54)]
Finding 2	The supervisor: this way of understanding was focused on monitoring the patient's medical status, test results and nursing care while staying in the background
Illustration	"I talked to him [the fiance] and said, 'You really have to tell them, or I'll do it!' And then he did, and they [the staff] became more active about his diabetes, his blood sugar tests and so. Without me nagging about that, I think they were a bit off-handed, but I watched over them and made things happen …. Well, I told him over and over again 'If you don't talk to them, I will!' It was obvious that when I pushed and he asked the right questions – then, things happened."[26(p.55)]
Finding 3	The advocate: the informants who understood being a family member of a hospitalized patient as being an advocate of the patient
Illustration	"So, he was placed in this room, he had to stay in the ward where he didn't want to be – his lungs were the problem and they belonged to that ward. And he couldn't go home … and it was hard to say, 'You should terminate the cancer treatment', like that. They [healthcare staff] were so careful and, like respectful, you know. But he got just worse and worse and he had no energy, so I thought, I'll have to ask for a talk with the resident, and ask him, 'Since he [the father] can't go home, and since he's not going to have any more treatment – well, this is a ward for cancer treatment, there must be somewhere else for him to be, a hospice ward or something'."[26(p.56)]
Finding 4	The carer: the informants' descriptions focused on how they not only monitored the medical status of their loved ones and took over communication with ward staff as well as the coordination of care, but also that they were forced to take over much of the care, both in hospital and at home

Illustration	"I am trained to observe and monitor patients' vital signs, that's what I'm there for [at work]; observe and tell nurses or doctors when there is a change … I could see her puff and I thought, 'She will develop pulmonary edema'. So I said, 'You would need one of those pipes'. Well, I went to my ward for a pipe so that she could do her breathing exercises. On Monday, the resident in charge praised me for having started the exercise. She asked if the physiotherapist had prescribed the pipe. 'No, it was Mum', my daughter said! And I felt a bit embarrassed."[26(p.56)]
Giles and Williamson[23]	
Finding 1	Dual role conflicts: Nurse-FMs experienced a conflict between wanting to hide and wanting to reveal their RN status
Illustration	"I didn't mind they knew I was a registered nurse but during a family meeting I was asked if I was and of course I said I was, and after that the staff would always say 'oh are you the nurse?'. [It] made me feel that I was often the topic of conversation at hand-over when I was actually there as a sister and medical and legal guardian."[23(p.7)]
Finding 2	Wanting acknowledgement of specialized knowledge: nurse-FMs believed their specialized knowledge made them different to general-public-FMs, and wanted their knowledge acknowledged and respected by staff
Illustration	"We like more information and want to be included when possible. Respecting the increased amount of knowledge that we have vs. the general public is important."[23(p.7)]
Finding 3	Wanting specialized communication: nurse-FMs highlighted the need for specialized communication that took into consideration previous knowledge and skills
Illustration	"We should be given more time for explanation because we need more depth and have more questions than most other people who would simply accept what was going on and the treatment offered."[23(p.8)]
Finding 4	Keeping watch and advocating: nurse-FMs felt compelled to watch over and advocate for their FM, fearful that care would deteriorate in their absence
Illustration	"The weeks during his stay when his care was appalling were very difficult as I did not want to be 'over reacting' but could not tolerate what was happening. When expressing my concern to people I was labelled as 'anxious' and 'stressed'—both true and real but hardly the reason for expecting my husband to be kept clean, dry and warm, let alone covered and dignified in front of strangers."[23(p.8)]
Finding 5	Stepping in on numerous occasions to ensure their FM received adequate nursing care, believing their specialized knowledge and skills prevented significant deterioration in the patient's condition
Illustration	"Many times I had to be there to request basic care, notice when he was deteriorating and feed and keep him clean …. Thankfully my own abilities possibly saved him from deteriorating further … I was not prepared to sit back and watch the appalling care my husband received … [he] would not have made the progress he has without the input my knowledge added …. He had to have someone to keep him safe."[23(p.8)]

