

The Lived Experience of Nursing Severe Burns Injury Patients A Phenomenological Inquiry

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**A thesis submitted for the degree of Masters of Nursing Science of the University of
Adelaide, South Australia**



School of Population Health & Clinical Practice

Faculty of Health Sciences

Discipline of Clinical Nursing

October 2009

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DECLARATION

The University of Adelaide

This work contains no material which has been accepted for the award of any other degree or diploma 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.

I give consent to this copy of my thesis, where deposited in the Discipline Library, being available for loan and photocopying.

Signed:

Dated: 17th of September 2009.

ACKNOWLEDGEMENT

As a devoted mother of three young children and a doting wife, writing this thesis has been challenging at times. However, it has been my passion for burns nursing that has been the driving force behind this project although, this academic journey would not have been possible if it were not for the support of family members and numerous friends. Without the acknowledgement of those individuals who have encouraged and assisted me throughout this journey, this thesis would not be complete and I would like to thank them all for allowing me this opportunity.

Firstly, I would like to thank my parents Elizabeth and the late Thomas Kornhaber for all the years that they have supported me in my education. My wonderful husband and friend of 11 years Hilary Nissenbaum, for putting up with ironing, washing and research papers consuming all rooms of our house for the entire duration of this project. My mother in – law Celina Nissenbaum, for all those times she looked after the children at a moment’s notice. Thanks to my three children Thomas, Rebecca and Joshua for being patient and at times not so patient with me throughout the writing of this dissertation. I dare not forget to mention my pseudo step father Geoff Scott who remained positive throughout the research project.

I want to express my gratitude to my principal supervisor Dr Anne Wilson, for her undying support, patience and tolerance over not only the past year but also in the previous year leading up to my Masters dissertation. I am heartily thankful to her, whose encouragement, guidance and support from the initial to the final level enabled me to complete this thesis. I would especially want to thank Dr Anne Wilson for assisting me through the very challenging times during the data analysis process, giving me encouragement when all was lost and for fielding my hundreds of questions at a moment’s notice throughout the entire year. Also I would like to thank my co-

supervisor Associate Professor Rodney Baber, his positive encouragement and in put during the proposal stage was invaluable and with providing assistance in numerous ways throughout. I am also grateful to Associate Professor Rodney Baber and his secretary Coral Anderson for their patience throughout. I am grateful for the assistance of Dr Loyola McLean for her assistance with the methodology and during the data analysis stage whilst having all my three children in her office and popcorn strewn all over the floor, I thank her. I am grateful for the assistance of Frank Donnelly for his guidance with writing the chapter on the methodology of phenomenology. I must mention the assistance of Dr Jacqueline Baker for her assistance during the data analysis process and for steering me in the right direction when I charted off course.

To my two comrades and colleagues Julia Philips and Agnes Wroblewski at the Douglas Piper Library for assisting me with literature searching and often at a moment's notice however, having a laugh along the way. I must in addition say that I am eternally grateful to Julia Philips for her patience and assistance with teaching me the referencing programme EndNote and with formatting the final document in preparation for examination. I wish to thank Gina all the way from Paris, France for her assistance with analysing and organising the data at Little Hartley and that cold, cold day in my kitchen sorting through the data cards.

I would also like to thank the NSW Burns Injury Service, the Director of the Severe Burns Injury Unit at Royal North Shore Hospital Dr John Vandervord and the Nursing Unit Manager of the Severe Burns Injury Unit Di Elfleet, for their support throughout the project. I direct a special thanks to all the seven participants and I would like to acknowledge all the many people who have contributed to the formation of this thesis even if they have not been personally identified in the above acknowledgement. Finally, my hearty gratitude goes again to Hilary, my husband for his eternal patience.

ABSTRACT

Little nursing research has focused on nurses' experiences of nursing severe burns injury patients. This study has provided a gateway to explore, describe and document the experience of nursing severe burns injury patients. This thereby adds to the existing body of nursing knowledge upon which the nursing care of patients with severe burns injury can be made in an informative manner with confidence.

This descriptive phenomenological study describes the lived experiences of seven full time registered nurses that care for patients who have sustained a severe burns injury. The descriptive phenomenology of Husserl and the methodological interpretations of Colaizzi underpin this study. Purposeful sampling was utilised to select participants who work in a severe burns injury unit in New South Wales, Australia. The use of in-depth interviews was used to generate data about the participants' personal and professional experiences' of nursing severe burns injury patients. The interviews were transcribed verbatim, analysed and described using a descriptive phenomenological methodology.

Twenty eight cluster themes emerged from the participants' experiences which were further merged into nine emergent themes that depicted the experiences of nurses caring for severe burns injury patients which formed the basis of the findings reported. Participants described burns nursing as both physically and emotionally demanding yet rewarding. It was shown that burns nurses have a resilient nature with the ability to cope with the challenges of burns nursing. Participant nurses described how they emotionally detached and became hardened to the devastation of a severe burns injury. The unique bond that formed between burns nurses and their patients' demonstrated a relationship embedded in trust and understanding that allowed the

nurse to continue caring for burns patients for extended periods. Commitment and dedication were found to be fundamental elements for nursing burns patients. Participant nurses were found to feel emotionally exhausted, powerless and burnt out; however, feelings of accomplishment and motivation outweighed these negative emotions. Support and unity was identified as fundamental to burns nursing, without the support of the burns team nurse participants believed that they would not be able to care for patients with severe burns injury.

The findings of this study have provided an insight into the experience of nursing severe burns injury patients. It is hoped that the findings of this study will contribute to the care of burns patients and the well being of the burns nurses who care for these patients. The paucity of available literature in the area of burns nursing concludes that more research is required into the impact of nursing severe burns injury patients.

CHAPTER ONE

INTRODUCTION

Introduction

There is limited information that explores the experiences of burns nurses caring for severely burnt patients. The evidence found was mainly anecdotal and or empirical, with evidence of rigorous studies conducted in the area of burns scarce (Lewis, Poppe, Twomey & Peltier 1990; Nagy 1998).

The current study utilises a phenomenological methodology to investigate the lived experience of those nursing severe burns injury patients. The study provides a rich description capturing the essence of the phenomena through the lived experience of nurses who have, in their own eyes experienced the challenges and dilemmas of nursing severely burnt patients. Nurses and other health professionals working in the area of trauma and burns injury may profit from this study through learning from the experiences of those nurses portrayed within this research. Through greater understanding, nurses can better assist themselves and patients through the burns recovery journey.

Statement of research problem

Nurses are more likely to be exposed to human suffering than other health professionals. Chronic exposure in this occupational environment has implications for nurses' health and well being (Cronin 2001; Murji, Gomez, Knighton & Fish 2006; Nagy 1998). It is well documented that burns nurses experience many occupational stressors working with severe burns injury patients (Cronin 2001; Murji et al. 2006; Sutton 1993). However, little has been published on actual stressors experienced by burns nurses. Murji et al. (2006) suggested that burns staff experience low levels of emotional exhaustion and experience high levels of personal accomplishment.

Although, Cronin (2001) stated that it is necessary to acknowledge that emotional exhaustion has widespread consequences on the nursing profession. Furthermore, Cronin (2001) suggested that nurses do not deal with their emotions adequately because of time constraints and a lack of opportunity to do so and stressed the need for nurses to reflect on their personal experiences.

Burns nursing has been described as both emotionally challenging and confronting (Badger 2001; Cronin 2001; Lewis et al. 1990; Steenkamp & van de Merwe 1998). Clinical settings such as burns units are stressful occupational environments in which burns staff are in need of emotional and clinical support (Rafi, Oskouie & Nikravesheh 2007). Murji et al. (2006), suggested that chronic occupational stressors have resulted in emotional exhaustion, depersonalisation and reduced self esteem. Burns nurses are continually exposed to patients who suffer for extended periods of time (Nagy 1998). Exposure to patients' pain and disfigurement has resulted in emotional distress and desensitisation to pain, having implications for both the care of the patient and the nurses' well being (Cronin 2001; Murji et al. 2006; Nagy 1999). Yet, there is little support available for nurses addressing the issue of how to manage emotions as a result of performing painful procedures on burns patients (Nagy 1999).

Purpose of study

The purpose of this descriptive phenomenological study was to explore the nurses' lived experience of caring for severe burns injury patients; articulate these experiences and to make recommendations for further practice and research. This was achieved through interviews with seven burns nurses who work full time in a burns unit in Sydney, Australia.

Objectives of study

1. To explore and describe the lived experience of burns nurses who care for patients with traumatic burns injury.

2. To identify stressors and strategies used by burns nurses to cope with negative traumatic events in relation to patient care.
3. To describe the level of commitment and motivation displayed by burns nurses.
4. To identify the psychological and sociological needs of nurses working with patients who have sustained a severe burns injury.

Significance of the current study

Nursing literature over the last several years has begun to describe the nurses' perspective within the clinical setting. However, there still remains limited information that addresses the nurses' perspective of their experiences (Drury 2001). As technology advances, more patients are surviving major burns injuries in which the dilemmas faced by burns nurses are becoming more prevalent (Camhi & Cohn 2007). This current study will contribute to the growing literature of nurses' perspective by focusing on the lived experience of burns nurses with the intention of providing an improved understanding of the effects of exposure to traumatic burns injury on nursing staff. The outcomes of this research can assist in how support for burns nurses and other members of the burns team is delivered in particular new staff members such as those new to the area of burns and new graduate nurses.

It is hoped that an understanding of the lived experience of burns nurses presented in this thesis, may potentially benefit nurses and other health professionals within the domain of burns and similar clinical settings to understand and reflect on their own personal thoughts, feelings and experiences when faced with the physical and emotional demands of a traumatic injury. Nurses need to be aware of how their reactions to a patient's traumatic condition are perceived by the patient, their family and the greater community (Drury 2001). The manner in which nurses are affected by burns trauma is likely to influence the delivery and quality of care the patient receives (Nagy 1998). The findings of the reported study will provide for improved understanding of the dynamics of nursing acute burns patients, assist in instigating the necessary support for nursing staff and in turn ultimately improve the quality of care

for the patient in line with current best evidence based practice.

Assumptions

It is essential that the researcher identify biases, assumptions and preconceptions related to the phenomenon. This enables the researcher to be able to bracket these assumptions and let the text reveal itself engaging in the experience without preconceived notions (Gadamer, Weinsheimer & Marshall 2004). This provides the researcher with the means of reducing the chance of imposing existing assumptions and preconceptions on the study and therefore influencing the outcome. Streubert and Carpenter (2007) claim that bracketing is critical if the researcher is to impart the participant's viewpoint of the phenomena under investigation. The assumptions and preconceptions evident below originated from the researcher own experiences in the field of acute burns nursing. However, it is important to acknowledge that these assumptions and preconceptions may be experienced by nurses across all areas of nursing practice.

1. Burns nurses are a very unique group of people within the nursing profession.
2. Nurses working in an acute care burns unit have a personality trait of hardiness.
3. Most experienced burns nurses become desensitised to the patient's pain.
4. Burns nurses do not experience a high level of burnout.

Summary of thesis

The thesis presented provides a comprehensive report of the research inquiry in six chapters. The introduction, literature review and methodology chapters frame the research providing the background and design. The research analysis and findings are presented in chapters four and five as a descriptive phenomenological account of the lived experiences of acute care burns nurses working in a severe burns injury unit. The final chapter provides an in depth discussion of the findings and the significance to clinical practice, limitations of the study and presents recommendations for further

investigations arising from this thesis.

Chapter one: The introduction of the thesis provides a statement of the research problem, purpose and objectives of the study, significance of the research and underlying assumptions.

Chapter two: Provides an analysis of the literature regarding experiences of burns nurses, including nurses' experience of pain and pain infliction, psychosocial functioning including stressors, coping strategies and burnout. The review highlights gaps in previous research and demonstrates how the reported study relates to previous studies.

Chapter three: This chapter introduces phenomenology as a methodology used in qualitative research. The philosophical assumptions that underpin the methodology utilised in this study are discussed. An overview of phenomenology and the two main fields of phenomenological research Husserlian (descriptive) and Heideggerian (interpretive) are presented. Descriptive phenomenology provides the philosophical and methodological framework for this study aimed at describing and gaining a rich understanding of the experiences nursing severe burns injury patients.

Chapter four: The methods chapter provides the research strategies utilised in this study. This chapter discusses the sample population, recruitment of participants, ethical considerations, data collection and analysis. The issues of methodological rigor and trustworthiness are addressed in this chapter.

Chapter five: The chapter presents the findings, which involves the participants' experiences of nursing severe burns injury patients. This chapter gives an overview of formulated meanings, cluster themes and emergent themes that emerged from the

data. The focus of this chapter is the exploration of how each emergent theme is supported by the participants' experiences. The emergent themes which emerged from the data were: Virtues of burns nurses, powerlessness, unique bonds, resilience, the necessity for support and unity, burnout, traumatic caring, making meaning and job satisfaction.

Chapter six: This final chapter is the concluding chapter which discusses the findings confirming and opposing results with the available literature and in addition presenting new knowledge that has emerged from the study. This is then followed by the limitations of the study. This chapter considers the significance of the study and makes recommendations for future research into experiences of nursing severe burns injury patients.

Appendices: Contains the recruitment letter, Department of Psychological Medicine endorsement letter, participant information sheet, consent form, interview questions, extracts from an interview, examples of coded significant statements, coded formulated meanings extracted from coded significant statements pertaining to the objectives of the study and the emergence of cluster themes and emergent themes.

Summary of chapter

Chapter one of the thesis introduces the research inquiry and utilisation of a descriptive phenomenological methodology providing a rich and deep understanding of the lived experience of the seven burns nurses presented in the study. The chapter presents the research problem, purpose of the study with specific objectives identified and the significance of the study. Assumptions and preconceptions underlying the study have been identified and listed. A summary of the content of all the chapters of the thesis was provided. The following chapter is the literature review, discussing the available literature in relation to this area of research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The purpose of this literature review was to establish what research had been conducted in order to determine the gaps in knowledge and other inconsistencies within the literature. In doing so it assisted with the development of arguments to justify the necessity of the phenomenological study and to establish the importance of the topic. The literature focused on stressors, coping strategies and burnout among burns nurses. However, the bulk of literature was centred on nurses' perceptions of pain and experiences of pain infliction. The aim of the literature review was to clearly demonstrate how this thesis related to previous studies and has become a link in the chain of research that has developed knowledge in the area of burns nursing. An online search primarily focused on electronic data bases that included Journals @ OVID, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO and MEDLINE. The searches conducted were limited to literature in the English language pertaining to adult burn units only. Due to the limited amount of literature published on nurses' perspective of burns nursing, no publication time frame was placed on the literature search in order to capture a greater scope of papers and in addition, grey literature was accessed such as theses.

Nurses' experience of pain and pain infliction

Inflicting pain and discomfort is unfortunately an inevitable part of everyday nursing for many nurses, especially those who work in acute care settings such as burn units (Madjar 1999a; Nagy 1999). Moreover, it is the nursing profession that is exposed to patients' pain and suffering more than any other health professional (Nagy 1998). In particular, due to the traumatic nature of the injury and burns care practices, nursing severely burnt patients involves infliction of severe pain for extended periods of time more often than other areas of nursing (Brack, LaClave & Campbell 1987; Heidrich,

Perry & Amand 1981; Nagy 1998, 1999). Heidrich, Perry and Amand's (1981) investigation of nursing staffs' attitudes about burn pain, identified burns nurses as a unique group of nurses due to the severely painful and often traumatic burns procedures performed on a daily basis by the nursing staff. Most of the literature regarding infliction of pain on patients in general and within the realm of burns is scant with a majority of the literature published prior to 1999 (Brack, LaClave & Campbell 1987; Heidrich, Perry & Amand 1981; Nagy 1998; Sandroff 1983). Two quantitative studies in particular utilised questionnaires to assess nursing staffs' attitudes about pain (Brack, LaClave & Campbell 1987; Heidrich, Perry & Amand 1981). However, investigating the lived experience of nursing severe burns injury patients lends itself to a qualitative methodology in order to capture the essence of the phenomenon, the essential meaning that gives understanding to the lived experience of nursing severe burns injury patients. Both Nagy (1998, 1999) and Madjar (1999a, 1999b) explored nurses' experience of pain infliction on patients. However, of recent times, few studies have addressed burns nurses' emotional responses to not only pain infliction but also the physical, emotional and psychological impact on nurses who care for patients with severe burns injury. The exploration of these 'lived experiences' is crucial in understanding how the experiences affect nurses in their occupational environment and other aspects of their life. As such the reported investigation sought to capture and explore these experiences, identifying themes and pertinent issues that have an impact on nurses working with acute care burns injury patients.

Using a small sample size utilising both quantitative and qualitative methods Nagy (1998) compared the effects of patients' pain on burns and neonatal nurses. Nagy's (1998) findings demonstrated considerably higher anxiety regarding patients' pain compared with neonatal nurses, inferring that pain was a significant source of anxiety for burn nurses. Despite the anxiety experienced by burns nurses in Nagy's (1998) study, it was shown that burn nurses "demonstrated a greater sense of personal competence and control" (p, 339) compared to neonatal nurses in relation to patient care. However, Nagy (1998) did not make any correlation between both the length of time in nursing and burns nursing in relation to anxiety scores although this data was collected. Furthermore, data was collected on the educational status of nurses yet no

correlation was made between anxiety scores and level of education. Iafrati's (1986) investigation of burn nurses' perception of patients' pain demonstrated significant correlation in regard to length of time in both nursing and burns nursing and the level of education.

Nurses and medical officers are seen as contributing to the welfare of the patient by relieving pain and suffering rather than contributing to their pain. It is ironic that a core role of nursing is related to the relief of pain and suffering, and yet, nurses delivering care often inflict pain upon their patients. Brack, LaClave and Campbell (1987) stated that burns nurses are often in a paradoxical position in that the aim is to save the patient's life, nonetheless, burns nurses had feelings of hopelessness where the patient's death was the preferred option. Madjar (1999a) suggested that nurses cannot feel the pain they inflict on their patients both in the physical and emotional sense, therefore this allows them to conduct painful procedures. Furthermore, Madjar (1999a) found that patients' traumatic reaction and experience to pain was problematic for nurses eliciting stressful reactions. Surprisingly, pain control practices such as inhalation analgesia, patient controlled analgesia (PCA) and continuous infusions of narcotics, have been referred to as not practical involving considerable risk for the patient (Madjar 1999a), yet these practices are an integral part of burns pain management practices today (Faucher & Furukawa 2006; MacPherson, Woods & Penfold 2008; Smita 2004).