Finding 6	Expectations placed on self: nurse-FMs actively nursed both their own FM and other patients in the vicinity
Illustration	The obligation they felt to provide this care, and the added pressure they felt to maintain control, lest everything "fall apart"[23(p.9)]
Finding 7	Family member expectations: nurse-FMs also felt under considerable pressure from the patient and other family members to play a particular role.
Illustration	"I was more anxious and worried than other family members and this was reinforced when they tended to rely on me to make decisions for them all …. Other family members relied on me but I did not want to be in control or responsible for decisions."[23(p.9)]
Finding 8	Staff expectations: nurse-FMs felt pressured by staff to undertake tasks that would not be expected from a general-public-FM
Illustration	"When I visited they hardly came near my father and I felt they were leaving me to attend to the care. In the end I was distant to [my father] as I felt all care was being left to me … I wanted to be me and not a nurse …. It was difficult to see what was happening with my knowledge and wanting to 'hide' as my [father] was dying, but having to keep him in bed, make sure the IV wasn't pulled out etc. Not my job!!! The topic of me doing the care should have been dis-cussed. Some people may want to do it, others not."[23(p.9)]
Finding 9	Specialized knowledge amplifying emotions: the impact of nurse-FMs specialized knowledge on their emotional state
Illustration	"Just that situation of being emotionally involved, and trying to make decisions on behalf of the family. [It was] very difficult to be professional and play RN professional role …. The knowledge and experience is still there—but the emotion is stronger I think—that's what I found difficult. Regardless of my knowledge it was very hard to be on the other side of the care … I was not scared by the ventilators, could help with suction etc. but it was my dad on that bed and it scared the hell out of me."[23(p.9)]
Finding 10	Emotion vs intellect: they stressed the importance of staff recognizing both the FM-self and the nurse-self to provide effective care and support
Illustration	"It is the opinion of everyone else that nurses who are family members should know all about what is going on. Yet people forget that we are human too and when it is your family it is different, often you can't shut off as easily from the emotions as you do when you are at work. We also need that medical jargon conversation as that satisfies the working nurse in us and the knowledge side. Once that side is sorted we can then … be the support for the family member who is sick."[23(p.9)]
Ledwidge[24]	
Finding 1	Disclosure unnecessary: participants did not generally want or expect to take over the nursing of their parent. They expected the hospital staff to nurse their parent
Illustration	"People know their job. What are you hoping to achieve by telling staff you're an RN? That they're going to look after your father better? Aren't they already doing the best job they can? The implication in telling people you're an RN is that they'd better watch out because you're watching them. It's just not necessary."[24(p.96)]

Finding 2	Rather be treated as a lay son/daughter: staff would treat them differently and that they would be disadvantaged by disclosing their RN status so they preferred to be treated as a lay son or daughter rather than as a RN
Illustration	"... because I think it does make the other registered nurses uncomfortable. Sometimes you could tell that they looked at you and you thought ohhh. I think that registered nurses are a bit sort of hesitant. It's like when you go in as a registered nurse [as a patient] and people know you're a registered nurse I think you either get under-cared for or you get over-cared for big time. I don't think there's a happy medium."[24(p.100)]
Finding 3	Disclosing to be treated as a peer/colleague: advised staff of RN status to be recognized as a peer/colleague
Illustration	"So many of the registered nurses knew me so we got treated differently: more intimately, we got more information, we got involved in different ways ... I remember when I worked with them – when they were students because I had a rapport with them – so this rapport just bubbled in."[24(p.110)]
Finding 4	Disclosing to get action: the need to advise staff of their RN status to gain added power to intervene in a way that was as influential as possible and resulted in getting their parent the care and attention they needed
Illustration	"As Mum was dying from cancer it was horrible. She went in for a palliative ileostomy and I wanted her home as soon as possible. After surgery care was ordinary and staff at one stage even taped the bag on with Elastoplast. Every lunch time and tea-time I would arrive and her legs would be dangling in a recliner and her bag would have leaked all over her. I would change her and clean her up and elevate her legs that were very swollen. After 2 days of this it was time to let staff know. They even referred Mum to the stomal therapist. She ordered appropriate bags that didn't leak and Mum's legs were always elevated. Until they found out that I was an RN the staff had told my aunty that it was normal for stoma bags to leak."[24(p.116)]
Finding 5	Leading and staying strong at any cost: being the eldest child was an important factor in relation to taking a leading role
Illustration	"Fundamentally that comes about because I'm the eldest of six. I'm the only nurse. There is a medical doctor but he was not in the state at the time when things first happened. I'm also very close to both my father and my mother and because this was an experience for my father, my mother needed a lot of support so for those reasons I got pulled in and was the main support for both of them."[24(p.132)]
Finding 6	Expertly observing, detecting and protecting: being vigilant served a number of purposes.
Illustration	"Dad was hospitalized in the hospital where I trained, so the environment was very familiar to me. I think the experience is much less foreign if you are an RN. You understand what the bedside charts mean .... You also become quite critical of the deficiencies of the public hospital system."[24(p.145)]
Finding 7	Being adept at hospital language: the RN-on-standby understood hospital talk and could interpret it for the family

Illustration	"The rest of the family needed me to interpret the language that the doctors and nurses were using – the staff could not seem to explain anything easily in layman's terms – thank god I could or confusion would have been greater. (My brother) was listening and being very polite to the doctors and nurses and then as they'd walk out the room sometimes he'd cross his eyes and say 'what the heck was that'?"[24(p.151)]
Finding 8	Keeping it real: providing reality grounding: at times participants spoke up to correct the family's misguided ideas about the parent's prognosis or expectations of improvement and this sometimes challenged family members who were in denial, or dramatically altered or shattered the family's hopes of the parent's recovery, and at times resulted in conflict between the participant and family members
Illustration	"I just very quietly would say don't get your hopes up too high just expect that things aren't going to be good. But just very quietly and comfortingly really … because … I knew that if I were to say yes she'd be ok then they'd literally take my word for it and it would have been devastating for them to have discovered that she wasn't going to be ok. And because they trust my word so much I couldn't pretend that things would be ok but at the same time I had to be very gentle and not direct and really well I'm sorry this is it sort of thing. So just tried to soften it by saying look don't get your hopes up too much just try to think the worst because then that way if something else happens well it's a bonus."[24(p.153)]
Finding 9	Filling in gaps: over-stepping boundaries and gender differences: overstepped the usual child-parent boundaries and this intruded on the parent's privacy and led to feeling uncomfortable
Illustration	"When (the nurse) arrived I assisted her to change my father because he had been slightly incontinent when she was putting the syringe driver in and I regret that I had done that because Dad was a very, very private person and he would have hated me doing that … and it's just something that I think about now and again and I just wished I hadn't done it because he wouldn't have liked me doing it. I think she should have asked for one of the other nurses to come and help her not me. It was her request and it was a spontaneous thing and I just did it without thinking – and I can remember thinking – we were finishing the task and I was thinking – oh I wished I hadn't done that – I just thought it was invading his privacy in a way that I don't think he would have liked."[24(p.156)]
Finding 10	Being the fixer and fixing: intervene in the management of care
Illustration	"I wrote an official complaint but nothing … they phoned and said 'we're sorry about the loss of your mother but we felt we did everything we possibly could and perhaps you might have been affected because you were too close to you mother' … I thought oh no."[24(p.157)]
Lines *et al.*[25]	
Finding 1	Specialized knowledge: nurse-parents found themselves in a unique position where they possessed not only an intimate knowledge of their child's personality, idiosyncrasies and medical history, but also considerable nursing knowledge and expertise. However, they were quick to acknowledge the limits of their knowledge, which was generally linked to their clinical specialty

Illustration	"I certainly felt comfortable saying ... you don't need to speak that basic, or that's a little bit too complex."[25(p.13)]
Finding 2	Evaluating care: nurse-parents were aware of general standards of care expected in the hospital setting and often compared their child's care to the nursing care they would ordinarily provide
Illustration	"I had requested about three times for ... a medical review and ... they [nursing staff] would come back and say 'well we've spoken to him [the doctor] on the phone and ... he said she's okay and ... we'll give her a bit more pain relief'."[25(p.15)]
Finding 3	Personal impact of child's hospitalization: describing overall unpleasant experiences
Illustration	"He [son] couldn't cry because ... of the tube in his throat ... it was heart-breaking, and ... I was in tears, it was horrible."[25(p.15)]
McNamara[13]	
Finding 1	A nurse's nightmare describes unexpected intense emotions experienced by ICU nurses when a family member is admitted, critically ill, to an ICU
Illustration	"I know that feeling of utter helplessness, it's that fear, it's that fear that is so persuasive ... I think you underestimate the absolute fear that you're actually related to everything."[13(p.26)]
Finding 2	Knowing and not knowing: Alongside knowing, not knowing also caused feelings of anxiety and stress. Not knowing what was happening while sitting in the waiting room and not having answers for relatives created feelings of frustration and powerlessness
Illustration	"I was scared ... it was just that there was that nurse part of me that maybe added to that personal role that actually kept me from panic ... I'd be panicking about something and thinking .... Don't be ridiculous this is how it would normally go ...."[13(p.29)]
Finding 3	Feeling torn: the nurse as relative cannot simply switch off the nurse in her being. Inextricable connections mean that she cannot act as a detached family member
Illustration	"... I wanted to be watching his monitor because we can watch the monitors from theatre, and then part of me said: 'Look, I might even go and sit in the gallery' ... I mean totally illogical sort of things you wouldn't allow family members to do normally. Part of me wanted to do that but the family side of me said I had to go home and be with my family ...."[13(p.30)]
Finding 4	Gaining deeper insight and new meaning: the insights have also provided their practice with new meaning
Illustration	"... I would regard it as probably quite a pivotal turning point for me. I have started to maybe question things a lot more ... I do a far better family handover ... I have a deeper understanding of relatives and it has changed my reaction to them quite a bit. It was a huge eye opener to me just ... seeing the way things happened and seeing it from the other side ...."[13(p.35)]