Psychosocial functioning: stressors and coping strategies among burn nurses

The literature on psychosocial functioning of nurses contains considerable discussion and debate addressing occupational stress and coping strategies of registered nurses within the healthcare setting. However, there remains little literature that addresses the psychosocial functioning of nurses working in a burns unit. The available literature mostly utilised questionnaires and surveys from a small sample size (Brack, LaClave & Campbell 1987; Lewis et al. 1990; Murji et al. 2006; Steenkamp & van de Merwe

1998; Von Baeyer & Krause 1983). Although these quantitative studies highlighted sources of stress and anxiety and identified coping strategies within the burns unit environment, these studies did not explore the subjective experience, meanings and beliefs of the phenomenon of burns nursing which serves as a rich source of knowledge. Cronin's (2001) hermeneutic inquiry of five nurses working on a burns unit provides a rich insight into how nurses deal with their emotions highlighting the importance of nurses addressing their emotions and the inadequacy of formal support services. Cronin (2001) suggested the necessity of formal and informal support for nurses caring for burns patients, with the need for further research in similar clinical environments. The reported study endeavours to investigate the lived experience of nursing severe burns injury patients identifying psychological and sociological needs, stressors and strategies used by burns nurses to cope and describe the level of commitment and motivation displayed by burns nurses.

A study conducted by Lewis et al. (1990) investigated stressors and coping strategies among burns unit nurses, and identified the following as the most stressful factors experienced:

- Pain and infliction of pain.
- Inappropriate behaviour from patients.
- Complex critical patients.
- Abuse and neglect of patients.
- Mortalities.
- Conflicts with the medical team.

The nurses in Lewis et al.'s (1990) study conveyed that occupational stressors affected their personal home life in which irritability, preoccupation, impatience and fatigue were identified as manifestations of stress. Lewis et al. (1990) also investigated anxiety levels of nursing staff and found that 59 percent of nurses expressed that they occasionally experienced anxiety prior to the commencement of their shift. This anxiety manifested itself in the form of sleep disturbances, stomach

pains, headaches, moodiness and fatigue. In contrast, Steenkamp and van de Merwe (1998) investigated the psychosocial functioning of nurses in a burns unit, which surprisingly found that the only sources of stress that held any significance were heavy patient workloads and insufficient remuneration. Hall (2004), who researched occupational stress of nurses in the hospital setting, also found that sources of stress that contribute to negative emotions included both workload issues and poor pay that was not commensurate with nurses' responsibilities. It is interesting to note in the study conducted by Steenkamp and van de Merwe (1998), that no correlation was found between the age of the nurse or years of nursing experience and nurses' psychosocial functioning. Although, Tyler and Ellison's (1994) study illustrated that nurses with post graduate qualifications were observed to have greater levels of stress. In addition, Von Baeyer and Krause's (1983) investigation of the effectiveness of stress management training for nurses working in a burns unit, found that experienced burn nurses encountered significantly greater levels of stress compared with their inexperienced colleagues. Furthermore, nurses with very little experience in the field of general nursing benefited considerably more from training provided than nurses with greater nursing experience. Remarkably, disfigurement of burn patients was not mentioned in the literature as a source of stress or anxiety for burns nurses. Hirsch (1982) suggested that disfigurement of patients becomes accepted as normal in which nurses look past the disfigurement and behave as if it was the norm. This may be as a result of desensitisation among nurses who are regularly exposed to gross disfigurement. However, societal views are far from accepting, responding to disfigurement in a negative manner (Robinson, Rumsey & Partridge 1996; Sainsbury 2009). In fact, McGrouther (1997) a prominent professor of plastic surgery from Wythenshawe Hospital, Manchester in the United Kingdom, stated that facial disfigurement was "the last bastion of discrimination" (p. 991).

Coping strategies used by burns nurses have been identified by a few authors. Steenkamp and van de Merwe's (1998) study found that teamwork, good working relations, talking to co-workers and maintaining a sense of humour, were the most frequently used strategies to cope with stress associated with the work environment in which these findings are supported by other authors (Boyle, Grap, Young & Thornby

1991; Lewis et al. 1990; Murji et al. 2006). Moreover, nurses in both Steenkamp and van de Merwe's (1998) and Lewis et al.'s (1990) studies identified teamwork as the burn's unit greatest asset. Nonetheless, Nagy (1999) conveyed that there is a need for social support and demonstrated in her study that support was not always available when required most. In contrast to Steenkamp and van de Merwe (1998), both Lewis et al. (1990) and Murji et al. (2006) reported that 53 percent and 52 percent of nurses respectively, stated exercise after work was an effective coping mechanism.

Nagy's (1999) qualitative study utilising content analysis to identify strategies used by burns nurses to cope with the infliction of pain on patients, identified four emerging themes: distancing oneself, engaging with the pain, social support and reconstruction of the nurse's core role. It was found that 94 percent of nurses reported distancing as a strategy employed to cope with pain infliction on patients. Nagy (1999) stated that placing an emotional distance between the nurse and the pain experienced by the patient, reduces the impact felt by the nurses without denying the reality of pain. However, in doing so, this desensitised the nurses to both the patients' pain and needs (Nagy 1999). Camhi and Cohn (2007) also reported emotional distancing as an emerging theme used as a barrier for clear thinking. In contrast, 59 percent of nurses in Nagy's (1999) study utilised engagement as a coping strategy, focusing on the patients' pain in order to assist in pain control which in turn increased nurses satisfaction towards their work. The concept of reconstruction of the nurse's core role in Nagy's (1999) study seems to take on a fatalistic attitude in which 19 percent of nurses coped by accepting that there was no alternative but finding ways to come to terms with the circumstances at hand. Mannon (1985) suggested that nurses reframe patients' problems by viewing problems as a symptom related to treatment. This was found to be successful in improving nurses' attitudes towards their work and environment.

It is apparent from the evidence presented, that stress and anxiety have an influence on the psychosocial functioning of nurses. This requires a deeper understanding in order to assist burns staff to cope with the arduous task of burns care and will

ultimately benefit, both the nurse and patient. The research study reported in this thesis demonstrates how a phenomenological study offers a greater insight into the lived experiences of burn nurses.

Burnout and hardiness among burn nurses

Although burnout has been studied across a broad range of occupations within the health profession, there is a lack of research regarding the phenomena of burnout and hardiness in burns unit staff. The majority of the literature examined, utilised standardised measures to quantify stressors and coping strategies. Moreover, instruments used to measure burnout and hardiness was varied across the literature, therefore this made a comparison between these studies difficult.

According to Kobasa (1982) hardiness is a constellation of personality traits characterised by a high level of personal control, commitment, and challenge in responding to events of daily life. As yet there is no accepted definition of burnout (Gustafsson, Persson, Eriksson, Norberg & Strandberg 2009), however, most authors agree that burnout is a concept to describe stress that includes physical, emotional and mental exhaustion, as a result of exposure to emotionally demanding situations for extended periods (Hallsten 2005).

Murji et al.'s (2006) investigation of burnout using the Maslach Burnout Inventory, found a majority of burns unit personnel did not experience emotional exhaustion. In fact, 75 percent of burns staff in this study experienced low levels of depersonalisation compared with the critical care unit staff at 49 percent. In addition, burns unit staff were found to have high levels of personal accomplishment which is consistent with the findings of both Steenkamp and van de Merwe (1998) and Sahraian, Fazelzadeh, Mehdizadeh and Toobae (2008). However, Balevre (2001) found that nurses who have high demands for perfection and control, set expectations that are considered unrealistic leading to frustration, stress and burnout. It was

interesting to note, that nurses who were single reported higher levels of emotional exhaustion compared to their counterparts who were in personal relationships (Sahraian et al. 2008). Furthermore, Maslach and Jackson (1985) found that staff who were married or had children, experienced less burnout in the work place.

Nurses' personality traits and patients' characteristics have been linked to the phenomena of burnout. Rafi, Oskouie and Nikraves's (2007) research identified that nurses' and patients' characteristics alter the nurses' responses to burnout. Toscano and Ponterdolph (1998) postulated that nurses who display characteristics of submissiveness, unassertiveness, anxiety, fear and overloaded, are more likely to experience burnout. Yet, Toscano and Ponterdolph (1998) found no correlation between the personality trait of hardiness and burnout in the critical care setting. In contrast, Wright, Blanche, Ralph and Luterman's (1992) investigation using the Tedium burnout scale to assess hardiness, stress and burnout in the intensive care settings in which 23 percent of the sample was from a burns centre, found that nurses who displayed greater levels of hardiness demonstrated lower levels of burnout. Conversely, those who were found to have low levels of hardiness displayed high levels of burnout. However, Wright et al. (1992) found no correlation between stress and burnout in relation to demographic data collected. DePew, Gordon, Yoder and Goodwin (1999) replicated the study by Wright et al. (1992) researching the relationship of burnout, stress and hardiness in nurses, discovered that the burns unit nurses experienced the most burnout and lowest hardiness score with the second highest score for stress. Interestingly, DePew et al. (1999) found that nurses who had been working for more years displayed lower hardiness and greater burnout. In addition, hardiness was found not to be a buffer in the stress burnout relationship which was in contrast with Wright et al.'s (1992) findings that claimed hardiness was a buffer in stress burnout relationships. Topf's (1989) findings also did not show support for stress buffering the effects of hardiness although, postulated that hardiness was predictive of stress and burnout in nurses.

While examination of burnout and hardiness was difficult due to differing measurements used, the literature regarding burns nurses appears to support the notion that burns nurses experience high levels of personal accomplishment and low levels of depersonalisation. However, research on hardiness and burnout produced conflicting results requiring clarification. A qualitative perspective is necessary to obtain a greater understanding of the subjective experience of nurses' emotions regarding burnout and hardiness.

Summary of chapter

The literature reviewed brought to light the paucity of research directly related to the experience of burns nurses. This has been emphasised by the lack of data that exists to explain the experiences of nurses dealing with severe burns trauma. However, reviewing the literature in a broader context has highlighted several real and perceived challenges that exist for burns nurses in relation to the infliction of pain and nurses' experience of patients' pain.

The literature suggests that significant challenges exist for the nurse working in the area of burns injury. The literature review identified that the psychosocial functioning and needs of those caring for severe burns injury patients, has not been adequately explored. There is a need for a well executed study investigating the effects of nursing severe burns injury patients and the needs of these nurses. The results of this study will add to nursing's body of knowledge and provide recommendations for health care professionals benefiting both nurses and patients within their care. The research will further investigate the phenomena of burns nursing by describing the lived experiences of seven nurses who provided care to burns patients and their emotional journey and challenges they experienced. The following chapter is a discussion of the research methodology, phenomenology, which is the framework within which this study is situated.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter introduces the qualitative research method of descriptive phenomenology, as the methodology that underpins this study. Phenomenology is recognised as an appropriate approach to the study of human phenomena and its importance to the discipline of nursing. Two prominent leaders in phenomenology both Husserl (positivist) and Heidegger (interpretivist) are examined showing differing perspectives of phenomenology. Justifications for the use of Husserl's phenomenology as the applicable framework for this research are discussed.

Phenomenology

The philosophical movement of phenomenology and its origins date back to Greek philosophy. The word phenomenology is made up of two Greek words *phainómenon* and *lógos*. The word *phainómenon* is derived from the Greek verb meaning to show oneself and *lógos* meaning thought or concept (Moran 2000). The rise of phenomenology as a philosophical method of research was seen in Europe approximately in or around about the first decade of the 20th century (Barkway 2001; Streubert & Carpenter 2007). The founder of the phenomenological movement is acknowledged as Edmund Husserl, a German philosopher and mathematician with epistemological goals (Dowling 2007). Phenomenology has become widely held within the domain of nursing research (Dowling 2007) with contemporary nurse researchers embracing phenomenological methodology in research (Barkway 2001).

Phenomenological research is centered on the investigation of the description of the lived experience. It is a process where one learns and constructs meaning of the human experience through the discourse of those that are living the experience

(Streubert & Carpenter 2007). Spiegelberg (1975) an American philosopher who made significant contributions to the phenomenological movement in America, stated that phenomenology is:

...the name for a philosophical movement whose primary objective was the direct investigation and description of phenomena consciously experienced, without theories about their casual explanation and as free as possible from unexamined preconceptions and presuppositions (p. 3).

Merleau-Ponty a French phenomenological philosopher believed that a phenomenological and methodological approach contributed greater insight into understanding. Merleau-Ponty thought that the human existence is filled with personal experience with perception being the pivotal access to the human experience (Morse 1994). Merleau-Ponty (1962, p. 7) described phenomenology as:

...a transcendental philosophy which places in abeyance the assertions arising out of the natural attitude, the better to understand them: but it is also a philosophy for which the world is always “already there” before reflection begins – as an inalienable presence; and all its efforts are concentrated upon re-achieving a direct and primitive contact with the world, and endowing that contact with philosophical status. It is the search for a philosophy which shall be a “rigorous science,” but it also offers an account of space, time and the world as we “live” them. It tries to give a direct description of our experiences as it is, without taking account of its psychological origins and the

causal explanations which the scientist, the historian or the sociologist may be able to provide.

The goal of phenomenology is to gain a deeper understanding of the everyday experiences with its central focus being the lived experience of the world within everyday life (Priest 2002; Streubert & Carpenter 2007). It is the lived experiences which are not open to an empirical approach, therefore a phenomenological methodology is utilised to capture and reveal how people experience the world in which they live (Rapport & Wainwright 2006). Within healthcare, researchers have embraced phenomenology as a way to examine, explore, describe and understand the human experience (Caelli 2000). Phenomenology is seen as an important methodology for understanding the nurse's experience. The goal of phenomenology research is to attain a deeper understanding of the participants' everyday experiences (Broussard 2006). Therefore a phenomenological methodology is suited to the reported research for this approach is valuable and effective in the investigation and description of all phenomena, in the way the phenomenon appears. It is expected that the nurses participating in the reported study will recount these perceptions when describing their lived experiences of nursing severely burnt patients.

Descriptive and interpretive phenomenology

The two main schools of phenomenological research evident within nursing research include descriptive and interpretive phenomenology (Bradbury - Jones, Sambrook & Irvine 2008). These methodologies are underpinned by the phenomenologists, Husserl (descriptive) and Heidegger (interpretive) (Bradbury - Jones, Sambrook & Irvine 2008; Rapport & Wainwright 2006). There are two significant differences between Husserlian and Heideggerian phenomenological methodology. The Husserlian approach concentrates on an epistemological inquiry (the study of knowledge) and a Heideggerian approach concentrates on ontological inquiry (study of being). Koch (1995) stated that there are distinct differences between Husserlian transcendental and Heideggerian hermeneutic phenomenology which have implications for the

methodology that is utilised. The following is an appraisal of the philosophical underpinnings of both Husserl's and Heidegger's phenomenological methodologies.

Husserl's phenomenology

Husserl's philosophical ideals gave rise to descriptive phenomenology and played a part in the departure of positivism and brought inspiration to the methodology of social science (Schultz & Cobb-Stevens 2004). Husserl was concerned with the essence of consciousness emphasising the description of a person's lived experiences that is free of interpretation. Husserl believed that consciousness was the path to the material world in which all knowledge was a result of experience (Priest 2002). Husserl's approach aims to bring understanding to phenomena in everyday life, with the investigation of people's experiences (Secret 2007) utilising a rigorous scientific methodology in order to answer questions related to "how do we know it"? (Bradbury - Jones, Sambrook & Irvine 2008, p. 664). Husserl proposed that the truth can be found in the study of human experience. This is attributed to the meanings which humans assign to their existence and this is the essence of living (Roberts & Taylor 1998).

Husserl's descriptive (eidetic) phenomenological methodology suggests there are three core elements these being essence, intuiting and phenomenological reduction.

Essences

The word essence is derived from the Greek *ousia*, meaning the inner essential nature of a thing and the true being of a thing (van Manen 2000). An essence is purely the core meaning of any given phenomenon that makes it what it is, in which these concepts give understanding to the phenomena researched (Streubert & Carpenter 2007). Natanson (1973, p. 14) suggested that "essences are unities of meaning intended by different individuals in the same acts or by the same individuals in different acts". Essences therefore represent the real nature of phenomenon studied

(Lopez & Willis 2004). Phenomenological research identifies the essence of a phenomenon and truthfully describes it through the lived experience (Rose, Beeby & Parker 1995).

It is the essence of the phenomenon that the researcher is attempting to extract in which the essence of the experiences has been referred to by Polit and Hungler (1993) as the “lived-in” experience. In the current study it is the “lived-in” experience of the nurses which is the goal of this thesis. In the reported study, the purpose was to establish the experience of how nurses working in a burns unit care for burns patients, uncovering how the nurses identified themselves within the world they live in order to understand the lived experience of nurses caring for severe burns injury patients. Therefore this study seeks to identify the essence of caring for severe burns injury patients.

Intuiting

Intuiting is the process whereby one comes to know the phenomenon by the descriptions provided by the participants. Streubert and Carpenter (2007) state that intuiting is “an eidetic comprehension or accurate interpretation of what is meant in the description of the phenomenon under investigation” (p. 79) resulting in a common understanding. Drew (2004) suggested that Husserl intended the meaning of intuiting to be an “all-at-once grasp” (p. 217) of its meaning.

Streubert and Carpenter (2007) suggested that intuiting requires the researchers to imaginatively modify the data until a common thread appears. It is through the imaginative variation of the data, the researcher begins to gain an understanding of the phenomena in relation to the descriptions that are generated (Streubert & Carpenter 2007). The researcher is required to view the phenomenon under investigation as it is described; as free as possible of presuppositions and in an unprejudiced manner so the phenomenon can present itself with an accurate description to be understood (Seamon

2000). Intuiting occurs through deep contemplation and rigid adherence to the meanings of the phenomena as by the descriptions of the participants in order to grasp the uniqueness of the phenomenon researched (Parse 2001). Through intuiting, the researcher expects to experience insight in which the phenomenon is seen with deeper clarity.

Phenomenological reduction

Phenomenological reduction is a key epistemological approach of phenomenology (Dowling 2007). It is the suspension of ones' beliefs, assumptions, preconceptions and biases related to the phenomenon that is under investigation, in which the phenomena can be seen with a fresh approach (Streubert & Carpenter 2007). Phenomenological reduction is achieved through bracketing or otherwise known as epoché, a Greek term, which describes the suspension of judgment. This is a fundamental concept to Husserlian philosophy which ensures a trustworthy description of the phenomenon (Sadala & Adorno 2002). It is through phenomenological reduction that patterns of meanings and themes begin to emerge allowing the exploration of the phenomenon exactly how they are experienced (Rapport & Wainwright 2006). Husserl (1970) described the process of phenomenological reduction as being off the ground and looking down upon the world with great clarity stating that:

It is from this very ground that I have freed myself through the epoché; I stand above the world, which has now become for me, in a quite peculiar sense, a phenomenon. (p. 152).

Bracketing is an important method of phenomenology within phenomenological nursing research today (Norwood 2000) and is utilised as a skill in nursing research providing scientific rigor. However, Walters (1995) suggested that nurse researchers

often associate bracketing with phenomenology in general, despite the philosophical framework in which it fits. It is the researcher and not the participants who engage in bracketing, for it is the participants' natural attitude the researcher is attempting to understand (Giorgi 2000). Bracketing an experience is not to change it but to leave it exactly as it is. The aim of phenomenological reduction (bracketing) is to isolate the pure phenomenon from what the researcher already knows about the phenomenon; however, this is only possible when the researcher remains void of any preconceptions (Streubert & Carpenter 2007).