Mills and Aubeeluck[4]	
Finding 1	Quality of life: as a consequence of caring for their family member, they had experienced a negative impact on their quality of life
Illustration	"He never made me feel bad for it, but you're trying to please everyone, you're trying to give everyone a bit of you and you can't. Our own needs got really pushed down to the bottom of the needs of others."[4(p.161)]
Finding 2	Personal and professional boundaries: as a consequence of being a nurse and family member, they had to deal with the difficult issue of boundaries
Illustration	"It confidentiality was an issue for me throughout. The confidentiality had been broken initially, so until she gave me permission to talk to her doctors about her, I didn't. I had ample opportunities to break her confidentiality. I could have looked on the Trust's computer system, I could have spoken to the doctors specifically about her and I chose not to and I was very strong about that."[4(p.162)]
Finding 3	Disempowerment: all had experienced some dissatisfaction in the delivery of care and of the responses to their own needs
Illustration	"You know the holes in the system, you know everything that could've gone wrong, did go wrong and I felt I just, I fought his corner constantly."[4(p.162)]
Salmond[6]	
Finding 1	Heightened emotional turmoil: They pictured different scenarios of what might happen and what might go wrong as they dealt with the present and projected ahead to "what ifs."
Illustration	"At times it was like no matter what they said to me, I could not feel comfortable and confident that everything was going to work out. I kept thinking of the 'what ifs . . .' and kept wishing I did not know anything so I could just go in there and sit by the bedside and just be supportive. Knowing made it much harder."[6(p.14)]
Finding 2	Required to be "in-charge": outwardly they wore a mask so that they appeared in control
Illustration	"Oh my God, it was the scariest time of my life. But I couldn't, I wouldn't let them [family members] know how concerned I was. They looked to me for their hope and I did not want to diminish that."[6(p.14)]
Finding 3	Surveillance and protection: Vigilant observation was the key to surveillance and protection
Illustration	"They were phenomenal. They never questioned any-thing about whether I should be there beside him. I was part of the team. They shared details, gave me real information. It allowed me to be in control."[6(p.15)]
Finding 4	Gaining information and seeking meaning: Nurse family members intentionally built relationships to facilitate acquisition of detailed information and explanation of the meaning of this information
Illustration	"I was insisting on seeing every blood test, to know every vital sign. The nurses were wonderful. They gave me a short course on all the new technology in the ICU. They interacted with me knowing I was a nurse and not an average daughter sitting at the bedside."[6(p.15)]

Finding 5	Advocating for: advocacy occurred with or without collaboration; however patient and family needs were best served when collaboration existed
Illustration	"I came in in the morning. They told me he was unstable. I started asking questions, his blood gas, his pH was like 7.0. I was like 'what,' he's going to code. You need to do this, you need to do that . . . I wasn't trying to manage the situation but I knew what needed to be done and I had to be sure everything was being done."[6(p.16)]
Finding 6	Resuming family roles: development of trust was pivotal to managing the challenge of resuming family roles
Illustration	"By staying with her I witnessed the competence of the nursing staff. They communicated what they were doing, what they were finding, what they would do. They were there when I interacted with the physician requesting that care be changed. It made me feel safe. I could act like her mother for a while instead of the nurse in charge. Then I would come back to being the nurse in control."[6(p.16)]

How Healthcare professionals experiences of having a significant other admitted to an acute care facility: a qualitative systematic review

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Keywords

Healthcare professionals; significant others; nurse-family member; experiences; acute care.

Introduction

In an acute care hospital, direct patient care is not only provided by healthcare professionals, but also by patients' significant others. Significant others are described as assuming the roles of informal carers.[1] This may involve providing both physical and psychological support such as providing assistance with bathing and feeding as well as being emotionally supportive. The need for a significant other's presence alongside a loved one is well-documented in the literature.[2] Therefore, healthcare professionals must provide care for patients while also addressing the needs and emotional states of significant others.

Having a healthcare professional who is a significant other may create challenges in meeting the needs of the patient and the other family members. Researchers have explored the experiences of healthcare professionals who are also significant others; they determined that these healthcare professionals' experiences are very different from the experiences of significant others who are non-healthcare professionals.[3-9] In other cases, staff members excluded nurse family members from the process of care. These experiences are unique and challenging for both healthcare professionals and family members.

Aim/ Review question

The objective of this review was to synthesize the qualitative evidence regarding the life experiences of healthcare professionals when their significant others are admitted to an acute-care hospital.
Specifically, the review addresses the following research question: what are the experiences of healthcare professionals as significant others to hospitalized loved ones in an acute-care facility?

Methodology

Inclusion Criteria
Types of participants
This review considered studies that include registered nurses and physicians who reported their experience as a significant other when a relative was admitted to an acute care facility.
Phenomena of interest
This review considered studies that explored the experience of healthcare professionals when a significant other is admitted to an acute care facility.
Context
The review considered research conducted in any acute care facility.
Types of studies
This review considered qualitative studies that have examined the phenomena of interest including, but were not limited to, research designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

Search strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was utilized in this review. An initial search of PubMed and CINAHL was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Thirdly, the reference list of all identified reports and articles was searched for additional studies. Only studies published in English were considered for inclusion in this review. There was no date restrictions. The databases searched included: PubMed, CINAHL, PsycINFO, and Embase. The search for unpublished studies included: Google Scholar, ProQuest Dissertations and Theses, and Trove. Databases were searched on the 01-05 February 2016.

Methodological quality

Qualitative papers selected for retrieval were assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI).[10]

Data extraction

Qualitative data was extracted from papers included in the review using the standardized data extraction tool from JBI-QARI.[10]

Data synthesis

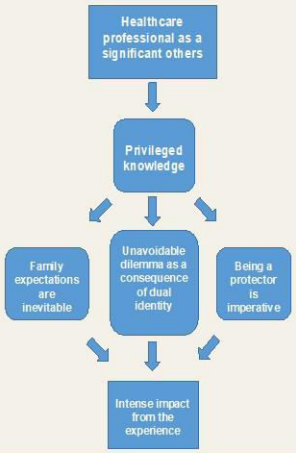
The data were synthesized using the Joanna Briggs Institute approach to meta-synthesis by meta-aggregation using the JBI-QARI software and methods.[10]

Results

Following critical appraisal seven studies were included in the review. Forty findings were extracted and aggregated to create ten categories, and five synthesised findings were derived from these categories. The synthesized findings were:

1. Privileged knowledge
2. Unavoidable dilemmas as a consequence of dual identity
3. Being a protector is imperative
4. Family expectations are inevitable
5. The intense impact of the experience

Figure 1: Model depicting the experiences of healthcare professionals as significant others to hospitalised loved ones in acute care settings and the impact from the experience.



Conclusion

The qualitative systematic review produced a synthesis of a number of moderate quality studies that explored the experiences of healthcare professionals as significant others to hospitalized loved ones in acute care settings. In difference to 'lay' family members, health professionals possess additional knowledge and understanding that alters their perceptions and expectations and the expectations others have of them. Good communication about their expectations and needs is a logical step in reducing the impact on these individuals when a loved one is acutely ill.

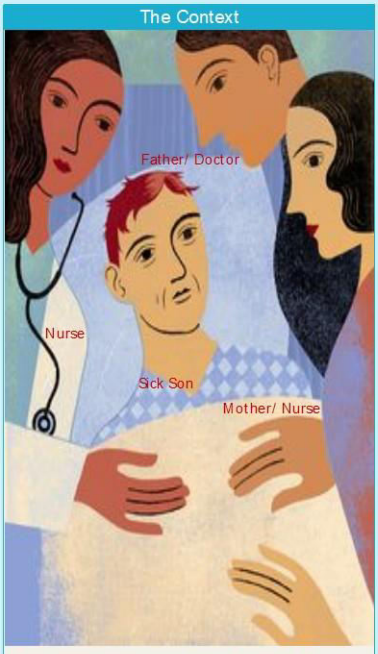
Implications for practice

The needs and expectations of all family members should be considered by staff but when that family member is a healthcare professional there are some additional considerations. The knowledge that a healthcare professional possesses can be advantageous because they may have a deeper and more detailed understanding of the patient's history and condition but this must not be assumed. Healthcare professionals may or may not want to disclose their professional identity to staff and this should be respected. Depending on the context relatives of any kind can play a role in providing some care to their loved one but when health professionals are involved staff should be conscious of the boundaries between personal and professional care and ensure that care provided by the health professional family member is negotiated and appropriate. Finally when dealing with a family member who is a healthcare professional staff should be aware that the knowledge that person possesses may amplify the impact of the situation.

Implications for research

This review identified that research has been particularly focused on the experience of nurses and in particular registered nurses. A broader population sample should be considered to include clinicians from other disciplines. It would also be useful to consider the experience of staff when dealing with healthcare professional family members. It is noted that most of participants of the included research were female participants. Further research exploring the experiences of male healthcare professionals in this situation will promote an understanding from a gender perspective. Finally, in this review the participants from one study reported the impact of the phenomenon on their professional practice. Therefore, further research is needed to explore how the experiences may influence professional practice.

The Context



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A survey of how nurses respond when their loved ones admitted to an acute care hospital

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Background and Aims

When a nurse who is a member of the family of someone admitted to an acute care setting, particular challenges may be created in meeting the needs of the patient and the other family members. While some nurses support the nurse-family member receiving different care as compared to lay-family member, other nurses exclude nurse-family members from the process of care.

The aim of this study was to explore the opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital and to identify the contributing factors. It was expected that the outcomes of this study would provide nurses with a better understanding of current information about the experiences of nurses when their relatives are hospitalised. This may be used within the health care system to a clinical practice policy.

Study question

'What are the opinions of nurses regarding their experiences when their ill loved one is admitted to an acute care hospital?'

Methodology

A descriptive cross-sectional design was performed among nurses using an online survey as a data gathering instrument. Nurses of hospitals within South Australia were the study population. Survey data were collected by using a mixed type of questionnaire and descriptive statistics were used for analysis and the results presented using tables and figures.

Results

Of the of 700 nurses from one metropolitan and one country hospital were invited to participate in the survey, 116 responded (17%). Most respondents indicated that they had experienced two to three instances of having family members hospitalised in acute care hospitals. Parents were identified as the most significant category of relationship: 87 (39.9%) of the respondents chose this option (Figure 1).The medical/surgical area was selected as representing the main category of admission by 81 (78.6%) of the respondents (Table 1).

The 5-point Likert scale of agreement and frequency as perceived by the nurses was used for 46 items which are grouped under six categories (Table 2). Most respondents strongly agreed or agreed that their nursing knowledge influenced their role as nurse-family member (Figure 2). They stated that this knowledge put them in a better position to judge the quality of care their loved ones were receiving but also made them different from other relatives.

The findings of the survey further showed that nurses with more years of practice have higher expectations to be the primary advocate for others than nurses with fewer years of nursing experience. Lastly, most respondents stated that they rarely or never felt that being recognised as a nurse impeded them from providing effective support to their ill family members.