Heidegger's phenomenology

Heidegger, a student and colleague of Husserl was influenced by the teachings of Husserl. However, Heidegger altered and developed Husserl's work challenging some of the assumptions on how phenomenology guided meaningful research (Lopez & Willis 2004). Heidegger's phenomenology is the basis of interpretive or hermeneutic phenomenological inquiry. Hermeneutic is derived from the Greek word Hermes, who was the Greek messenger from the Gods to the humans (Thompson 1990). Hermeneutics is an ontological approach that seeks the meanings of a phenomenon in order to understand the human experience (Crist & Tanner 2003). Heidegger did not agree with Husserl's view of the importance of the description, rather, Heidegger was interested in the understanding (Racher 2003) in which he sought to provide meanings that are embedded in everyday life (Lopez & Willis 2004).

Heidegger's primary interest was the notion of *being* in which Heidegger used the German verb *Dasein* meaning 'being in the world' (Bradbury - Jones, Sambrook & Irvine 2008) in order to refer to the way humans exist and act in the world (van Manen 1990). Heidegger disagreed with Husserl's notion of bracketing, Heidegger believed that it was impossible to divest the mind of prior preconceptions and knowledge (LeVasseur 2003), in fact Geanellos (2000) suggested that hermeneutic phenomenologists see personal knowledge as valuable and a necessity to phenomenological research. Bracketing is an untenable process in hermeneutic

phenomenology, however, making preconceptions clear and describing how this will be utilised in the research is an aspect of hermeneutic phenomenology (Lopez & Willis 2004).

Husserl's descriptive phenomenology as a research methodology

It is vital to articulate which methodological approach will guide the study and the philosophical assumptions that underpin the research. Lopez and Willis (2004) state that a lack of clarity regarding the study's methodology, often creates difficulty in understanding how the knowledge and data from the study, is to be assessed and utilised.

The research presented in this thesis utilised the Husserlian transcendental (descriptive) phenomenological methodology. This method involves the "direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation" (Spiegelberg 1975, p. 3). As such, this is a descriptive study investigating the lived experience of nurses caring for severe burns injury patients. A Husserlian approach was adopted and considered to be the best framework with which to conduct the research and answer the questions that are relevant to the research.

The selection of a descriptive phenomenological methodology was based on the study conducted by Gunther and Thomas (2006). The authors explored similar phenomena to what is explored within this thesis utilising a descriptive phenomenological methodology based on the philosophical perspectives of Husserl. This allowed the researchers to gain a rich and deeper understanding of the lived experiences of nurses caring for trauma patients from several clinical specialities. Gunther and Thomas (2006) conducted a study to explore nurses' unforgettable patient care experiences with an aim to gain a deeper understanding of nurses' experiences. It is evident that

the investigation of phenomenon that is essentially important to the nursing profession requires nurse researchers to investigate the lived experiences which are present in the everyday world within which they practice (Streubert & Carpenter 2007).

Phenomenology and the relevance to nursing practice

Phenomenology is regarded as a valuable methodological tool for focusing on research questions that are relevant to education and nursing practice that is grounded in the experience of both the nurse and the patient (Rapport & Wainwright 2006). Phenomenological research has the ability to clarify and enlighten phenomena that provide descriptions which are rich in detail and reveal meanings entrenched in the circumstances, as opposed to making inferences or identifying causality (O'Brien 2005). The holistic perspective is valued in a phenomenological methodology providing the foundations for phenomenological research. This allows for investigation of the phenomenon important to the nursing profession (Streubert & Carpenter 2007). The need for change in nursing practice can be highlighted utilising a phenomenological framework. Walton and Madjar (1999) stated that phenomenological research challenges nurses to question further and provides the framework to do so.

Nurse researchers are progressively implementing qualitative methods for the investigation of current issues (Charalambous, Papadopoulos & Beadsmoore 2008). Among the nursing profession, phenomenology has been significantly utilised as a qualitative research method investigating issues through the lived experience of the participants researched. For the nurse researcher, the value of phenomenology exists in the fact that it holds the nurse or patients subjective experience as the central focus (Hallett 1995) aimed at a greater understanding.

Summary of chapter

In this chapter the philosophical assumptions which underpin the methodology utilised in the reported study were discussed. An overview of phenomenology and the two main fields of phenomenological research, Husserlian (descriptive) and Heideggerian (interpretive) were presented along with the relevance to nursing practice. Descriptive phenomenology provides the philosophical and methodological framework for this study and is aimed at describing and gaining a rich understanding of the experiences of nursing severe burns injury patients. The following chapter discusses the methods used in conducting the study presented in this thesis.

CHAPTER FOUR

RESEARCH METHODS

Introduction

This chapter describes the methods utilised to describe the nurses' lived experience of caring for severe burns injury patients and articulates these experiences. A qualitative research framework underpins the study reported in this thesis utilising a Husserlian descriptive phenomenological approach to explore the lived experience of nursing severe burns injured patients. This facilitated the emergence of the essences of nursing patients with a burns injury.

This chapter discusses the design utilised in the reported study outlining the sample population including inclusion and exclusion criteria for those participating, and the recruitment strategy employed. Ethical considerations in phenomenological research are described to ensure adherence to ethical standards. This is followed with the method of data collection and techniques used for analysing the data including an overview of Collaizi's method of data analysis. The chapter concludes with strategies that were utilised to ensure trustworthiness and methodological rigor.

Sample population

Qualitative research does not investigate variables but events and incidents that are informative and specific to the needs of the study (Patton 2000). The richness of information provided by participants explains the comparatively small sample size utilised in qualitative research (Ayres 2007). Relatively small sample sizes are required due to the large volume of information that is generated and collected from participants (Ayres 2007). Morse (2000, p. 4) stated that:

There is an inverse relationship between the amount of usable data obtained

from each participant and the number of participants. The greater the amount of useable data obtained from each (as number of interviews and so forth), the fewer the number of participants.

Purposeful sampling was utilised for the recruitment of burns nurses for this research. This method of sampling is frequently used in qualitative research, in fact the researcher must purposefully select participants that provide information rich in personal knowledge in line with the objectives of the study (Howell & Prevenier 2001). Purposeful sampling is a strategy in which the researcher selects participants that will yield information necessary for the needs of the study (Morse 1991; Polit & Beck 2006). The participants in this research must have experienced nursing acute burns injury patients to be able to reflect on and be willing to share their experience about this phenomenon. Seven registered burns nurses were approached by the researcher and given a recruitment letter (Appendix 1) inviting them to be part of the study. All seven nurses approached agreed to join the study. Seven participants allowed a significant generation of data that was sufficient to construe themes and concepts for this research.

Study's setting

The setting for this study was a tertiary teaching hospital located in Sydney, New South Wales. The burns unit consisted of 12 beds of which all were single rooms. An onsite burns operating theatre and burns ambulatory service encompassed the unit. The burns unit forms part of the New South Wales Severe Burns Injury Service of which this setting is one of three hospitals that form the service. Apart from burns, reconstructive plastic surgery is also a speciality that is incorporated into the unit.

Selection criteria

The selection criteria for participants in this study included registered nurses that were capable of articulating their experiences of providing care to severe burns injury patients. The burns nurses were required to be working full time on an adult burns

unit with no less than 3 years full time burns nursing experience. This inclusion criterion was used to ensure greater depth and richness of the data provided from those with the greatest experience and exposure to the burns environment.

Ethical considerations

Research studies involving human participants require ethical approval prior to the commencement of the proposed study. This is to ensure that participants' rights, dignity and privacy are protected and to minimise potential risks to the participants (Denzin & Lincoln 2005). Formal ethics approval for this research was obtained from both the University of Adelaide Human Research Ethics Committee and Northern Sydney Health Human Research Ethics Committees where the research was conducted. In addition, the proposed research study was peer reviewed and endorsed by the Discipline of Psychological Medicine (Appendix 2) and the Discipline of Nursing at the University of Adelaide. Recruitment and the subsequent data collect process did not commence until after formal ethics approval was sought from both institutions.

The researcher was aware that the experiences described by the participants may not be analogous with the researcher's own code of profession practice. As a result, it was critical that the researcher would remain non judgmental throughout the interview process and display no body language that would suggest censure.

Participant information

During the recruitment process, potential participants were given a participant information sheet (Appendix 3) explaining the purpose of the study and a detailed explanation of the benefits, risks and procedures involved. The information sheet (Appendix 3) informed potential participants that the identity of participants involved would not be identifiable in the research. It was made clear that participants could withdraw from the study at any point in time with no repercussions and provided the name and contact details of the researcher and the academic supervisor overseeing the

research in the event further information was required.

Privacy and anonymity

The National Health and Medical Research Council (NH&MRC) (2007) states that privacy is “a domain within which individuals and groups are entitled to be free from the scrutiny of others” (p. 101). In order to maintain the privacy of individuals involved in this study, it was explained to the participants that the researcher would be the only person who could link the names of the participants with the interviews and the digital recordings would be deleted after transcription so as to maintain anonymity. Participants were informed that the transcriptions of the interviews would be stored securely in a locked filing cabinet on a universal serial bus (USB) which was password protected and would be destroyed seven years after the completion of the study. Direct quotes from the participants’ interviews are incorporated into this research and participants will not be identifiable. The researcher has ensured those participants’ names and any other potentially identifiable information not be contained into this document. To ensure anonymity the participants’ identifiable information was coded and stored on a separate password protected USB and was deleted at the completion of this research. The NH&MRC (2007) states that “confidential information must only be used in ways agreed with those who provided it” (p.2.3).

Consent

After all potential participants had read the participant information sheet detailing the study and the researcher had answered all questions in relation to the research, each participant was asked if they wished to be involved in the research. All participants approached agreed to be involved in this research study with the knowledge that the nature and aims of the study were clearly explained to them. Each participant was required to sign a consent form (Appendix 4) prior to the commencement of the interview. The consent form signed by each participant detailed the following information: the nature and the purpose of the study were explained to participants;

participants might not directly benefit from taking part in the research; the researcher assured participants of their anonymity and confidentiality; participants were free to withdraw from the study at any point without consequence; participants willingness to participate in this study for no monetary payment; and that the interviews would be digitally audio recorded.

Specific considerations

It was anticipated that participants may suffer significant emotional distress as a result of sharing their experiences. In the event the participants displayed emotional distress, the researcher would terminate the interview and offer a referral to the counsellor through the Employee Assistance Program at the hospital. During the course of the interviews, no participant displayed emotional distress and the hospital counsellor was not required.

Storage of data

The NH&MRC (2007) recommends that the data should be kept for a minimum of five years prior to being destroyed; however, the data for this research will be kept for seven years on recommendation from the Northern Sydney Health Human Research Ethics Committee. After this period, all data that was generated from this research will be destroyed. During the course of the research, all data generated in the form of transcriptions and consent forms were kept in a securely locked filing cabinet in the researcher's office. The participants were informed that all research data would be securely locked in a filing cabinet to ensure privacy and anonymity, in order to deny access to anyone other than the researcher to the confidential data.

Data collection

The role of the researcher is to have an understanding of what the participant is expressing about their experience and engage the participant so as to impart rich in-depth descriptions (O'Brien 2005). Therefore an unstructured open-end interview

method was chosen for this study allowing for a greater scope in the response provided by participants (Streubert & Carpenter 2007). Open-ended interviews are one of the most frequently used tools for data collection in qualitative research (Streubert & Carpenter 2007). Using open-ended questions allowed the participant freedom to control the interview in relation to issues discussed and completely describe their experience. Moyle (2002) suggested that by not restricting the participants' response, rich data is gained. Open-ended questioning permits the researcher to pursue a participant's lead, to seek clarification and assist in imparting information related to the participant's lived experience (Streubert & Carpenter 2007). Robinson (2000, p. 18) is of the opinion that:

...the formal qualitative interview is an unstructured conversation with a purpose that usually features audiotape and verbatim transcription of data and the use of an interview guide rather than a rigid schedule of questions...

The researcher knew all seven participants and as a result the researcher believed that participants would express themselves freely in a relaxed environment during the interview process. The researcher personally conducted each of the interviews, which assisted in gaining a sense of the whole experience of the participants. Data was collected via a digital audio recorder in which all the participants were aware of the recording device. The interview process for each participant lasted approximately 35 minutes with a range of 19 minutes to 52 minutes. The interviews in this study were conducted in the participant's own place of residence on a day they were not rostered on duty, apart from one interview which was conducted within the hospital. The researcher travelled to the participants' residence in order not to disrupt the participant during working hours. Prior to the commencement of the interviews, the purpose and objectives of the research was clearly explained to all participants and then each participant was asked to sign the informed consent form (Appendix 4) and given a copy for their reference. All participants were reminded that they could withdraw from the study at any point in time without repercussion.

Prepared open-ended questions were used to guide the interview process (Appendix 5). The interviews began with the objective of obtaining a description of the participants' lived experience of nursing severe burns injury patients. The interviews covered aspects of the effects of nursing severely burnt patients, infliction of pain during painful burns procedures and how these experiences has changed their nursing practice. During the interview, the researcher only spoke to seek clarification of participants' thoughts, and for the use of prompts to assist with imparting valuable information from the participant (Appendix 5). Examples of prompts used were such as "Can you elaborate on that point some more?" and "Can you describe in more depth how this made you feel?" and "What does this mean to you?"

The researcher had all digital audio recordings transcribed within 48 hours of the interview process. The recordings and transcriptions were then cross referenced to ensure accuracy of the data transcribed. This was to ensure that the transcriptions accurately reflected the experience of the dialogue. Data collection for each interview continued until the researcher believed data saturation had been achieved. This was evident when no new information was forthcoming and the data became repetitive. It is interesting to note that Morse (1989) suggested that the concept of data saturation is an illusion proposing that if another group of participants were interviewed on the same topic at a different point in time, new data would possibly emerge.

Data analysis

Colaizzi's method of data analysis

Colaizzi's methodological approach to phenomenological inquiry was utilised and deemed most fitting for this research study. Colaizzi's (1978) method employs components of Husserlian phenomenology, placing an emphasis on the description of the lived experience as opposed to an explanation (Beck & Watson 2008). Beck and Watson (2008) suggest that the Colaizzi's method of data analysis, assists in achieving objectivity in which Colaizzi (1978, p. 52) stated that "objectivity is fidelity to phenomena. It is a refusal to tell the phenomenon what it is, but a respectful listening to what the phenomenon speaks of itself."

Each transcribed interview of the nurses' experience of caring for severe burns injury patients was analysed by means of Colaizzi's (1978) phenomenological method of data analysis.

Colaizzi's (1978) method of data analysis consists of seven steps:

1. Read and re read all the participants' verbatim transcripts of the phenomena in order to acquire a feeling for them.
2. Significant statements or phrases are extracted from participants' transcripts pertaining directly to the research phenomena.
3. Formulated meanings are constructed from the significant statements.
4. Formulated meanings are arranged into clusters themes which evolve into emergent themes.
5. Incorporation of the results into a rich and exhaustive description of the lived experience.
6. Validation of the exhaustive description from the participants involved in the research.
7. Incorporation of any new or pertinent data obtained from participants' validation, and adapted to attain congruence with the lived experience of the participants' studied.

After each interview was conducted, the audio digital recording was emailed to a professional transcription service specialising in qualitative research. Each interview was found to be transcribed verbatim and cross checked with the audio recording for accuracy. Figure 1 below demonstrates a concise summary of the data analysis process undertaken for this research:

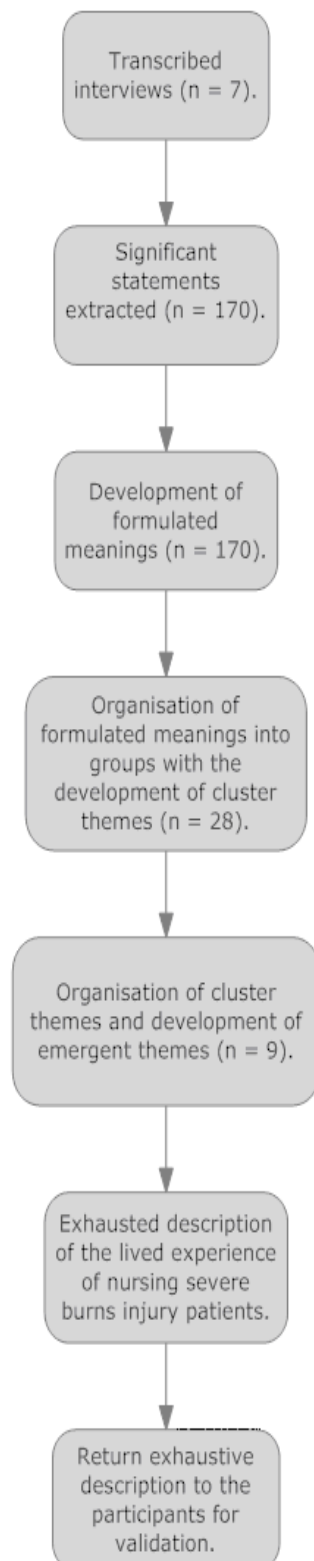


Figure 1: Summary of sequential stages of data analysis

In order to gain a sense of the participants' descriptions of their lived experience of nursing severe burns injury patients, the researcher firstly actively listened to each of the participant's audio recordings on three occasions and each transcript was read five times. An extract from a participant's transcript of an interview conducted can be found in Appendix 6.

Extraction of significant statements

One hundred and seventy significant statements and phrases pertaining to the phenomena of the current study were distilled and coded. Examples of coded significant statements are demonstrated in Appendix 7. All significant statements were reviewed by the researcher to ensure that statements extracted reflected the objectives of the study. There were many statements found to be repetitive, therefore the most rich and descriptive statements that represented the objectives of the study were included. Extracted significant statements were reviewed by the researcher's supervisor to ensure that a rigorous and auditable process was adhered to throughout. Table 1 below demonstrates how significant statements were distilled from an interview conducted with a participant in this study. The sentences in bold and underlined below in Table 1 illustrate some of the significant statements extracted.

Table 1: Example of how significant statements were identified and distilled from an interview (transcript 5, lines 134 -153).

Yep, um, huge team, big multidisciplinary um, specialty, so um, obviously from the consultant through the medical staff to the nursing staff who um, of all different grades and then obviously the allied health, so a big team. **I think we all support each other. We have um, differences of opinions and are comfortable with each other I think to vocalise those which means I think we work as a very close team.** I have a very supportive and excellent nursing team who um, have many different personalities which make it, um, which make it a challenge some days and ah, keeps life interesting.

And, ah, **without the team** you can't, **you can't nurse without the support of your peers** um, **you can't, I don't think you can do burns nursing,** it's a very, **I think we're very close as a group on the unit and** um, **I think it's pretty unique to, certainly to burns,** but maybe, maybe something similar would be spinal, which is another um, catastrophic injury with the long term, huge long term, um, issues and often the patients are in for quite a long time so you get to know them. So with burns, some of the big burns, they're in for months.

So because they're in for months you get to know them, you get to know their families and because of that then the whole team becomes very close. And one of the really nice things I think is that if there are issues or somebody finds it difficult looking after that patient, everybody rallies around and if it's a particularly difficult patient, then we share the load.

Formation of formulated meanings from significant statements

The next step involved developing core meanings for each of the significant statements distilled. This required the researcher to acknowledge the statements before and after each significant statement. This was to ensure that the researcher remained cognisant of the contextual significance of the verbatim transcripts. Colaizzi referred to this process as the “precarious leap” from what the individual said to what they mean requiring a “creative in-sight” (Colaizzi 1978, p. 59).