Figure 1: Types of relationship with the patient/s (multi-select items)

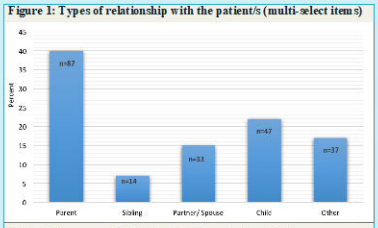


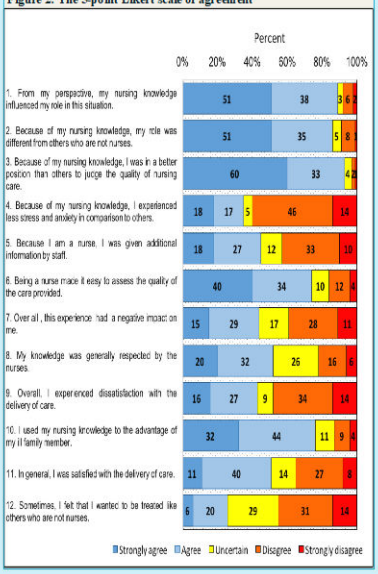
Table 1: The area of admission for the majority of their stay

Category	Frequency	Percent (%)
Medical/Surgical	81	78.6
Critical care	17	16.5
Palliative Care	3	2.9
Mental health	1	1.0
Emergency	1	1.0
Total	103	100

Table 2: The six categories

Category	Number of respondents	Number of Items	Possible Range	Actual Range	Mean (SD)	Cronbach's alpha
*Nurses' Knowledge**	97	8	8-40	8-34	17.49 (4.88)	.703
*Satisfaction with care**	97	3	3-15	3-15	8.38 (3.17)	.884
Ability to evaluate care	100	2	2-10	2-10	3.57 (1.60)	.502
Different Expectations on Nurses	96	12	12-60	15-59	33.94 (9.42)	.876
Self-impact	96	14	14-70	25-65	42.71 (7.25)	.700
*Relationship with staff**	94	6	6-30	10-30	20.18 (4.16)	.595

Figure 2: The 5-point Likert scale of agreement



The Context

Implications for practice

- It is essential that health care providers not assume that all nurse-family members desire the same level of information that is provided to lay-family members. Because of their nursing knowledge, nurse-family members want to be treated like a nurse by health care providers to gain information about their loved ones' care.
- Health care providers need to understand that nurse-family members may experience stress and anxiety which may be of value in providing quality health care.

Implications for research

- Future research could focus on the experiences of nurse-family members working in a setting where they are known to the staff.
- Research into the experiences of nursing staff assigned to patients whose family members are nurses.
- The experiences of patients whose family members are nurses may be of value.

Conclusion

Nurse-family members perceive their experiences to be different from those of lay-family members. The majority of the respondents were older nurses with several years of experience and some were working in management roles, which put them in control of the care delivered at their workplace.

This experience often led nurses to demand specialised care for their ill loved ones. Nurse-family members expressed that, in the context of care, they want to be identified and treated as nurses rather than just family members.

Acknowledgements

- Study participants
- Staff of both hospitals
- Suzanne Edwards, Statistician
- Adelaide Nursing School Staff
- Human Research Ethics Committee

‘Oh, that's fine. I'm a nurse too’: The experiences of nursing staff in general wards caring for adult patients who have a family member who is a nurse

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THE UNIVERSITY of ADELAIDE

Keywords

Nurse-family member; Acute care hospital, Phenomenological Study

Background and Aims

In the general ward area, nursing staff will often communicate and consult with family members in many aspects of patient care. However, when those family members are also nurses, a unique and challenging situation may present. An increased awareness of these situations and the dynamics they create may help nursing staff to develop trusting and confident relationships, not only with the patient but also the nurse-family member.

The purpose of this study was to gain an understanding of the experiences of nursing staff working in general wards when caring for adult patients whose family members are nurses.

Study question

‘What are the experiences of nursing staff caring for adult patients whose family members are nurses in a general ward?’

Methodology

Exploring the essence of how nurses deal with adult patients whose family members are nurses in a general ward and what it meant to them reflects a concern of the life world. To achieve this, it was important to use an open question, in keeping with a hermeneutic phenomenological approach.

The study was conducted at the Adelaide Nursing School at the University of Adelaide. The study participants were Registered Nurses working in non-critical care areas and who were completing postgraduate studies.

The inclusion criteria for this study were as follows: nurses employed at an acute care hospital in a general ward who had experienced caring for an adult patient who had a family member who was a nurse within 24 months. Nurses were excluded from the study if they worked exclusively in critical care areas.