The fundamental meaning or restatement of each significant statement and phrase, known as a formulated meaning was numerically coded with the same numeral as the corresponding significant statement. In total, 170 formulated meanings were developed from the significant statements extracted. Table 2 below illustrates examples of the process taken in the creation of formulated meanings from the significant statements. Appendix 8 illustrates all coded significant statements and corresponding formulated meanings relating to the objectives of this study.

Table 2: Development of formulated meanings from significant statements.

Significant Statements	Formulated meanings
...it's not really an option not to do dressings. It's not an option not to do physio. 145 P7: L 152 – 153	Being grounded in the reality of the injury assists burns nurses to be dedicated and committed towards burns care. fm 145
So obviously you want them to get better very quickly and you do your utmost to get them there. 146 P6: L 26 – 27	Passion, motivation and commitment to nursing severe burns injury patients is fundamental towards a positive patient recovery. Fm 146
...especially if it is a younger person who's got a young family, you want to get them as quick as possible back to their - maybe you put in extra effort in getting them back. 147 P6: L 28 – 30.	A young patient with a family is a motivational aspect towards a rapid recovery for the burns nurse. fm 147

To ensure a rigorous, trustworthy and auditable interpretive process throughout, the significant statements, formulated meanings and accompanying participants' transcripts, were reviewed by both the supervisor and an academic psychiatrist leading to the agreement and subsequent confirmation of the formulated meanings with minimal alterations.

Development of cluster themes and formation of emergent themes

Once the process of developing formulating meanings from the significant statements and phrases was complete, arrangement of the formulated meanings into theme clusters commenced. The formulated meanings were arranged into 28 thematic groups

each representing a specific cluster theme. Each of the 28 cluster themes were coded and the formulated meanings belonging to the specific theme was incorporated and listed under the theme.

The next step taken in the data analysis was to group the theme clusters with commonalities into emergent themes. Twenty eight cluster themes were collapsed into nine emergent themes providing a rich and descriptive picture of the lived experience of nursing severe burns injury patients. Table 3 listed below illustrates examples of the development of formulated meanings and associated cluster and emergent themes, demonstrating clearly how the researcher arrived at the development of the emergent themes. Appendix 9 shows a full listing of formulated meanings, cluster and emergent themes.

Table 3: Illustration of the development of formulated meanings and associated cluster and emergent themes.

Formulated meanings	Theme cluster	Emergent theme
2*. Rapid development of a unique relationship between burns nurse and the patient with a severe burn injury is grounded in trust assisting in the recovery process. 27*. Burns nursing is complex in both the physical and emotional sense often involving intensive relationships with patients based on trust. 34*. Self disclosure to burns patients in order to divert attention away from traumatic injury for both the nurse and the patient. 66*. A unique friendship and bond develops between the burns patient and nurse with professional boundaries.	Interactions	Unique bonds
38*. Importance of communicating feelings about withdrawing care and the challenge of communicating with burns patients that are dying. 87*. Burns victims that have been burnt in mass disasters are difficult for the burns nurse to communicate with due to the sensitive and tragic circumstances that surround the	Empathetic communication	

Formulated meanings	Theme cluster	Emergent theme
patient.		
84*. Burns nursing is a highly stressful and emotional job that can leave burns nurses feeling burnt out 85*. Burns nursing is emotionally exhausting, demanding and draining that leaves the nurse feeling she is unable to give anymore to the patient. 89*. Burns nurses can feel severely stressed and burnt out manifesting in the inability to make competent decisions about patient care and function as a valuable member of the burns team. 103*. The nurse experiences burnout earlier due to the high levels of emotions experienced with nursing severe burns injury patients.	Feelings of stress	Burnout

**Numbers indicate coded formulated meanings*

Integration of results into an exhaustive description of the phenomenon

The final step in the data analysis was the development of an exhaustive description of the phenomena in the reported study based on the integration of themes from all participants. The exhaustive description provided a comprehensive insight into the phenomenon of nursing severe burns injury patients. Colaizzi (1978) suggests to “formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible” (p.61). An exhaustive description should do more than state what a person is doing going beyond facts and appearances presenting “detail, context, emotion, and the webs of social relationships that join persons to one another.... the voices, feelings, actions, and meanings of interacting individuals are heard” (Denzin 1989, p. 83).

Colaizzi’s (1978) final step for the method of phenomenological data analysis, states the researcher should return to the participants for validation. All participants were sent the fundamental structure (See exhaustive description of the lived experience of nursing severe burns injury patients page 75) in order to seek validation that the

exhaustive description truthfully depicted the participants' lived experience of nursing severe burns injury patients. The validation process was undertaken by returning to the participants and asking them if the researcher's description confirmed their own personal experiences. All seven of the participants contacted articulated the view that the researcher's description of the lived experience of nursing severe burns injury patients was congruent with their own experiences and represented an accurate description of the fundamental structure. No new or relevant data was obtained from the participants' validation.

Methodological rigor

The aim of rigor in qualitative research is to accurately depict the experiences of the participants in the study (Streubert & Carpenter 2007). Without methodological rigor the research becomes insignificant, fabricated and the utility of the research is lost (Morse, Barrett, Mayan, Olson & Spiers 2002). Furthermore, Morse et al. (2002, p. 9) stated that:

...strategies for ensuring rigor must be built into the qualitative research process per se. These strategies include investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance, and saturation. These strategies, when used appropriately, force the researcher to correct both the direction of the analysis and the development of the study as necessary, thus ensuring reliability and validity of the completed project.

Lincoln and Guba (1985) suggested that trustworthiness of the research entails four aspects: credibility, transferability, dependability, and confirmability. The following methodological strategies were used to maintain rigor in this study:

Purposeful sampling was selected as a strategy for recruitment of participants in this study. A benchmark was set at a minimum of 3 years burns experience as it was essential to select participants that yielded information necessary for the needs of the

study. Verbatim transcription of data generated through interviews has become a frequent method for managing data in qualitative research and is considered fundamental to the analysis and interpretation of verbal data generation (Halcomb & Davidson 2006). A critical problem with transcribing data is the potential for transcription error. As a result, each audio interview was transcribed verbatim by a professional transcription service specialising in qualitative research. All transcripts were proof read and cross checked three times for accuracy so as to accurately represent the participants' experiences.

The researcher identified and acknowledged biases, assumptions and preconceptions related to the phenomena so as not to compromise the analysis. The researcher is required to be aware of implications and the impact on data collection and analysis with the imposition of the researchers' own personal preconceptions and agenda (Streubert & Carpenter 2007). The Husserlian technique of bracketing to ensure rigor, identifies and articulates assumptions prior to the data collection and analysis process (Morse 1994). Prior to the commencement of the study, the researchers' beliefs were listed and reflected upon relating to the care of severe burns injury patients. These assumptions and preconceptions are listed in chapter one of this study.

The process of participant validation was utilised in this study. Colaizzi's method of data analysis is the only method that requires validation of results by returning to the participants. All participants were asked to validate their experiences by sending each participant a copy of their transcript. The response from each participant demonstrated that their transcripts accurately depicted what was said during the interview and represented their experience of burns nursing. Colaizzi (1978) suggests that the final validation process of the data analysis involves returning to the participant to further interview and obtaining participants' standpoint on the essential structure of the phenomena ensuring representation of participants' experiences. However, the exhaustive description of the phenomena is often more identifiable than the essential structure in which to remark upon (Holloway & Wheeler 1996). Therefore to ensure methodological rigor, the exhaustive description was sent to each participant in order to validate their lived experiences of nursing severe burns injury patients.

In order to ensure the credibility of the study, an auditable trail of decisions taken throughout the data collection and analysis process is required (Sanders 2003). Koch (1994, p. 978) supports this notion stating:

A decision trail provides means for the researcher to establish audit trail linkages. Leaving a decision trail entails discussing explicitly decisions taken about the theoretical, methodological and analytical choices throughout the study.

The process taken for extracting the significant statements and the development of the formulated meanings from the transcripts was performed independently. The transcripts, significant statements and formulated meanings were shown to the researcher's supervisor and an academic psychiatrist from the Department of Psychological Medicine at the institution where the research was conducted. This was to ascertain if the interpretive process was auditable and clear in which it was established that the formulated meanings accurately represented the lived experiences of the participants. The development of formulated meanings into cluster themes and the subsequent development of emergent themes were examined and validated by the same academic supervisors ensuring trustworthiness. Wolf (2003, p. 175) states that "the audit trail helps to establish the credibility of qualitative studies and serves to convince the scientific community of their rigor". Appendices 8 and 9 demonstrate an audit trail of the extracted coded significant statements, formation of formulated meanings and the development of cluster and emergent themes.

Summary of chapter

In this chapter, the research methods are described for conducting this Husserlian descriptive phenomenological study. The sample population utilising purposeful sampling methods and the use of unstructured open-end interview for data collection were discussed. Ethical considerations addressed participant information and safety, privacy and anonymity, consent and the storage of data. The Colaizzi method of data analysis was addressed in depth, illustrating how the data was analysed with the

extraction of significant statements and development of formulated meanings, cluster and emergent themes. The issue of rigor and trustworthiness surrounding the methodological approach was discussed in this chapter. The next chapter, the findings, will provide an understanding of nursing patients who have sustained a severe burns injury through the experiences of seven experienced burns nurses.

CHAPTER FIVE

FINDINGS

Introduction

The purpose of the reported study was to provide a rich description of the lived experience of nursing severe burns injury patients. The prime objectives of the study were to: explore and describe the lived experience of burns nurses who care for patients with traumatic burns injury, identify stressors and strategies used by burns nurses to cope with negative traumatic events in relation to patient care, describe the level of commitment and motivation displayed by burns nurses and identify the psychological and sociological needs of nurses working with patients that have sustained a severe burns injury.

Colaizzi's methodological approach to phenomenological inquiry was utilised for analysing the data in the current study. All transcriptions were read multiple times in order to acquire a feeling for them. The significant statements were extracted from participants' transcripts pertaining directly to the research phenomena. Formulated meanings were constructed from the significant statements and arranged into cluster themes which then evolved into emergent themes. The results were incorporated into a rich and exhaustive description of the lived experience. Validation of the exhaustive description was sought from the participants involved in the research.

This chapter focuses on the themes that emerged from participants' narratives which underpin the experiences of nursing severe burns injury patients. From the transcribed interviews, 170 significant statements were extracted with the development of 170 formulated meanings reflecting the lived experience of these burns nurses. Twenty eight cluster themes were formed which were further merged into nine emergent themes. The findings of the reported study will be discussed thematically with the

arrangement of common experiences grouped into cluster themes and then the formation of emergent themes forming the basis of the findings.

Cluster themes

During the data analysis process 170 formulated meanings were developed from the extracted significant statements leading to the emergence of 28 cluster themes (Appendix 9). The cluster themes reflected the experiences of seven burns nurses caring for severely burnt patients on a burns unit in Sydney, Australia. The process involved grouping formulated meanings that shared similar concepts in light of the study's objectives. Table 4 below demonstrates how the coded formulated meanings describing emotional exhaustion were grouped together which then lead to the emergence of the cluster theme: *Feelings of stress*.

Table 4: Emergence of cluster themes.

Coded significant statements	Cluster theme
84*. Burns nursing is a highly stressful and emotional job that can leave burns nurses feeling burnt out 85*. Burns nursing is emotionally exhausting, demanding and draining that leaves the nurse feeling she is unable to give anymore to the patient. 89*. Burns nurses can feel severely stressed and burnt out manifesting in the inability to make competent decisions about patient care and function as a valuable member of the burns team. 103*. The nurse experiences burnout earlier due to the high levels of emotions experienced with nursing severe burns injury patients.	Feelings of stress

**Numbers indicate coded formulated meanings*

Emergent themes

The 28 cluster themes developed were further merged into nine emergent themes forming the basis of the findings reported. The nine emergent themes were: virtues of burns nurses, powerlessness, unique bonds, resilience, the necessity for support and unity, burnout, traumatic caring, making meaning and job satisfaction. Each emergent theme will be defined and discussed with excerpts from the transcripts used to highlight and support each theme.

Virtues of burns nurses

The emergent theme *virtues of burns nurses* is defined as the characteristics and qualities that burns nurses possess. These characteristics and qualities included: passion, compassion, competency and skills, pragmatism, commitment and dedication.

When participants spoke they often displayed considerable passion towards nursing burns patients. The following is indicative of how a participant described how she felt about her role as a burns nurse:

I think looking after burns patients ...it's what I'm passionate about, I'm very committed to burns and how burns patients are looked after... (Participant 5, L: 109 – 110).

The same participant reaffirmed her passion for burns nursing stating that:

...I think you have to have a certain amount of passion to be looking after burns patients. (Participant 5, L: 185 – 186).

Another participant described how she is driven by the challenge of nursing burns patients and gaining knowledge to fulfil her role as a competent burns nurse:

... I just want to up the knowledge and actually I feel like I want the challenge to get a big burn down there again so I can try and do a better job next time.

(Participant 4, L: 104 – 106).

Compassion was more apparent in the nurses who had the least years of burns experience, indicating that compassion seemed to dwindle with experience. Participant 2 describes how compassionate she felt at first towards burns patients and their circumstances:

And when you look back on it, when first you're involved you, a lot of compassion taking lots of care and trying not to hurt them and kind of stopping when you do. And now I look back on it and I think, I try and control the pain but I also persevere because I think the sooner it's over and done with the sooner the person can relax. (Participant 2, L: 227 – 231).

This same participant then expressed how over the years her level of compassion has declined and she has now become emotionally detached:

...you're still compassionate, but you lose a lot of your compassion. It's true what they say when you're with the more experienced burns nurses, you are, the quicker and more rough, that you are which is always a joke I thought, but

it's not. It's...you get to that point where you become detached. (Participant 2, L: 232 – 236).

However, participants did not lose their humanity. It was apparent that participants had the compassion and humanity to be able to see the patient as a person not just a patient with a burns injury:

...yes they've got a wound...or they've got a burn, but they're still a person. So I don't see the burn as the main thing. I see them as a person. (Participant 4, L: 408 – 410).

The importance of having the competency and skills to be able to perform large burns dressings swiftly featured throughout the interviews. This participant highlights this point by emphasising the unavoidability of pain during dressing changes, therefore the necessity for staff to have the skills and knowledge to perform dressings swiftly and not traumatise the patient for longer periods than necessary:

You know you cannot avoid that pain, but the only thing you can do is just do it very quickly, so you need staff who can do it quickly instead of drag it on for many hours. (Participant 6: L 229 – 231).

Another participant offered a different perspective stressing the importance of educating nurses with current evidenced based best practice that will contribute to improved outcomes for burns patients:

...what motivates me is keeping up to date and moving forward with things that are happening. Um, it's a very specialised subject so making sure that as

many people as possible get the education, so the earlier the care starts the better the outcomes. (Participant 5, L: 123 -127).

Pragmatism was apparent among the participants with a *matter of fact* approach to burns care. Participants were often extremely honest and blunt when explaining necessary procedures to patients as this participant described:

You know, you trip over at home and it hurts, so you just have to remember that there is lots of degrees of pain and unfortunately they've got to get through that pain as well if they want to get better and you just have to say to them, look it's going to be painful, we'll do everything we can to lessen the pain, but we can't stop it. (Participant 1, L: 264 – 268).

Another participant echoes this same pragmatism prior to a dressing change:

...it is, you know, this isn't forever, suck it up, deal with it, come on, let's get through it. (Participant 2, L: 260 – 261).

Other participants displayed a more practical perspective focusing on returning function, movement and independence back to the patient. This participant expressed how looking past the visible injury focusing on returning a level of function and independence as a priority:

...as long as you get them functioning, whether they're going to look terrible, it's sort of comes secondary, I look behind that. But I think to get them to

function on their own is the most important thing. (Participant 6, L: 114 – 117).

Commitment and dedication concerning patient care and rehabilitation was voiced fervently by the participants, expressing their drive towards returning function and independence back to the patient with a severe burns injury. This participant said of her patients:

So obviously you want them to get better very quickly and you do your utmost to get them there. (Participant 6, L: 26 – 27).

The same participant described how she tries to motivate patients to do their utmost during therapy or whilst attending to activities of daily living:

You try and convince them to go that bit extra when they do their physio or their daily living skills or whatever, you just push them that little bit extra. (Participant 6, L: 72 – 74).

While other participants expressed their commitment and dedication towards burns care with a more hard lined approach:

...the patient often just wants to lie there and you're a bit of a bully and it's like no, come on, use your hands, eat, stuff like that. And, you know, if you don't eat I'm going to put a tube down your nose so you also become a little bit of a bitch... (Participant 2, L: 17 -20).

The same participant said:

Whether you like it or not, you're kind of going to have to do it. (Participant 2, L: 53).

However, it was apparent that the participants also had the ability to advocate on behalf of the patient as this participant expressed:

...It's standing up and saying, enough's enough, we can't do this. (Participant 5, L: 208 – 209).

Powerlessness

The emergent theme *powerlessness* is defined as feelings of inadequacy, apprehension, vulnerability and frustration.

Participants often felt inadequate due to their inability to relieve patients' pain and suffering experienced as a result of necessary burns procedures. The following text from a participant described how the patient's reaction to painful procedures elicited strong emotions questioning her competency as a burns nurse:

It's just this horrible inadequacy that I can't do my job properly, that this patient is showing this emotion and this level of pain that you're angry at them, that you're sad for them. Um, it kind of goes against everything in nursing: you're supposed to help these people and fix these people but you can't. And they just have to live through this and to know that after a dressing or after rolling a patient or whatever or the physiotherapy, that you have to

then go back in and see this patient and try - you almost feel like you have to justify what's happened and what you've done and like, oh I can give you more, I can give you this and knowing that it will never be enough.

(Participant 2, L: 398 – 406).

Participants often felt apprehensive about patients being discharged from the care of the severe burns injury unit. Concerns were raised by the participants about how the patient would cope without the support of the burns team:

I do worry just how they will cope when they are outside of the safety of the burns unit. Um and it's nice when they've got the very supportive families and yeah, how they cope when they're outside of that safety zone.

(Participant 3, L: 101 – 104).

Participants on occasion felt vulnerable about someone close to them or even themselves sustaining a traumatic burns injury. This participant expressed how she felt vulnerable knowing what a burns patient endures and questioning her own resolve if she was ever to sustain a major burns injury:

Makes you feel a bit vulnerable because...you know, it can happen to people that are close to me, means it can happen to me. So it just makes you realise that, you know, like I mean I've often thought, you know, if I ever got burnt, I would hate it because I know, I know what's ahead of me, I know all the trauma that's going to be ahead of me and I think it would be the worst thing. I've often thought how would I cope in that situation, would I fall to pieces

knowing that I know (laughs) or would I be strong... (Participant 4, L: 63 – 69).