Results

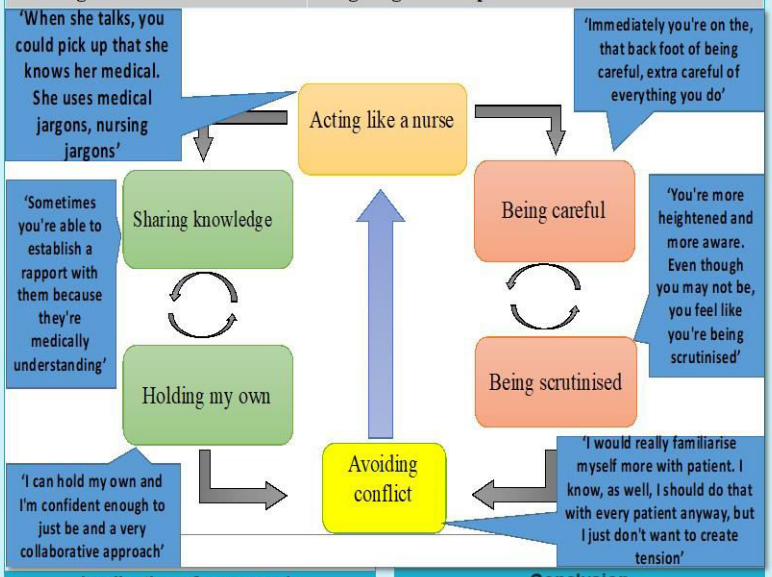
A total of five nursing staff were interviewed and their answers generated rich and descriptive data that illustrated their lived experiences. Although the results cannot be generalised, this study offers insights into the experiences of nursing staff working in clinical practice, particularly in general wards.

Significant quotes were grouped into twelve subthemes. The twelve subthemes were shaped and further merged into six main themes that became the basis of the reported findings (See table and figure).

Implications for practice

To provide a support resource to nursing staff on how to deal with nurse-family members in case of conflicts. Conflict resolution is usually accomplished using problem-solving tools, such as involving the manager and other health care professional teams, including social worker and counsellors.

Main Themes	Subthemes
Acting like a nurse	Identifying as a nurse
	Process of identifying role
Being careful	Being on guard
	Can be combative
	Rising conflict
Being scrutinised	Feeling worried of being judged
Sharing knowledge	Recognising their knowledge
	Enabling rapport
Holding my own	Being comfortable with practice
Avoiding conflict	Being diligent with patient care



Implications for research

Future studies could include a survey to explore the prevalence of nursing staff experience in encountering nurse-family members during an ill loved one’s admission to an acute care hospital.

A qualitative study of patients’ experience of having a nurse-family member would be helpful in adding comprehensive knowledge to the study.

A comparative study between family member groups (lay-family members and health care professional family members) to examine the differences between support of patients’ family members and improvement in the quality of patient care is needed.

Acknowledgements

- Study participants
- Adelaide Nursing School Staff
- Human Research Ethics Committee

Conclusion

Nursing staff experience a unique situation when discovering that a patient’s family member is a nurse.

Caring for patients with nurse-family members requires different approaches that nursing staff needs to consider to manage and support nurse-family members in caring for their ill loved ones. Because of nurse-family members’ specialised knowledge, nursing staff members are encouraged to conduct free dialogue with nurse-family members in relation to not only the care provided to ill loved ones but also knowledge sharing to build a rapport with nurse-family members.

This dialogue may include the expectations nurse-family members have of nursing staff and the level of participation and level of control nurse-family members have over their ill loved ones’ care.

Portfolio Appendix VI

Who am I? Brother or Nurse

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University of Adelaide

Who am I? Brother or Nurse

University of Adelaide

THE UNIVERSITY of ADELAIDE

When a patient's family member is a nurse

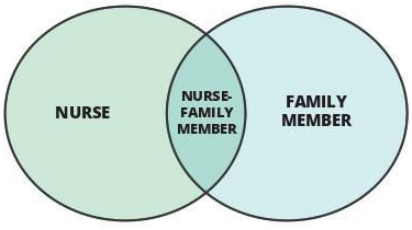
PORTFOLIO FACT SHEET

The purpose of this portfolio fact sheet is to summarise the best available evidence about the experiences of nurses when their family members have been admitted to an acute hospital and those of nurses caring for a patient whose family member is a nurse.

WHAT ARE THE KEY CONSIDERATIONS?

Having a relative admitted to hospital is usually a stressful and difficult time. With the meeting of two dynamic sets of responsibilities, family and professional. The term 'nurse-family member' denotes a double identity. It may be inevitable that they participate in their loved ones' care. Indeed, the phenomenon of dual responsibilities varies and is complex when family members are also nursing staff within an acute care hospital.

The research presented in this fact sheet investigated the experiences of nurses whose family members have been hospitalised and examined the experience of caring for a patient whose family member is a nurse. It also offers an insight to the experiences and needs faced by nurses as family members. This fact sheet offers recommendations for practice based on current evidence that may inform regarding the support required for both nurses and the family members.



DEFINITIONS

For the purposes of this portfolio fact sheet the following definitions are used:

Family member is a person who belongs to a (particular) family; a (close) relative.

A **nurse** is a person who has completed a program of basic, generalised nursing education and is authorised by the appropriate regulatory authority to practice nursing in his/her country. In Australia, nurses are also designated as registered nurse, enrolled nurse, and nurse practitioner.

Nurse-family member is a member of the family of the ill patient who is a nurse.

An **acute care hospital** is an inpatient care facility that provides necessary treatment for a disease or severe episode of illness for a short period of time, with the goal of discharging patients as soon as they are stable, they may also offer out-patient services.

REFERENCES

Study 1: Experiences of Healthcare professionals of having their significant other admitted to an acute care facility: Qualitative Systematic Review.

Study 2: The opinions of nurses regarding their experiences when their ill loved ones were admitted to an acute care hospital: Quantitative Study.

Study 3: The experiences of nurses in general wards caring for adult patients who have a family member who is a nurse: Qualitative Study.

PROJECT STAFF

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WHAT IS THE CURRENT EVIDENCE?

1

For any individual, the experience of having a family member with an acute illness can be an anxious or even a distressing experience. When that individual is a nurse, there is added complexity to the experience. This arises from the professional knowledge nurses possess. As a consequence, the nurse the dual identity of being a relative and a nurse may bring an unavoidable dilemma. In addition, their privileged knowledge brings inevitable expectations from other family members but also their own expectations of using their knowledge to protect their loved one. Consequent ly, these experiences have an intense impact on nurses both personally and potentially on their own practice. (Study 1)

'We like more information and want to be included when possible. ***Respecting the increased amount*** *of knowledge that we have vs. the* ***general public is important.'***

Study 1
Cited in Giles & Williamson2015, p. 7

2

In most developed nations the population is ageing and as a resu lt, the nursing workforce is also ageing. This means that nurses are more likely to have a fami ly member hospitalised. These nurses are generally experienced nurses and have established expectations of the healthcar e service which is often coupled a personal responsibility for their hospita lised ill relatives. It is a common experience among nurses to accompany their loved ones during hospitalisation . This may potentia lly impact on factors including, communication with staff, role conflict and expect ations of care provided. While some nurses expressed satisfact ion with care provided to their ill loved ones, others stressed that they were unhappy with some aspects of car e. (Study 2)

'As a Clinical Nurse I am confident ***with making clinical decisions and*** *changes to patient care. I felt that nurses were following established patterns of care rather than* ***providing care individualised to*** *changing clinical signs.'*

Study 2
Participant No. 112

3

Although hospital policies address the issue of supporting lay-family members, there is no clear information on managing nurse-fami ly members along with their ill loved ones. In daily practice, there existed a level of tension when nurses manage lay-family members, but there may be even more pressure when the fami ly member is a nurse. This is due to nurse-family members' specialised knowledge, which causes nurses to be on guard during delivery of care. Caring for patients with nurse-family members requires different approaches by nurses to manage and support nurse-family members in caring for their ill loved ones. This provides the benefit of promoting pre-existing know ledge regarding nursing care and enabling a rapport between nurses and nurse-family members, optimising the relationship and creating partnership in the care provided. (Study 3)

'So it sometimes can go either way. *You can get them as a mediator or they can be off guard straight away because they are a nurse and their mom needs to be taken care of the best. I don't like ward very much, but it can be, you hope that they're* ***a nice person because it can be very combative.'***

Study 3
Participant No. 3

IMPLEMENTING EVIDENCE INTO PRACTICE

HOSPITAL SUPPORT

Hospital administrators must be cognizant that healthcare providers need to be able to use all the information and resources available, not only to improve the quality of care but also to provide sufficient support to all family members. Providing hospital support for both nursing staff and nurse-family members has the potential to improve the quality of care provided. It is vital that supports are created to help not only nurses with their dual roles but also healthcare professionals who deal with the nurse-family member to meet their needs and of those of their ill loved ones.

SUGGESTIONS

Hospital administ ration should develop a communication model for **nurses to use when dealing with the nurse-family member about their** expectations, dual roles and resources available when needed. For **example, it is recommend the nurses introduce themselves to the** patient and family members.

Hospital administrators shou ld identify during staff orientation the support availab le when nurses are required to deal with both lay family members and nurse-family members. Incl uding how their professional ro le is impacte d during the care provided.

Hospital educators should conduct an annual review of the current prevalence of nurses having ill family members hospitalised. This is to evaluate the available support and create additional strategies based **on the outcome.**

Hospital policy makers should collaborate to identify the ways in which nurse-family member gets involved in the care of their ill loved one (e.g. medication administ ration).

PROFESSIONAL SUPPORT

Creating professional support for nurses with dual roles will help facil itate the care provided to their ill loved one. There additional **issues which must be considered by nurses who deal with a nurse-**family member require in order to provide adequate support as compared to other family members. However, staff should be conscious of the boundaries between personal and professional care and ensure that care provided by the nurse-family member is safe and app ropriate (for example desired by the patient).

SUGGESTIONS

To acknowledge the presence and contributions of the nurse -family **members, nursing staff should treat a nurse-family member as a nurse which includes communication, evaluation of care and advocacy.**

Nurses should adopt an open dialogue with nurse-fa mily members to understand their role within the family relationship to avoid conflict. For example, adhering to a pract ic e of introducing oneself to the family at the beginning of a shift.

Nurses are encouraged to build a rapport with nurse-family members in relation to care provided to ill loved ones specifically, during their involvement with care . They could ask nurse-family members to discuss the negotiated level of involvement with the care (e.g. showering, feeding).

In a conflict situat ion, it is suggested that a conflict resolution process is undertaken which may involve the wider multidisciplinary team **such as a manager, social worker and counsellors.**