Participants were found to experience a high level of frustration in relation to patients' progress. Positive progress was seen by the participants as an extremely rewarding experience; however, the tediously slow progression left some participants feeling frustrated and questioning the validity of their efforts as one participant expressed:

...seeing them mobilised for the first time...you know, you feel like you're really making a difference when you actually see them taking those first steps. Then, you know, sometimes with the dressings and...because it is such a slow process, you know...sometimes you feel like, am I actually making any difference whatsoever? (Let's elaborate on that a bit more.) Yeah, um, with trying to get the slow road to more of an independence, any independence with their, within activities of daily living, it can be and you feel, you do feel sometimes like you're just not, not achieving much. (Participant 3, L: 72 – 81).

Unique bonds

The emergent theme *unique bonds* is defined as the relationships formed between the burns nurse and the patient. How nurses interact with patients and the use of empathetic communication were found to be key elements.

Participants felt that they developed a unique bond with patients who were severely burnt. Trust was seen as a fundamental element in the relationship whilst caring for

someone who had sustained a devastating burns injury. One participant expressed her feelings this way:

You get to have quite an amazing relationship very quickly with a person who has suffered a large burn. It's a very intense time for them and as nurses we're automatically trusted so you have this quite amazing relationship with them which I think really helps. (Participant 7, L: 9 – 12).

Another participant described how she develops a unique caring bond with patients. She forms a friendship while acknowledging her professional boundaries:

...it's also I suppose a bonding experience with the patient that you're showing that you know why I'm doing the stuff, I do care and I'm trying to make this experience better for you in any way that I can, but it's a hard thing to do and you put a lot - you form a friendship with the patient, not the normal friendship say you'd have with someone outside because you obviously have that nurse/patient relationship, that there is a friendship there, especially if it's a patient - this patient who I think was in hospital for over a year, from memory. (Participant 2, L: 203 – 210).

Withdrawing care was seen as a challenging event, requiring nurses to be empathetic towards the patient and their family. This participant described her feelings as:

I know, um, talking about how you feel, too, deciding when not to care for someone, like just to make them comfortable and let them die, um, is also a challenge with burns because they're so compos, you know, they can talk and everything. And you know, as a junior nurse, it was harder to understand why we're letting this person go, um, once you're much more experience you can understand it and appreciate, you know, it's a lot nicer to let them go. But it's always very hard...(Participant 4, L: 456 – 463).

Resilience

The emergent theme *resilience* is defined as coping strategies utilised by the participants in order to cope with caring for severely burnt patients. Cluster themes identified were: toughening up, natural selection, emotional toughness, coping with the challenges, regrouping and recharging and emotional detachment.

Participants often stated that they felt burns nursing had toughened them emotionally due to the repeated exposure of burns trauma. As one participant stated:

I think I'm probably more hardened to it because I've seen so much of it and I have a quite a good idea of how things are going to play out and move on. Um, so I don't think - things that would stress other people by look, I mean the whole physical change and disfigurement would horrify people, but so I suppose, yes, from that point of view I've become hardened...(Participant 5, L: 173 – 177).

Another participant expressed how she feels she has hardened and acknowledges hardiness as a necessary trait to nurse severely burnt patients:

I could definitely say I've hardened. Maybe not on the inside, but definitely I come across a little bit hardened on some situations, but I think you kind of have to be if you need to do something, I think you need to harden a little bit.
(Participant 1, L: 436 – 439).

The principles of natural selection *survival of the fittest* may be applied to burns nursing. The participants expressed a survival of the fittest mentality in which one participant suggested:

I think if you're a burns nurse, you're a burns nurse and if you can't find that level of compassion and detachment then you're not going to make it and you're going to reach burnout. (Participant 2, L: 245 – 247).

It was apparent that the participants developed an emotional toughness in order to perform painful procedures. As this participant described the need to be hard to assist in the patient's recovery without losing all compassion:

I'm probably a lot harder now in mentality. It's - it is, you know, this isn't forever, suck it up, deal with it, come on, let's get through it. I am still, I hope, well I feel I am, but I hope I am compassionate...(Participant 2, L: 460 – 462).

Another participant described how she would rarely help patients' with activities of daily living therefore encouraging the patient's independence:

...helping someone dress, I would probably rarely do that now unless they really needed to, but before you'd be quite happy to slip something on someone for them because you see that they needed the help, but now...it takes a little bit longer, but now you say, you need to do it for yourself and then you just remind them that when they're going home, they have to do it for themselves anyway. So that's the way to do it. (Participant 1, L: 318 – 324).

Participants often described burns nursing as extremely challenging due to the physical and emotional demands endured whilst nursing severe burns injury patients. One participant who discussed coping with the challenges of burns nursing claimed that coping skills developed over a period of time:

...I think you cope, the longer you work there, the more coping skills you develop...(Participant 6, L: 256 – 257).

However, another participant expressed the view that burns nursing is a highly emotional area of nursing, in which she felt that one can never entirely become immune to:

Um, it's definitely very emotional, lots of different emotions you're having to deal with and I've been doing this for quite a while and I feel like it's something you never get used to. (Participant 3, L: 10 – 12).

This response was echoed by another participant who felt that one does not become impervious to the trauma of burns injury:

...I don't think you get used to it, I think when you get used to it it's probably time to give up. (Participant 5, L: 31 – 32).

The same participant described the necessity to make the challenge of nursing severely burnt patients a more positive experience than negative for her nursing colleagues:

...looking after patients that become end of life, you look at ways to make that experience more positive than negative, so you also have to look at that from a nursing point of view, for your colleagues, so it becomes a more positive experience. And I think that's the same with burns. You have to and certainly I see that as part of my job as a manager, is to make the nursing experience as positive as possible and as enjoyable for the staff in what's the majority of time is tragic circumstances, whether it be self inflicted, you know, an accident or somebody having it inflicted upon them. (Participant 5, L: 326 – 334).

This participant expressed a more pragmatic view on coping with the challenges of nursing severely burnt patients:

...I'm very much of a, you get in, you do your job, you get out mentality which may not be the best for the patient or the family at the time, but that's my coping mechanism, that's how I get through it. (Participant 2, L: 454 – 456).

The need to regroup and recharge was apparent among the participants. There was a realisation of the importance of having a means for which to remove themselves from the burns environment during times of high emotion and stress. One participant expressed the necessity for time out during a painful and traumatic dressing change:

If it is really nasty, well I think time out again, you just go out, have a cold drink, get your thoughts together, put some happy music on, that often helps.

Um, or you talk positive things with your co-workers. If somebody's really in pain, well I think sometimes it's good just to leave the room for a little while.

(Participant 6, L: 212 – 215).

Exercise and other recreational activities outside the work environment were found to be ways in which participants were able to de-stress and escape from the events on the burns ward:

Exercise, that's how I um, how I get rid of frustrations or upset...(Participant 5, L: 81).

An example another participant shared was having enough time off between shifts so as to be able to regroup and recharge before returning back to work. Here she explains:

...having a life really helps. You need other things in your life, so get out and get some exercise, get out and do something completely different. Just having that escape from...work. Um, at home (New Zealand) on the burns ward

people are employed 0.9, so work nine days in a fortnight. That's a really good way around it. You just have that little bit extra time off because it is really intense, you know. (Long silence) It's not a cruisey easy job and yeah, so I just think you need other things in your life. (Participant 7, L: 134 - 141).

The need to emotionally detach was prevalent among the participants. Emotional detachment enabled the burns nurses to competently perform necessary tasks that were often lengthy, painful and traumatic for the patient:

...I think when I switch off I switch off for that time, so for the, you know, 30 minutes that I'm in there, knowing that somebody else is seen to be the part, is looking after the patient and I can go in and see it as a task rather than, than as a whole and I can do it both ways. I don't know whether it's a coping mechanism for that 30 minutes...I'm not aware that I switch off to it altogether. It's just literally to do that task, I can switch off to what's happening around me. (Participant 5, L: 252 - 259).

Pain during large dressing changes was seen as unavoidable as this participant recounts her attempts to lock out the screaming in order to complete the dressing change as swiftly as possible:

I just, I just absolutely try and lock it out (screaming) and get on with my work and get it over and done as quickly as possible. You know you cannot avoid that pain, but the only thing you can do is just do it very quickly, so you need

staff who can do it quickly instead of drag it on for many hours. (Participant 6, L: 228 - 231).

Another participant expressed her difficulty in finding an effective method to emotionally detach from the patient's pain and trauma:

...the hardest thing was the learning to find a way to detach because otherwise you were taking it home with you, you were thinking of it 24/7, you were getting angry at him (the patient), you were getting angry at yourself that you couldn't stop thinking about it. (Participant 2, L: 64 - 67).

The necessity for support and unity

The emergent theme *necessity for support and unity* is defined as the informal, professional and peer support networks that exists including collaboration with the multidisciplinary team. However, a lack of support for the burns nurses was also identified.

An informal support network existed between the nursing staff. This was evident through means of debriefing with fellow colleagues or sharing experiences off the ward in a social environment. This participant described feelings of anxiety, anticipation and tension related to difficulties experienced with nursing severely burnt patients and the need for an outlet to vent her frustrations:

It can keep you up at night, um, especially if you know that you're going back to the same patient late tomorrow, you're trying to think of better ways you can do it so your day doesn't quite end so badly, not that they always end

badly, but if it has been a shocking shift. Um (long silence) at home it can put you in a bad mood. It can cause tension with other people you live with or other family members. Um, it's always good to have a de-stressing or even a debriefing consult and the ward gets that, we feel that and unfortunately it usually involves alcohol, but you need to go out to the pub, you need to discuss it, you need to say, you know, this is crap, I can't believe it and blah, blah, blah, blah, blah. (Participant 2, L: 259 - 263).

Another participant expressed that informally debriefing with an impartial entity her partner; she could discuss frustrations and concerns experienced within the burns unit:

I um, debrief at home about either frustrations or um, issues not obviously um, revealing names or specific things, but um, with my partner who has nothing to do with the medical profession, so that's quite a good take on that, he doesn't have to...be involved, he is a different stabilising I suppose to my life. (Participant 5, L: 77 - 80).

The same participant expressed that in assisting others to cope with the ordeals of burns nursing she; herself is gaining from this experience:

...helping a junior member of staff get through a particularly unpleasant experience, we're talking about it, we're discussing it and we're going through it in detail. So that, I think, possibly helps me as well. (Participant 5, L: 338 - 340).

In relation to professional support, participants spoke about the enlistment of a professional counsellor or psychiatrist as a means of discussing issues and feelings as a whole unit. This participant recalls:

...you go and see a counsellor. I think we did have a counsellor come to us to the ward when we had a specific patient or a long term stay and we did have a counsellor or a psychiatrist involvement in where we could all sit and talk about our feelings and I think that really helps. And maybe we should have a bit more of that sometimes. (Participant 6, L: 139 - 144).

Another participant recounts the hospital counsellor and psychiatrist formally debriefing with the nursing staff and offered assistance with effective coping strategies and guidelines for managing difficult patients:

...we've had the employees assistant person in to talk about and coping mechanisms or strategies and debriefing and things that have been difficult to deal with, but also we've had the psychiatrist in who's doing services or discussions with staff about how to deal with difficult patients or put in boundaries or um, to let the nurses know what's, what it's alright for them to say. (Participant 5, L: 352 - 357).

It was apparent from the participants' experiences, the importance of peer nursing support which was continually voiced by the participants in this study. Participants expressed the significance of having their peers as a support network as this participant described:

...having colleagues in there just to help you...it's just, it just seems emotionally supportive to have someone else in there go through it with you.

(Participant 7, L: 114 - 115).

Another participant described how their fellow nursing colleagues assist each other during difficult periods often sharing the work load:

And one of the really nice thing I think is that if there are issues or somebody finds it difficult looking after that patient, everybody rallies around and if it's a particularly difficult patient, then we share the load. (Participant 5, L: 150 - 153).

Participants considered the well being of their fellow nursing peers when caring for patients with major burns trauma. Participants identified that nursing the same patient for long periods of time contributed to feelings of burnout and ultimately providing care that was deemed unsatisfactory. This participant described how it is vital to discuss with their fellow nursing colleagues allocation of patients in order to avoid becoming overwhelmed by caring for the same patient for long periods:

If you look after the same patient for a long time you might get burnt out and you might not provide as efficient as nursing care could be. I think that it's important that you discuss with the other staff who looks after whom and how often. (Participant 6, L: 132 - 135).

Another participant said:

...it's one of the areas only the people you work with can really understand...

Participant 1, L: 530 – 531

Participants' engaging in conversation with each other was seen as therapeutic giving the nurses a chance to informally debrief with one another. This participant expressed:

I know just chatting to staff and going through things, I'm sure it's a debriefing type of process that just naturally goes on, on a ward. (Participant 4, L: 159 - 161).

Participants felt that a multidisciplinary team approach gave them support, direction and assisted in providing nursing care which contributed to the ultimate goal of independence. One participant said of the multidisciplinary approach:

...with other people's assistance, other members of the team, the multi-disciplinary team, you know, makes you feel like you are assisting them (the patient) to become more independent which is a good, a good feeling. (Participant 4, L: 65 - 67).

This is resonated in another participant's response describing the multidisciplinary burns team as aiming for the same goal, the rehabilitation of burns injured patients:

...so huge multidisciplinary care which is what's, what's great because you work as a big team of people all working towards the same goal. (Participant 5, L: 22 - 24).

The same participant went on to express that without the support of the multidisciplinary team, nursing patients with severe burns injury would not be possible. This participant brings to the forefront the uniqueness of the burns team engendering a collaborative and affable support network:

...without the team you can't, you can't nurse without the support of your peers um, you can't, I don't think you can do burns nursing...I think we're very close as a group on the unit and um, I think it's pretty unique to, certainly to burns...So with burns, some of the big burns...they're in for months you get to know them, you get to know their families and because of that then the whole team becomes very close. (Participant 5, L: 142 - 150).

Few participants felt unsupported by their work colleagues and other members of the burns team. Skill mix and staffing numbers was rarely mentioned by the participants. However, one participant expressed that she felt unsupported at times related to staffing on the burns ward:

I think sometimes...if there's...ever any staffing issues and things and you don't feel like you're being fully supported, sometimes it can get a little too much when...you don't really have anyone to...sort of fall back on because of

staff shortages which means that...other senior members of staff are having to...look after their own patients. (Participant 3, L: 89 – 94).

Another participant expressed that not only feeling unsupported by her work colleagues, the passing of judgement in relation to her nursing practice by fellow colleagues left her feeling dire:

...that's a horrible feeling when you're feeling that you're not supported by your work people or that people are doing that judgment of you and your practice. (Participant 2, L: 333 – 335).

Burnout

The emergent theme *burnout* is defined as highly stressful feelings and emotions experienced by the burns nurses. As one participant expressed her feelings about nursing severe burns injury patients she stated:

It's stressful, it's emotional, it's - I can see how nurses, burns nurses get burnt out, because it is a highly stressful, emotional job. (Participant 3, L: 263 – 264).

This response was shared by another participant echoing the burns environment to be highly emotionally compared with other surgical settings:

I find I reach burnout a lot quicker here because you're dealing with a lot more emotionally where not necessarily you do on other surgical wards.

(Participant 2, L: 463 – 465).

Participants felt that burns nursing was physically and emotionally exhausting, demanding and draining due to the nature of the work. For one participant the effects of burnout were described as:

I don't feel I have much to give. I don't have anything to give my patients which 'cause I'm trying to...you can give and give and then you end up with nothing left to give. (Participant 3, L: 269 – 271).

Another participant expressed burnout as manifesting in feelings of stressfulness and generally feeling unwell in which she likens it to a machine malfunctioning:

I find I get - if I feel like I'm getting burnout, I feel it's because I've got lots and lots and lots on my plate. I feel like I'm spinning heaps of plates and you can do that for a while but then they start to all start falling down and um, I suppose you get a bit on a high before (laughs) you hit burnout, in my book that is. Um, like to me, you know, you can cope with running, you know, doing a lot of things, juggling a lot of things and you actually quite enjoy it almost, my brain gets into a higher gear and seems to cope with it. But if it just goes a little bit too far, um, like I said before I start, I don't know what it is, it's almost like inside you just get stressed, like adrenalin keeps going when you don't need it and you just can't keep going at a hundred miles an hour. And to

me, it starts manifesting in, um, well not feeling to well almost. But also just, you know, beginning...not being able to make decisions properly and just, you know, the well oiled machine isn't just running properly anymore. (Participant 4, L: 200 – 213).

Participants felt that burnout was contributing to their inability to make simple decisions relating to patient care. The same participant described how a simple decision was difficult to make due to the nursing staff feeling burnt out:

I remember one situation where it wasn't just me, the ward had been busy for about six months or so and I think everyone was getting a little bit burnt out. And um, I remember we all got a bit acopic where it was very hard to make a decision. It was quite interesting actually, just watching. I remember there was about three of us standing in the corridor discussing making a decision and I don't even think it was that difficult, it was just because we were so overworked and stressed, we found it very hard to make (laughs) simple decisions. (Participant 4, L: 180 – 187).

Traumatic caring

The emergent theme *traumatic caring* is defined as the emotional and physical exhaustion experienced by the burns nurses. Participants felt that nursing severe burns injury patients was both emotionally and physically challenging, exhausting and demanding. As one participant described her experience of caring for a severely burnt patient as:

...it's just the emotional rollercoaster that you go through that you're putting a person through pain and you're doing it intentionally but not wanting to, the psychological issues that this patient also transfers to you as well. It makes you angry and it makes you upset that you have to deal with this and it's not particularly your issue. (Participant 2, L: 71 – 75).

Dressing changes were found to be traumatising experiences for the burns nurses largely related to the pain inflicted during the dressing changes. This participant expressed how she felt after a large burns dressing:

...it upset me so much, because I could see these patients in so much pain and even though I knew they needed to have these dressings done, I couldn't understand why - I came out of dressings, it was like, what am I doing to this patient...this is wrong, this is not how it should be done. I'm traumatising them and myself and they're going to be dreading their next dressing because of what's just happened...(Participant 3, L: 199 – 204).

The circumstances in which the patient sustained their injury had an emotional impact on the participants. The following describes how looking after the patients burnt during the Bali bombings in 2002 was an extremely stressful and emotionally taxing experience:

I also found people that have been burnt in a traumatic situation, like the Bali bombings, I found that very stressful actually because I, I find that um, like I

said before, I like to chat and sort of try and take the stress out of the situation. And I found with those people from Bali, I couldn't do that because I suppose for me maybe, it just wasn't something you could um, chat about, it was so traumatic. You couldn't make it light. You couldn't banter about it or anything, it was too serious, you know? People had lost their friends and stuff, so I actually found that looking after them very difficult. (Participant 4, L: 40 – 47).

Nurses found large burns dressing physically enduring requiring considerable time and effort when performing large burns procedures. As one participant reported:

...the ones that affect me I guess are um, the larger burns that have to go through dressings probably every second day, they have to have their outers changed which is still very, very painful, every day, every night, up to twice a day. (Participant 7, L: 27 – 30).

Another participant described dressing changes as physically exhausting stating:

It's horrible. You dread going into it knowing that you could look after them. You know you're going to be put through an emotional rollercoaster and not only that but you're going to be physically exhausted from everything that you have to do for the patient. (Participant 2, L: 112 – 115).

Making meaning

The emergent theme *making meaning* is defined as how the burns nurses perceived themselves and reflected upon their clinical practice. Participants stated that nursing severe burns injury patients caused them to often reflect upon their own clinical nursing practice and compare themselves to their colleagues. The participants were found to experience moments of self doubt and questioned their own abilities:

You're scared that, you know, you're doing the wrong thing, that you're causing this patient all this pain, you know. And it's a lot of self doubt. You're comparing yourself to other people and other nurses, would they have done this, what would they have done. Yeah. I suppose it also causes you a lot of reflection, but at the time it is just this horrible feeling, you feel like shit, you feel like you can't do your job properly, you know that you're going to cause this person pain and it's just horrible. (Participant 2, L: 159 – 165).

The manner in which patients sustained their injury influenced the way participants perceived patients and their family. Participants voiced an element of suspicion related to how the injury occurred and inconsistencies with the patients' recollection of events. This participant describes how burns nursing has changed her perception of the patient and their injuries adding some humour to how she classifies these patients:

...also I suppose it's made me a lot more suspicious of people, how their injuries occur, whether family were involved...it's like, oh, you know, this burn injury doesn't correlate to that or was there something else going on that you haven't told me and stuff like that. And when I first started, one of the nurses told me only the mad, the bad and the sad get burnt. I was thinking,

no, no, that's not true. And you're looking at it now and it does and you have had (laughs) judgment of which....category do you fit into...(Participant 2, L: 472 – 478).

Another participant expressed that the demographics of the burns patient influences their perception resulting in a different approach to the care:

It also depends whether they are young, married or not married, if they are very old. It depends whether...it's self inflicted, whether it's coming from an accident or whether it's because of stupidity, not that I differentiate my care, but you do take a different approach to the severity of the...burn and how you care for them. (Participant 6, L: 10 – 14).

Job satisfaction

The emergent theme *job satisfaction* is defined as a rewarding and gratifying experience for nurses caring for severely burnt patients. However, there was a definite need for the burns nurses to receive appreciation for their efforts.

Participants felt that burns nursing was both rewarding and gratifying. One participant described burns nursing as a very rewarding experience despite the pain and trauma involved:

The pain issues and the scarring of the patients and how they deal with that and, yeah, it's very tough. But it's also very rewarding - can be a very rewarding experience. (Participant 3, L: 12 – 14).

Another participant expressed her thoughts about patients returning to the ward to visit after discharge as an extremely rewarding experience. Seeing the patient rehabilitated and returning to society as a result of the care rendered by the burns team:

I think it's um, it's a nice, it's always nice to see a severe burns patient leave the ward in one piece and not, um, not commit suicide because they look horrible and I believe that not many do kill themselves after they leave. So that's a nice thought to think that, yes, the patient might hate you for the pain that you inflict on them, but when they leave, they're actually changed people themselves and often they come in and visit us afterwards. I think that's a nice outcome for...and to follow up patients that you looked after for a long time, that they keep visiting the ward. I think that's very rewarding. (Participant 6, L: 240 – 248).

One participant stated that burns nursing was rewarding due to nature of the work involved and complexity of care:

...I find burns nursing good too because I find it just the dressings and all that is quite stimulating. It's challenging the brain, it's something extra other than normal nursing. But um, you know, you can be specialised in and ah, yeah, I just find it very rewarding. (Participant 4, L: 488 – 491).

Although, the same participant also commented on the lack of job satisfaction she experienced when caring for patients affected by acts of terrorism as with the Bali Bombings:

I feel like I didn't get any job satisfaction from looking after them because I couldn't help them mentally. Like I could do the best for them physically in the sense of looking after their injuries, but I couldn't help them mentally and I get a lot of satisfaction out of, you know, making them smile, making it less stressful for them and being able to help them mentally as well as physically.

(Participant 4, L: 49 – 53).

There was a negative aspect that emerged concerning appreciation. A sense of inadequacy was felt knowing that the patient may not appreciate the physical and emotional input that burns nurses give to care for a severely burnt patient. One participant described her experience as:

It's horrible. You dread going into it knowing that you could look after them. You know you're going to be put through an emotional rollercoaster and not only that but you're going to be physically exhausted from everything that you have to do for the patient. Um, it's also a sense, I suppose inadequacy that you know you're going to get through the end of the day, the patient isn't really going to appreciate what you've done. (Participant 2, L: 112 – 117).

The participants elicited a different response in regard to caring for patients who had endured their injury due to suicidal acts of self emollition. One participant expressed a lack of appreciation from patients who attempted suicide from burning stating:

I find it hard to look after burns patients that have actually done it to commit suicide. Um, because you know you put all this effort in to try and help somebody and you know they actually don't even want the help, they don't want help to get better. Um and I've always found those category of patients difficult to look after. Um, probably as time has gone on, I've found it less difficult, but still difficult because...you want some kind of appreciation for all the effort you're putting in and...you think, oh these people are just going to go out and do something else, you know? (Participant 4, L: 431 – 438).

The amount of effort afforded to patients who suicide by self emollition was questionable. As one participant expressed that she may not do her utmost for the patient because of a lack of appreciation:

I'd still always give them the best care, like it's funny, I don't know if you would still go to the nth degree for them um... (Why is that?) Because they don't want you to and you don't get the appreciation for doing that. (Participant 4, L: 473 – 477).

Exhaustive description of the lived experience of nursing severe burns injury patients

Burns nurses display considerable passion, commitment and dedication towards caring for severe burns injury patients. A competent practitioner having the skills to carry out burns procedures swiftly is considered critical not only for the well being of the patient but also the physical and emotional wellbeing of the nursing staff. When

these nurses perform burns procedures they convey the need to be pragmatic in order for the patient to comply with often painful procedures and to assist in returning function and independence back to the patient. Despite nurses' pragmatic approach, burns nurses recognise the importance of compassion.

A sense of powerlessness is experienced which leaves the burns nurse at times feeling both emotionally and physically exhausted. This is as a result of the challenging and often demanding work load leading to feeling stressed and burnt out. However, a resilient nature is apparent with burns nurses displaying an emotional toughness and detachment in order to cope with the challenges. Burns nursing is viewed by these nurses as a very rewarding and gratifying experience although often a thankless job in need of recognition and appreciation.

Unique bonds are formed between the burns nurse and the patient with trust and empathy as the fundamental elements in the relationship. These nurses develop friendships with long term burns patients, while acknowledging the friendships as a nurse – patient relationship. This indicates the ability to maintain both professional boundaries and responsibilities during long admissions. Burns nurses recognise the importance of valuing empathetic communication incorporating the patient and their family with critical decisions relating to end of life or withdrawal of care issues.

Burns nurses' perception of patients with a severe burns injury is at times cynical altering their perception of how they view the patient. This may also influence other nurses to form a cynical or negative perspective. Demographically, burns nurses are influenced by the cause or nature of the injury and the patients' personal circumstances which may influence the care the patient receives. As such, burns nurses reflect on their clinical practice comparing themselves with their nursing colleagues recalling events which left them questioning their own abilities and at times doubting themselves. A lack of support related to the skill mix and staffing

levels in the burns unit is recognised. However, despite this element, informal and peer nursing support provides a valuable support and resourceful network for burns nurses. Debriefing with peers and social gatherings outside the bounds of the hospital are effective means of releasing stress in a relaxed environment. A multidisciplinary team approach is viewed by these nurses as a crucial element in the management of patients with severe burns injury and recognises the value of the burns team.

Summary of chapter

In this chapter the findings of the study were discussed incorporating extracts from participants' interviews to validate the findings. The lived experience of nursing severe burns injury patients has been shown to be unique because of the exposure to the traumatic nature of a major burns injury both in a physical and emotional sense. All of the participants agreed that burns nursing is both physically and emotionally exhausting, demanding, draining and at times leading to feeling stressed and burnt out. Powerlessness was apparent with participants feeling inadequate and frustrated in relation to the inability to control patients' pain and the extremely slow progression at regaining function and independence. This caused the participants to reflect upon their own practice and question their actions often doubting themselves and their abilities to be a competent burns nurse.

Despite these challenges, burns nurses displayed a resilient nature with a toughened exterior as well as emotionally hardened with the ability to emotionally detach from the patients' trauma. Commitment and dedication, passion, compassion and pragmatism all featured as characteristics and qualities evident in the participants. Participants found their roles both rewarding and gratifying displaying a high level of job satisfaction.

The development of unique relationships between participants and patients was apparent; however, a lack of appreciation and support was identified. Support was deemed critical for the participants' emotional wellbeing and gave them the necessary support to competently care for severe burns injury patients. Chapter six, the ramifications of these themes will be discussed and appropriate suggestions for practice will be made based on the findings with the intention of informing burns nurses and other health professionals caring for severe burns injury patients.

CHAPTER SIX

DISCUSSION OF FINDINGS, IMPLICATIONS AND CONCLUSION

The findings of this descriptive phenomenological study demonstrated that the lived experience of nursing severe burns injury patients is unique, due to the traumatic nature of a major burns injury both in a physical and emotional sense. The intention of the reported study was to provide a rich description of the lived experience of nursing severe burns injury patients. A Husserlian descriptive phenomenological methodology was utilised to explore the lived experience of nursing severe burns injured patients. This aided in the development of cluster and emergent themes describing the phenomenon of nursing severe burns injury patients. In this chapter, participants' perspectives on the major findings are compared and contrasted in relation to the relevant literature. The limitations of the study are highlighted with implications and recommendations for further research discussed. Finally, the chapter provides a conclusion to the reported study.

Coping strategies and support

Resilience

The burns nurses in this study clearly demonstrated a resilient nature which appears to be a fundamental characteristic within the domain of burns nursing. Natural selection was a cluster theme that emerged from the data analysis. Some participants expressed a survival of the fittest mentality stating the necessity to find a level of compassion and detachment in order to survive. Bernstein (1976) claimed that burns nurses pass through an adjustment stage and those who survive stay and remain committed to burns nursing. This was evident with the participants of the reported study expressing how they passed through a transition phase and toughened emotionally and physically in order to cope with these facets of nursing severe burns injury patients. Importantly,

Colosi (2002) adds that survival of the fittest mentality is necessary for recruitment and retention of nursing staff and it is interesting to note that the participants interviewed were employed on the burns unit for extended periods ranging from four years to twenty-five years. Interestingly, Wright et al. (1992) poses the question why do some nurses stay working on a burns unit while others leave in which the personality trait of hardiness is possibly one reason for this phenomenon.

Toughening up, emotional toughness and emotional detachment were fundamental elements evident in all participants. The participants felt it necessary to be emotionally tough and emotionally detached in order to facilitate patient compliance and conduct necessary burns care procedures swiftly. Cronin's (2001) study that looked at how burns nurses deal with emotions is in agreement, stating that nurses in their study felt they had to toughen up to enable them to care for burns patients. Mannon (1985) also supports this view suggesting that burns nurses appear tough in order to encourage patient compliance with the treatment of burns.

Participants often described burns nursing as extremely challenging due to the physical and emotional demands endured whilst nursing severe burns injury patients. The findings suggest that the participating burns nurses in this study had various coping strategies to manage their stress and the challenges they confronted. The use of emotional detachment (also referred to as distancing), exercise, time out, social gatherings outside the burns unit and talking amongst their colleagues and friends were identified as the core coping strategies utilised to manage the challenges of nursing severe burns injury patients.

Participants most often used emotional detachment in order to conduct painful and lengthy burns dressings. Distancing oneself from the patient's pain assisted participants in completing burns dressings competently and swiftly minimising the trauma for the burns patients' and was an effective safeguard for the participants'

emotional wellbeing. Nagy's (1999) study that investigated strategies used by burns nurses to cope with the infliction of pain, concurs with this finding. Nagy (1999) reported emotional distancing as the most commonly used coping strategy among participants in her study for it provided self protection for the burns nurses against pain experienced by burns patients. Nagy (1998) adds that emotional distancing gave burns nurses a sense of pride in that they were capable of continuing their work despite the patients pain. Camhi et al.'s (2007) study also found that emotional detachment was used as a safeguard facilitating clear thinking. Becoming emotionally detached from the patient's pain and trauma has the propensity to decrease sensitivity and tolerance to the patients' pain. Nagy (1999) suggested that burns nurses may become less concerned about inflicting pain during dressing changes as a result of distancing oneself from the patients' pain. In fact, Iafrati (1986) found that experienced burns nurses underestimated burns patients' pain compared with less experienced burns nurses. It remains paradoxical, that participants emotionally detaching themselves from patients' pain and trauma, the patients' needs may be compromised.

Participants were of the opinion that the longer the participant was employed as a burns nurse, the more copings skills she developed. Participants in the reported study had no less than three years of burns experience. This is consistent with Hinsch's (1982) findings which reported that burns nurses despite the stress experienced, the burns nurses mastered the required coping strategies and as a result stayed working in the area of burns for extended periods of time.

Within the burns unit, participants expressed taking time out, team support, and talking amongst their co-workers as coping strategies often utilised. This is consistent with Murji et al.'s. (2006), Steenkamp and van der Merwe's (1998) and Lewis et al.'s (1990) findings in which talking with co-workers and experienced staff, humour, team work and timeout were identified as coping strategies used by burns nurses. In fact, 88 percent of the participants in Lewis et al.'s (1990) study stated that they would talk

amongst colleagues in relation to work related problems. The nursing and multidisciplinary team was identified by participants in the current study as the greatest asset of the burns unit. Participants claimed that without the team, the participant would not be able to nurse burns patients competently, stating that a multidisciplinary team approach gave them support, direction and assisted in providing competent nursing care to their burns patients. This is echoed by both Steenkamp and van der Merwe's (1998) and Lewis et al.'s (1990) studies identifying team support as a quality which enabled the burns nurses to cope with the often stressful environment of a severe burns injury unit. However, Steenkamp and van der Merwe's (1998) study asked burns nurses what could be done to lessen stressors and promote coping on the burns ward, in which 41 percent of burns nurses stated that the multidisciplinary team was a source of stress, in particular, the medical team. This does not concur with the findings of the current study in which the multidisciplinary team was identified as an asset.

The current study's findings reported participants being pragmatic and having a task orientated focus in order to cope emotionally and physically as a burns nurse, often at the expense of the patient and their family. One participant stated that she had "*a get in and get out*" mentality in order to cope and finish the burns procedure. This pragmatism was apparent in all the participants across the study as an effective coping strategy and assisted in time management. Lewis et al. (1990) also identified task orientation as a coping mechanism used by the burns nurses in their study.

Outside the domain of the burns unit the participants often engaged in exercise, social gatherings with colleagues and talking with family and friends as effective coping strategies. Exercise and other recreational activities outside the burns environment were found to be effective strategies enabling participants to be able to de-stress and escape from the events on the burns ward. These findings are reflected in Murji et al.'s (2006), Lewis et al.'s (1990) and Steenkamp and van der Merwe's (1998) studies involving burns nurses and coping strategies. In fact, Lewis et al.'s (1990) study

reported that 53 percent of burns nurses in their study used exercise and 47 percent used talking with family and friends as a method of coping.

The necessity of support

The importance of peer nursing support was continually voiced by participants. Participants expressed the significance of having their peers as a support network. This suggests that these findings demonstrate a strong informal support network amongst the participating burns nurses. Participants' engaging in conversation with each other was seen as therapeutic giving the participants a chance to informally debrief with one another. This was apparent through the study via means of debriefing with fellow colleagues or sharing experiences off the ward in a social environment. Nagy (1999) found that the majority of support received was from their nursing colleagues with a heavy reliance on one another. These findings support the current study and are consistent with Cronin's (2001), Steenkamp and van der Merwe's (1998), Lewis et al.'s (1990), and Hinsch's (1982) findings. In addition, Nagy (1999) states that social support was a reflection of the nurses' necessity to be understood which provided reinforcement for the burns nursing staff who spend a majority of their shift performing painful dressings.

Participants found their personal lives were in some measure affected by the distress of the burns environment and often found it difficult to leave their work behind after their shift had ended. Participants expressed that they were taking their work issues home which created tension in their home life. There is little evidence to support these findings in the burns nursing literature. However, McClendon and Buckner (2007) concur with these findings reporting intensive care nurses experienced tension with their family after a distressing situation at work. Participants stated that they sought support from their partner or family friend (an impartial entity) to discuss frustrations and concerns experienced within the burns unit which is in accordance with both Cronin's (2001) and Lewis et al.'s (1990) studies. In addition, Lewis et al. (1990) stated that 41 percent of burns nurses in their study talked with family and friends as

methods of coping after their shift had ended. In regard to work related problems, Lewis et al. (1990) reported 53 percent of burns nurses would talk to a friend about work related problems, 35 percent said a spouse and 29 percent said they would talk to their family about work related issues.

Some participants spoke about the enlistment of a professional counsellor or psychiatrist as a means of discussing issues and feelings as a whole unit. Formally debriefing with the nursing staff offered assistance with effective coping strategies and guidelines for managing difficult patients. However, research suggests that these services have poor attendance among nurses (Cronin 2001). Cronin's (2001) study found that it was up to the individual burns nurse to seek support and that nurses were literally on their own in relation to finding support. However, Lewis et al. (1990) identified that the majority of nurses in their study indicated that they would like the services of a psychologist, and on a routine basis. Steenkamp and van der Merwe (1998) also identified that the burns nurses in their study indicated the need for support from a psychologist was ranked highly. Hinsch (1982) suggests that a psychiatrist on the ward could assist in the education of nursing staff in managing patient's emotional issues as well as for nursing staff themselves. This is consistent with the findings in the current study in which some participants believed that the enlistment of a counsellor or psychiatrist to debrief with staff would be valuable not only in the management of patients' behaviour also for the nursing staff to express their issues either as a group or individually. Tringali (1982) recommends the services of a psychiatric nurse consultant to conduct support groups for burns nurses on the unit allowing nurses to talk about concerns and feelings with each other. Tringali (1982) claimed that a psychiatric nurse consultant can identify issues at a peer level, assist in expressing these feelings and therefore facilitate problem solving in a supportive atmosphere.

Reflection

The reported study revealed that nursing severe burns injury patients caused participants to often reflect upon their own clinical nursing practice and compare themselves to their colleagues. This was evident in the less experienced participants (those with less than four years burns experience), in fact the less experienced participants in this study were found to experience moments of self doubt and questioned their own abilities compared to the veteran burns nurses, although, there is little available evidence to support these findings in regard to burns nursing. However, Edwards and Burnard (2003) reported in their study that experienced mental health nurses were less likely to experience personal self doubt in regard to their nursing abilities and experienced greater levels of emotional competency. Mavundla (2000) found that mental health nurses perception of themselves influenced their abilities, and those with a negative perception of self were associated with a lack of knowledge and skills, where as those with a positive self perception were associated with competent knowledge and skills. In addition, Brookfield (1994) claimed that nurses who reflected upon their clinical practice may experience feelings of self doubt, isolation and insecurity.

Perception of burns patients

The manner in which patients sustained their injury influenced the way participants perceived patients and their family. Participants described how burns nursing has changed their perception of the patient and their injuries. An expression one participant stated was “*only the mad, the bad and the sad get burnt*” (Participant 2, L: 476). Patients who endured their injury through no fault of their own were afforded a compassionate, dedicated and committed approach on the part of the burns nurse. However, if the injury was sustained as a result of a suicide attempt, participants expressed that they may not “*go to the nth degree for them*” (Participant 4, L: 473). In fact, nurses’ attitudes towards patients who self harmed could have an effect on the quality of care that these patients receive (McKinlay, Couston & Cowan 2001; Slaven & Kisely 2002). Participants often voiced an element of suspicion related to how the injury occurred and inconsistencies with the patients’ recollection of events.

However, no available evidence was found to support these findings within and outside the domain of burns nursing.

The demographics of the burns patient also altered participants' perception influencing their approach to care. Influencing factors were whether the patient was young, very old, married, or single and if the injury was self inflicted, accidental or as a result of stupidity. Once again, no available evidence was found to support these findings within and outside the domain of burns nursing. However, Suhonen, Valimaki and Leino-Kilpi (2005) found that the more often patients felt they received support for individuality through specific nursing practices, the higher the individuality of care the patient received. In addition, the more individualised patients' perceived their care, the higher the level of patient satisfaction in regard to nursing care.

Barriers to caring

Exhaustion and burnout caring for burns patients

There is a plethora of research regarding burnout in nursing which is beyond the scope of this thesis; therefore the focus will remain on burns nursing. Burnout is a phenomenon described as “a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who work with people” (Maslach, Jackson & Leiter 1996, p. 182). It is said to occur in occupations in which a majority of time is spent in close contact with others (Maslach & Jackson 1981). In addition, burnout has been linked to absenteeism (Jenkins & Elliott 2004) and the departure of nurses from the profession (Schaufeli & Janczur 1994). Maslach and Jackson (1981) state that a key element of burnout is increased feelings of emotional exhaustion depleting emotional resources in which employees feel they can not give anymore psychologically. This was apparent in some of the participants who displayed elements of burnout expressing that they felt they had little to give in which one participant stated “*you can give and give and then you end up with nothing left to give*” (Participant 3, L: 270 – 271). Participants described nursing

severe burns injury patients and the burns environment as highly stressful and emotional compared with other surgical settings. Tringali (1982) suggested that a source of stress for burns nurses is the high mortality rate of burns patients compared with patients in general wards. This was reflected in the current study whereby participants felt that they reached burnout more rapidly compared to nurses on general surgical wards.

Significant stress factors expressed by participants in this study were related to pain infliction during dressing changes and the participants' response to the patients' pain. Patients' pain was a major source of anxiety for all the participants which often left them feeling inadequate and powerless impacting on their general and mental health. These findings are in accordance with Nagy's (1998), Steenkamp and van der Merwe's (1998), DePew et al.'s (1999) and Lewis et al.'s (1990) studies where it was also found that burns patients' pain was a significant source of anxiety. It was surprising that remuneration as a source of stress was not identified by the participants in the current study since nursing has long been associated with poor pay (Turnbull 2007; Van Den Heede, Diya, Lesaffre, Vleugels & Sermeus 2008). However, poor remuneration among burns nurses was a significant finding of Steenkamp and van der Merwe's (1998) study which was ranked as a severe stress factor for the burns nurses in their study.

Participants expressed that the stressors of working in a severe burns injury unit affected their home life. On occasion participants stated that they became irritable and impatient, suffering sleep disturbances and generally feeling unwell. In addition, participants stated they often came to work feeling anxious knowing they will have to look after particular burns patients. This finding is congruent with Lewis et al.'s (1990) study which found that all nurses in their study experienced work related stresses affecting their home life manifesting in mainly sleep disturbances and stomach aches, with 59 percent of the nurses stating that they experienced anxiety prior to commencement of work.

As previously mentioned, the burns nurses in the current study displayed the personality trait of hardiness as evidenced by their commitment and emotional control whilst caring for patients with severe burns. It is interesting to note that Wright et al. (1992) found that burns nurses in their study experienced low levels of burnout and stress, and high levels of hardiness. However, this is in stark contrast with DePew et al.'s (1999) study which found that the burns nurses in their study experienced high levels of burnout and low levels of hardiness. Therefore it is evident that a correlation exists between burnout and hardiness among nurses. Participants felt that burns nursing was both physically and emotionally exhausting, demanding and draining due to the nature of the work. Participants themselves at times felt traumatised after major burns dressing describing it as an “*emotional rollercoaster*” (Participant 2, L: 71). This is contrary to Murji et al.'s (2006) study which found that the majority of staff working in the studied severe burns injury unit, did not experience emotional exhaustion. In addition, Murji et al. (2006) claimed that burns nurses experience lower levels of depersonalisation compared with critical care nurses in which Murji et al.'s (2006) rationale was related to the patient population being younger with fewer co morbidities compared with critical care patients who are generally older with complex co morbidities.

Job satisfaction with in burns nursing

Participants expressed that burns nursing was both a rewarding and gratifying experience. It was apparent that the participants in this study expressed a high level of job satisfaction and accomplishment as burns nurses. Seeing patients' who had sustained a severe burns injury regain their independence and return to society as a result of the care rendered by the burns team, was viewed as an extremely rewarding experience. Participants' feelings of reward and gratification were reinforced by patients returning to the ward after discharge to visit the staff and express their appreciation for all their efforts. These findings are in accordance with Hinsch (1982) who also reports burns nurses deriving great levels of job satisfaction. Hinsch (1982) adds that upon discharge of a patient who sustained a severe burns injury, the burns nurses expressed that they felt as though they have achieved a goal, especially on

seeing ex-patients return to the ward to visit. Lewis et al.'s (1990) findings also reported job satisfaction and personal reward among burns nurses interviewed in their study. In fact 16 out of 17 burns nurses in Lewis et al.'s (1990) study reported satisfaction gained from working with burns injury patients. The participants of the current study stated that the rehabilitation of burns patients leading to their independence was a satisfying and rewarding experience. This often displaced feelings of frustration and hopelessness experienced by burns nurses in relation to the patients' slow or lack of progress. Both Steenkamp and van der Merwe's (1998) and Murji et al.'s (2006) studies are in accord with these findings. Murji (2006) adds that twice the number of burns staff compared to critical care staff in their study reported elevated levels of personal accomplishment. Despite the negative feelings associated with burns nursing, participants' motivation, dedication and sense of personal accomplishment counteracted the negative aspects of burns nursing contributing to a burns nurse who displays hardiness and commitment towards the field of burns injury and rehabilitation. This is echoed by Steenkamp and van der Merwe's (1998) study that found positive feelings of achievement and satisfaction out weighed feelings of helplessness, stress and frustration.

Nursing burns patients whose injury was as a result of acts of terrorism or disasters was linked to a lack of job satisfaction. One participant in particular was deeply affected by nursing a patient burnt during the 2002 terrorist Bali bombings, recounting how mentally she could not help the patient in their recovery. Powers, Maher, Helm, Cruse and Luria (1986) reported that burns staff reported feelings of helplessness, rage and experienced nightmares and preoccupation about fire. In accordance with the current study, nurses expressed that no one beyond the burns unit could conceive or understand their feelings. However, Frank (2001) reports a different perspective, studying emergency nurses who were involved with the terror attacks on September 11 in New York. Nurses' interview conveyed an uplifting account of their experiences entrenched with passion, commitment and motivation.

The issue of patients not showing appreciation for the physical and emotional nursing care provided was an important finding of this study. Lack of appreciation towards nursing staff in this study gave an insight to how these nurses reacted and are affected by receiving little or no recognition from the patient and their family for hours of care to assist in the rehabilitation of a burns patient. Often a thank you or a smile was enough for the participant to feel appreciated as one participant expressed “*But most of the time it’s seeing the patient smile and just thinking, yeah, it’s been a good day*” (Participant 2, L: 217). Christiansen (2008) concurs with this finding stating the patient showing their appreciation for the care and attention with a thank you or being pleasant contributed to the nurse feeling that their day was good. Steenkamp and van der Merwe’s (1998) findings uncovered that the burns nurses in their study claimed that appreciation for their work was lacking and there was definite need for more appreciation to be afforded to the burns nurses.

Participants expressed a sense of inadequacy knowing that the patient may not appreciate the physical and emotional input that the burns nurses give to care for a severely burnt patient. This was mostly evident with regard to caring for patients who had endured their injury due to suicidal acts of self emollition or self harm. The amount of effort afforded to patients who suicide by self emollition was questionable and was often met with anger and frustration on the part of the nurses for having to deal with such a self destructive injury. One participant in particular expressed that she may not do her utmost for the patient because of a lack of appreciation. There was no available evidence to support these findings in the realm of burns nursing. However, McAllister, Creedy, Moyle and Farrugia (2002) found that generally, there were negative attitudes toward patients who self harmed. Vivekananda (2000) adds that health professionals often distance themselves from self harm patients, rationalising that the patient has manipulative behaviour, is attention seeking or is unable to be helped.

Feelings of powerlessness

Inadequacy, apprehension, vulnerability and frustration were felt by all the participants of this current study. Participants often felt inadequate due to their inability to relieve patients' pain and suffering. Heidrich, Perry and Amand's (1981) study investigating burns' nurses attitudes about patients' pain, also found that burns nurses often felt helpless to relieve patients suffering resulting in nurses feeling depressed, frustrated and angry. Goodstein (1985) adds that staff feel guilty for causing pain during dressing changes and debridement. Nurses in the current study often found themselves apologising continually to the patient for inflicting pain during dressing changes which left them feeling inadequate and frustrated. This is consistent with earlier finding by Heidrich, Perry and Amand (1981) who also found that burns nurses' response to pain infliction was to apologise profusely to the patients, which contributed to feelings of helplessness. Tringali (1982) suggested that the high mortality rate of burns patients is related to feelings of helplessness and failure. In contrast, Steenkamp and van der Merwe (1998) found that even though the burns nurses in their study did experience some frustration, stress and helplessness, the positive feelings of achievement and satisfaction were far stronger.

Participants often felt apprehensive about patients being discharged from the care of the severe burns injury unit. Concerns were raised by the participants about how the patient, especially those severely disfigured, would cope without the support of the burns team. However, there is little literature available to support this claim. Tringali (1982) suggests that a possible source of stress for burns nurses is the discharge of disfigured patients back into the community. Participants' in the current study did not appear to be affected by disfigurement or deformities as it became an acceptable norm on the ward. Hinsch (1982) also claims that burns nurses tend to react to disfigurement and deformities as though there is nothing wrong with the patient. However, this is problematic in itself for it does not prepare the patient for the general public's reaction after discharge. Clarke and Cooper (2001) suggested that nurses who work with patients who are disfigured, do not feel empowered to address the psychosocial issues of rehabilitation.

Participants on occasion felt vulnerable about someone close to them or even themselves sustaining a traumatic burns injury. Participants expressed how they felt vulnerable knowing what a burns patient endures and questioning how they would cope if they were or someone close to them was to sustain a major burns injury. Nagy (1998) found that burns nurses displayed a heightened sense of personal vulnerability related to continuous exposure to severe burns injury. Patients' experience of burns trauma increased burns nurses' fears resulting in the nurses feeling vulnerable themselves. Powers et al. (1986) stated that the effects of a burns disaster on a burns unit included helplessness, rage, thoughts of fire, nightmares involving fire and the victims. This is congruent with the participants' of the current study reaction to a burns disaster. This highlights how burns nurses and nurses in general are relentlessly exposed to the vulnerability of life. Davidson and Jackson (1985) claimed that nurses constantly exposed to trauma are likely to experience fear of death, delayed post traumatic stress reaction, burnout and maladaptive coping mechanisms. In fact, Davidson and Jackson (1985) stated that it is the vulnerable individuals that are more likely to be attracted into nursing as an attempt to conquer their fears. However, these fears are exacerbated and result in a series of maladaptive coping responses to constant trauma.

Participants were found to experience a high level of frustration in relation to patients' progress. The tediously slow progression left some participants feeling frustrated and questioning the validity of their efforts. Lewis et al.'s (1990) study found that 19 percent of burns nurses claimed that dealing with patients' setbacks was a source of stress. Although there remains little available current literature on this issue, Maslach (1978) highlighted frustrations in working with burns patients, stating slow progress or lack of progress is considered failure or incompetence on the nurses behalf. Goodstein (1985) claimed that feelings of anger, guilt and sorrow are in response to patients' condition especially the lack of or slow progression in their recovery. Goodstein (1985) adds that this may result in nurses distancing themselves from the patient and the projection of disappointment and anger towards the patient.

Striving to care

Commitment, dedication and passion

The personality trait of hardiness was evident in all participants. Korbasa (1982) indicated that commitment, control and challenge are facets of hardiness. Wright et al. (1992) suggested that individuals who are hardy are able to feel deeply committed and have the ability to realise their goals, values and priorities. Langemo's (1990) study found that the personality trait of hardiness was linked with high levels of personal accomplishment and less stress. The participants in this study experienced considerable passion, commitment and dedication towards burns nursing. This was driven by the challenges of nursing severe burns injury patients despite the often intense and stressful environment in which they worked. These findings are congruent with work by Riley, Beal and Lancaster (2008) who reported that nurses in their study were both passionate and committed to nursing and identified this as the driving force for all aspects of their work. Their study found that nurses felt uplifted and committed to the nursing profession. However, literature addressing passion and commitment generally in nursing and in the field of burns is not well reported in the literature. This is surprising since passion and commitment seem intuitively critical to an individual's professional satisfaction it is interesting that this area has not been more thoroughly researched previously.

Technical competency and skills

Participants of this study stated the importance of having the technical competence and skills to be able to perform large burns dressings swiftly in order to not prolong the pain and trauma experienced by the patient. Nagy's (1999) study is in accord with this, reporting that nurses in their study expressed the importance of improving technical competence and knowledge so as to conduct dressings swiftly and efficiently resulting in better pain control and reduced discomfort. In addition, Madjar's (1999b) and Steenkamp and van der Merwe's (1998) studies revealed that technical skills and competence for burns dressings was of significant importance.

Compassion fatigue

Compassion was a trait that was identified as a cluster theme for this study. Compassion is one of the essences of caring (Dunn 2009). Lamendola (1996) describes compassion as recognising patients' problems and responding with a desire and a commitment to assist and be present despite the outcome of their circumstance. Participants of this study expressed compassion and empathy for the burns patients in their care. However, compassion fatigue was apparent in some participants expressing wavering compassion and emotionally distancing themselves from the patient and family as a means of coping. This is consistent with Austin, Goble, Leier and Byrne's (2009) findings in which nurses in their study investigating nurses' experience of compassion fatigue, identified themselves as having compassion fatigue describing the use of emotional distancing to shield themselves from the trauma of the patient and family. However, McRae and McCutcheon (2004) state that when caring for burns patients and their family especially when the injury is related to a non – accidental burns injury, compassion and professionalism are fundamental requirements of clinical care.

Unique bonds and friendship

The extended length of stay for severe burns injury patients and the nature of burns care practices results in a unique emotional involvement between nurses and the patients and their families. Participants of the current study also reported a unique bond and friendship with their patients. Empathetic communication was a key element and participants often expressed how they would open up and share part of their private life with the patient. This is reflected in Davidson and Noyes's (1973, p. 1718) study in which they described the relationship between the burns nurse and patient with severe burns injury as "both intimate and prolonged". In addition, Nagy's (1999) study reported that during burns dressings the development of a unique bond allowed for the nurse to continue caring for the burns patient during their often lengthy admission.

Limitations of study

Recognising the limitations of the study provides an understanding of the scope of the study and assists in evaluating the implications of the findings. The limitations are primarily derived from the methodological approach taken within this study. As with other qualitative methodologies, a descriptive phenomenological approach is recognised as having a number of intrinsic limitations.

Whilst the findings reported in this study contribute to the body of knowledge regarding the phenomena of nursing severe burns injury patients, the results cannot be generalised or transferable to a wider population of nurses and patients. Despite this, the aim of this study was to illuminate and provide a rich description enabling understanding and gives a valuable insight into the lived experience of nursing severe burns injury patients.

The low participant numbers (seven participants) may be seen as a limitation of the study. However, in qualitative research the focus is on the quality and richness of data obtained from the participants (Patton 2000; Sandelowski 1995) which does not correlate to the number of participants. Therefore, the use of purposeful sampling was employed to select specific participants that provide rich data in order to gain an insight into the phenomena (Sandelowski 2000). The use of purposeful sampling does introduce the potential for bias within the study. However, the power of purposeful sampling lies in the selection of information rich data which one can gain insight and understanding into central issues of the phenomena (Patton 2000). In addition, the study only included females from an Anglo-Saxon background and therefore not representative of the other gender or cultures. The researcher knew all the participants while this may encourage open discourse, this may potentially prevent participants from being completely open about their experiences and may result in participants withdrawing from the study due to potential repercussions.

Time constraints for completing a Masters dissertation limited the study. Due to time constraints only burns nurses from one unit were selected for recruitment. This is largely due to where the researcher was based and the practicality of conducting the interviews.

Implications and recommendations

The findings of this study have significant implications for burns nursing in respect to education, research and practice. The unearthing of burns nurses' experiences can only enable this specialised field of nursing to expand and potentially improve burns nursing practices and the care of burns patients. There is a need for nurses to care for the complexities of burns patients. The findings of this study will be disseminated to the burns nursing population so that the findings may be translated into practice. Nurse education needs to better prepare burns nurses, for they may at one point in their careers experience barriers to caring, negatively affecting their nursing practice. Aspects such as physical and emotional exhaustion as a result of nursing severe burns injury patients needs to be addressed.

The studies that were critically analysed for this thesis demonstrated that research investigating nursing severe burns injury patients is limited. Therefore, it is fundamental to investigate experiences of burns nurses in other units and other geographical locations, incorporating participants of both genders and from different cultures. In addition, further research needs to be undertaken to determine educational deficiencies in the area of burns from the perspective of nursing staff. How to establish well educated, experienced, qualified burns nurses should be one object of future research.

Conclusion

This study examined the experiences of seven experienced nurses caring for severe burns injury patients within an acute care burns ward in Sydney, New South Wales,

Australia. The concept of the 'lived experience' as a research framework assisted in the development of a deeper understanding of burns nurses and their experiences.

The lived experience of the participants in this study exploring nursing severe burns injury patients confirmed that the work is both demanding although rewarding. It was shown and confirmed that burns nurses have a resilient nature with the ability to cope with the challenges by emotionally detaching and becoming emotionally toughened and hardened to the devastation of a severe burns injury. Commitment and dedication were fundamental elements in burns nursing to the rehabilitation of burns patient. Participants stated that at times they felt emotionally exhausted, powerless and burnt out. However, feelings of accomplishment and motivation outweighed these negative emotions. This is consistent with the available literature confirming that burns nurses are highly motivated and experience elevated levels of personal accomplishment. The study confirmed the necessity for support and unity was a fundamental element especially in relation to the support of the multidisciplinary burns team. The uniqueness of relationships between burns nurses and their patients' demonstrated a unique bond embedded in trust and understanding that allowed the nurse to continue caring for burns patients for extended periods. This was reflected within the available burns literature supporting the findings of this study.

New knowledge generated from this research was that burns nurses found it difficult to leave their work behind after their shift had ended. Participants described how issues at work were a source of tension in their private life affecting their family. It is surprising that no available evidence was found to support this finding since literature in other domains of nursing supported this finding. The less experienced participants stated that burns nursing caused them to often reflect upon their own clinical practice which resulted in moments of self doubt questioning their own abilities compared to the veteran burns nurses. However, there is little available evidence to support these findings in regard to burns nursing although other areas of nursing support these findings. The manner in which burns patients endured their injury was found to influence the participant's perception of the patient and the approach taken for care of

the patient. Patients whose injury was related to self harm, participants expressed wavering dedication and motivation towards their recovery. In addition, the demographics of burns patients also influenced the approach to care.

The findings of this study have provided an insight into the burns environment and the nursing of severe burns injury patients. The knowledge generated through the descriptive phenomenological approach furthers understanding of burns nursing with the potential to benefit burns patients, nurses and other health care professionals.

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APPENDICES

Appendix 1

Recruitment letter



Invitation to participate in a research study

A research study on: The lived experience of nursing severe burns injury patients: A descriptive phenomenological study.

Dear _____

You are being invited to participate in a research study conducted by myself, Rachel Anne Kornhaber, a Masters student at the Discipline of Nursing, School of Population Health and Clinical Practice, University of Adelaide, South Australia. This study is about revealing what it is like to nurse severe burns injury patients.

Participation will involve talking about what it is like for you to nurse severe burns injured patients. You will be asked to share your thoughts, feelings and experiences of nursing burns patients. With your permission, your experiences will be digitally audio recorded and then transcribed. The audio recording will be destroyed after transcription so as to maintain your anonymity. The transcription will be stored securely in a locked filing cabinet on a universal serial bus (USB) which is password protected. The transcription will only be privy to me and my supervisor and all identifiable information will be removed and will not appear in any other written report or publication of the research study. The information that you share will be strictly confidential and the transcriptions will be kept for seven years after the research study is completed and then destroyed.

If you choose not to participate for any reason, your choice will be respected. Due to time constraints to complete the thesis, please contact me as soon as possible if you wish to participate or if you have any questions.

My contact details are:

9452 4554

0418 646 592

Email: rkornhaber@nsccaahs.health.nsw.gov.au

The Human Research Committees at the Royal North Shore Hospital, St Leonards and the University of Adelaide has approved the study. If you wish to contact my supervisor (Dr Anne Wilson) her email is: anne.wilson@adelaide.edu.au or the Ethics Manager at Royal North Shore Hospital phone: 9926 8106.

Thank you for considering participating in this research study.

Rachel Anne Kornhaber

Appendix 2

Ethical endorsement letter

THE UNIVERSITY OF SYDNEY



Discipline of Psychological Medicine

Please reply to:

Dr Loyola McLean
Lecturer
Psychological Medicine
Level 5, Building 36
Royal North Shore Hospital
St Leonards NSW 2065

Telephone: 02 9926 7926

Facsimile: 02 9926 7730

Email: lmclean@med.usyd.edu.au

28.02.09

Ethics Committee

Peer review of project:

The lived experience of nursing severe burn injury patients: A descriptive phenomenological study

I am a psychiatrist and psychotherapist with research and clinical interests in psychosomatics and Consultation-Liaison Psychiatry including trauma. As a researcher developing collaborations with the Severe Burns Unit I was asked to review the project named above to assess its suitability as a research project. This qualitative project explores an important area of nursing experience, studying nurses' accounts of caring for patients with severe burns. This project employs a sturdy qualitative design, based on phenomenological methods and both its aims and proposed methods are suitable to the questions asked and are well thought through. This project carefully considers the ethics of the interview process described and the information it yields is likely to add to our current knowledge and may well inform further research into nursing care in this area. This area merits this effort as the avoidance of burnout amongst nurses and an understanding of how nurses may be supported to offer sustained care are important issues in trauma care. The aims to disseminate the results are important and appropriate.

Thank you for the opportunity to review this project.

Yours truly,

Dr Loyola McLean
BA MBBS(Hons) FRANZCP PhD Dip Psychodynamic Psychotherapy

Appendix 3

Participant information sheet



Researcher: Rachel Kornhaber.

Department/Hospital: Severe Burns Injury Unit, Royal North Shore Hospital, St Leonards, N.S.W.

You have the opportunity to participate in a research study conducted by Rachel Kornhaber who works as a clinical nurse specialist on the Severe Burns Injury Unit at the Royal North Shore Hospital. In order for you to decide whether you wish to participate in this research, it is necessary that you understand what is involved and what is expected of you if you wish to participate. This form gives detailed information about the research being conducted to enable you to make an informed decision whether to participate or decline. **There is no obligation to participate in this research.**

What is the purpose of the study?

The purpose of this study is to describe the burns nurses' experiential knowledge when assessing and nursing acute burns patients in a specialised severe burns injury unit.

The study aims to:

1. To explore and describe the lived experience of burns nurses who care for patients with traumatic burns injury.
2. To identify stressors and strategies used by burns nurses to cope with negative traumatic events in relation to patient care.
3. To describe the level of commitment and motivation displayed by burns nurses.
4. To identify the psychological and sociological needs of nurses working with patients that has sustained a severe burns injury.

What are the benefits of this study, for me and for the wider nursing profession?

The benefit that will be derived from this research is the opportunity to share and impart the burns nurses' experience with the researcher. The shared experience can contribute to improve the health outcomes for both the nursing staff and patients. Knowledge gained from this research will contribute to nursing's expanding body of knowledge.

What will be involved and asked of the participant?

This research will involve participating in a comprehensive and detailed recorded individual interview lasting between 45 – 60 minutes. The interviews will be conducted in a location that is comfortable for the both the researcher and yourself. The participant is encouraged to voice any concerns that she/he has regarding the interviews. During the interview you may decline to answer any questions, request to stop recording or terminate the interview. A follow up interview will be requested at a later date to clarify and verify information gained in the first interview. Participation in this study is completely voluntary.

What are the possible risks that I will encounter?

There are no known risks involved in the participation of this research; however, if significant emotional trauma is encountered from sharing your experience, a referral can be made to the counsellor through the Employee Assistance Program at the Royal North Shore Hospital.

How will my confidentiality be ensured?

Participants involved in this research will be reassured that all the information shared with the researcher will remain confidential. The researcher will be the only one who can link your name with the transcribed interview. In the research report, your name will not be identified in any manner. No one other than the researcher will have access to information that links you to the research. The transcribed interview will be kept in a locked filing cabinet in the researcher's office and all material will be destroyed after seven years. If in the event that this research is to be published, your identity will not to be released or contain any identifying information.

If I do not wish to be part of this research?

There is no obligation to be part of this research if you choose not to participate.

Can I withdraw from this study at any time?

Yes, you can withdraw from this study at any point in time without any repercussions to your position. The researcher may withdraw you from this study if circumstances warrant removal such as significant emotional trauma is encountered from sharing your experience, appropriate counselling will be offered through the Employee Assistance Program at the Royal North Shore Hospital.

Will I be paid for my participation in this research?

No, participation in this research study is of a voluntary nature and the participants will not receive payment for their participation.

What happens with the results?

If you give your permission by signing the consent document, I plan to discuss/publish the results in a thesis, peer-reviewed journals and presentation at ANZBA. In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

If you have any questions, who can you call?

If you have any questions or issues regarding the research please contact:

Researcher: Rachel Kornhaber, Clinical Nurse Specialist – Severe Burns Injury Unit,
Royal North Shore Hospital on 0418 646 592

Ethics Manager at Royal North Shore Hospital 9926 8106

Academic Supervisor: Dr Anne Wilson

Adelaide University

Faculty of Health Sciences

Discipline of Nursing, Adelaide, South Australia 5005

Ph: 08-83033595

Email: anne.wilson@adelaide.edu.au

Appendix 4

Informed consent form



Project Title: *The lived experience of nursing severe burns injury patients: A descriptive phenomenological study.*

Researcher: Rachel Anne Kornhaber

1. The name and purpose of the research project has been explained to me. I understand it and agree to take part.
2. I understand that I may not directly benefit from taking part in the research.
3. I understand that while information gained during the study may be published, I will not be identified and my personal details will remain confidential.
4. I understand that I can withdraw from the study at any stage without repercussion to my position.
5. I understand the statement contained in the participant information sheet concerning receiving no payment for participation in this study.
6. I understand that the conversation will be audio digitally recorded.

Name of Subject: _____

Signed: _____

Dated: _____

I certify that I have explained the study to the volunteer and consider that he/she understands what is involved

Signed: _____

Dated: _____

Appendix 5

Interview questions

1. What is it like to care for a severely burnt patient? Can you describe your experience?
2. What effect does nursing burns patients have on you?
3. Can you describe what it is like for you when have to cause a patient considerable discomfort and pain whilst attending to their dressings and activities of daily living?
4. Describe how have your experiences changed the way you care for patients?

Prompts that will be used to encourage the participant:

- Can you elaborate on that point some more.
- That's very interesting, can you illuminate this point
- Can you describe in more depth how this made you feel.
- What does this mean to you?

Appendix 6

An extract from an interview with a participant.

I: indicates interviewer (researcher) P: indicates participant.

Participant 7

I: I'm doing this research on the lived experience of nursing burns patients. So I just want to say that anything you say in here is totally confidential and I won't refer to you by name.

So to start off with I'm just going to ask you a series of questions. So can you tell me your experience, I need to know your experience, what it's like to care for a severely burnt patient? Can you describe your experience?

P: Um, I guess I find it, it's a lot more intense than nursing I've done on other wards. You get to have quite an amazing relationship very quickly with a person who has suffered a large burn. It's a very intense time for them and as nurses we're automatically trusted so you have this quite amazing relationship with them which I think really helps.

They know, well apart from the young guys, they tend to know that you've got to do what you've got to do and some of that isn't very nice, burns dressings being one of them. Like people give you this amazing trust that you will do your best, you'll do your best to sort out the pain relief properly if things aren't working, that you'll do something about it. And yeah, yeah, so I think it's quite awesome in that respect.

As far as what you have to do to people, um, like inflicting a great deal of pain sometimes; that can be really hard. And I guess you learn how to deal with that and I realise that not everyone can do that or wants to, you know, wants to be able to do that.

I: Is there any particular patient that comes to mind you can share your experience about, about nursing a severe burn injury patient?

P: I guess, I mean we deal with a lot of small burns as well and I guess I don't include that so much, even though I mean dressings are probably just as traumatic for them, but the ones that affect me I guess are um, the larger burns that have to go through dressings probably every second day, they have to have their outers changed which is still very, very painful, everyday, every night, up to twice a day.

So I guess I haven't looked after very many large burns, probably only half a dozen, but I guess they're the ones I'm thinking about. You know, the dressings take an hour, hour-and-a-half, two hours, you know, you're going - you can't knock people out completely, you're doing your best for them, and, mmm. (Long silence) I guess I'm thinking about those patients.

I: Okay, so can you tell me what effect does burns nursing, nursing burns patients have on you? Can you tell me the effect it has on you? The effect it has on you firstly at work.

P: Um, at work, well I guess it's twofold. There's really good things about it, like I was saying about the relationship you have with the patient, I think that's really quite special and that carries on as well. Like there's one guy, he was a big burn, I didn't nurse him while he was a big burn, he'd come back - when I first started here - come back because of wound breakdown, but he still couldn't stand up. He still had um, (long silence) like you touched him and it hurt him, you know, just a gentle touch would hurt him.

And like he was starting, come, he'll walk down the corridor now and he's looking so good and he, you still have this amazing relationship with them.

I: Is that a motivation for you in burns?

P: Well that's what I really like about, about it. You do um, like I got into nursing to work with people and I think you do, you work, you really do, they get to know you and trust you and you get to know them really well. And I think that's quite an extraordinary relationship that I haven't encountered anywhere else.

But on the downside, um (long silence) it does, it causes me quite a bit of anxiety doing burns dressings, especially big ones.

I: Can you expand on that?

P: Well I guess I start thinking about it beforehand because, you know, you've got to sort out the pain relief. If it didn't work very well last time you've got to sort that out prior. It's not, not so bad um, at North Shore because we use different types of drugs and different mechanism of giving them from my old ward in New Zealand.

Um, (long silence) yeah um, so that, you start thinking, well I start thinking about that before um, and you know, talking to the patient, how they feel about it, how it went for them last time and anything you can do to change it. But you both know that it's going to be pretty awful. Hopefully they don't remember a great deal. But I mean they wind up beforehand as well, nobody looks forward to that, um.

I: So how does burns nursing affect you actually on the ward in a general way?

P: Well I guess like it does (long silence) well I guess it's quite hard work sometimes (laughs) because you are - there is that anxiety involved. You do have the conflict of having to get on with it and do the dressing and the best thing you can do for a person is get on with it and well, I mean stopping, drawing it out, um, things like that are just going to make it worse for them, so you've just kind of got to hold it together and get on with it and do it.

Some, like sometimes I um, I find I can't do that, I kind of - I feel like I (long silence), how would I explain it, I kind of lose it a little bit, not emotionally, but I find I get, um - there was one occasion where the guy, the guy had, he had a Ketamine Midazolam PCA and he had a morphine PCA and it was still, he was just screaming at the top of his lungs. Must have been really awful for other patients to listen to as well.

Um and I found that really hard to deal with that particular time, but I found it really hard to concentrate on what I was doing, it was causing me quite a bit of anxiety as well and, um, but luckily there was, there's someone else in there to help and they kind of, even though it was my patient, they kind of took the leading role in doing the

dressing. So that was really helpful, you know, your workmates are really helpful in that respect.

And I think, because of that, because you are always helping each other, you wouldn't leave someone to do a big dressing on their own, it's just no possible, but also emotionally, you know, so we have a great team and I think that really helps as well.

I: So what coping strategies do you have in play when things turn like this?

P: Well I guess you, you've just got to be able to get on with doing what you're doing. You know, stopping, taking time out isn't an option, you've just got to be able to get on with it. And I get quite task orientated during that time, um, like it, beforehand I will talk to the patient about what I'm going to do, um, you know, pain relief wise, what I'm going to do with the dressing, how I'm going to proceed. But I guess once I - I do notice - once I get in there and start doing it, I tend to get very focused on what I'm doing and I don't seem to be (laughs) able to multitask very well.

So I do tend to forget to keep talking to the patient because I'm just so very focussed on what I'm doing and getting it done in a shorter time as possible.

I: And how does burns nursing affect you, nursing a burns patient affect you outside work?

P: I guess outside work, well (long silence) first of all I think it's really important talking to colleagues and stuff about this. I don't tend to talk to friends about it very much because people just have no concept of what it's like doing that. And like especially when it's really traumatic, like dressing children is really, I find really traumatic as do they.

And people just have no real concept of what it's like, even other nurses that don't work in the area, like, you know, a friend of mine who said to me that she, she has no idea of what it would actually be like to be involved in a big burns dressing. And so I think talking to colleagues is really important and like having colleagues in there just

to help you, I don't know, it's just, it just seems emotionally supportive to have someone else in there go through it with you.

Um, so I guess I don't, yeah, outside of work, I don't really talk about it.

Appendix 7

Examples of coded significant statements

Statement Number	Significant Statements	Participant Number	Line Number
1	I find it, it's a lot more intense than nursing I've done on other wards.	7	8
2	You get to have quite an amazing relationship very quickly with a person who has suffered a large burn. It's a very intense time for them and as nurses we're automatically trusted so you have this quite amazing relationship with them which I think really helps.	7	9 - 12
3	...the larger burns that have to go through dressings probably every second day, they have to have their outers changed which is still very, very painful, everyday, every night, up to twice a day.	7	27 - 30
4	You know, the dressings take an hour, hour-and-a-half, two hours....	7	32 - 33
5	You do have the conflict of having to get on with it and do the dressing and the best thing you can do for a person is get on with it...stopping, drawing it out...just going to make it worse for them, so you've just kind of got to hold it together and get on with it and do it.	7	71 - 75
6	...you've just got to be able to get on with doing what you're doing...stopping, taking time out isn't an option, you've just got to be able to get on with it.	7	93 - 95
7	...people who self harm, it's so hard to work with them. If they're still depressed, if they still don't want to be alive, then you really notice the difference in nursing them, but it's exhausting trying to motivate them...	7	154 - 156
8	I think it's definitely a reality check about what's important in life, um, and what's not...	7	193 - 194
9	Okay, it's inflicting pain but we're all there by choice, we know, you know, if someone couldn't handle doing it then they wouldn't.	7	159 - 160
10	...what I really like about it, well I really like wounds, looking after wounds.	7	212
11	...it's definitely very emotional, lots of different emotions you're having to deal with and I've been doing this for quite a while and I feel like it's something you never get used to.	3	10 - 12
12	...it's very tough. But it's also very rewarding - can be a very rewarding experience.	3	13 - 14

13	...seeing them mobilised for the first time...you feel like you're really making a difference when you actually see them taking those first steps. Then...because it is such a slow process...you sometimes you feel like, am I actually making any difference whatsoever?	3	72 – 77
14	I think I'm a lot more patient...especially with burns patients, things tend to take a lot longer to achieve, so it's a very slow process when you're not used to that and you want to see results quicker...whereas I think I'm a lot more patient and smaller achievements...	3	215 – 218
15	Well it's very challenging...especially the large cases.	6	9
16	It also depends whether they are young, married or not married, if they are very old. It depends...whether it's self inflicted, whether it's coming from an accident or whether it's because of stupidity...but you do take a different approach to the...severity of the burn and how you care for them.	6	11 – 14
17	...you have to be strong, you have to be a bit...strong to get them to do things for you. It's no good to lure yourself into their misery and think, oh it's so sad for them, they can't do it, therefore you mustn't do it if you can't do it.	6	69 – 72
18	...as long as you get them functioning, whether they're going to look terrible, it's sort of comes secondary, I look behind that. But I think to get them to function on their own is the most important thing.	6	114 – 117
19	You know you cannot avoid that pain, but the only thing you can do is just do it very quickly, so you need staff who can do it quickly instead of drag it on for many hours.	6	229 – 231
20	...often they come in and visit us afterwards. I think that's a nice outcome...and to follow up patients that you looked after for a long time, that they keep visiting the ward. I think that's very rewarding.	6	246 – 248
21	...well I'm careful that I don't get burnt.	6	
22	...so huge multidisciplinary care which is what's...great because you work as a big team of people all working towards the same goal.	5	22 – 24
23	I don't think you get used to it, I think when you get used to it it's probably time to give up.	5	31 – 32
24	If it's something that has to be done and it has to be done quickly, I can go in and do it, as long as there's somebody else looking after the patient's...mental wellbeing, the pain...	5	245 – 247
25	...to make the nursing experience as positive as possible and as enjoyable for the staff in what's the majority of time is tragic circumstances...	5	331 – 332
26	I couldn't do it without the team...because of the nature of the work...	5	368 – 369
27	...isn't like somebody's come in with appendicitis and it's straightforward...it's normally a very, a very sad accident...you get more involved with them.	5	87 – 90

28	So because they're in for months you get to know them, you get to know their families and because of that then the whole team become very close.	5	149 – 150
29	I think I'm probably more hardened to it because I've seen so much of it and I have a quite a good idea of how things are going to play out and move on.	5	173 – 174
30	I certainly think and I do believe that you either love working in burns and plastic surgery, or you don't like it and you wouldn't do it.	5	180 – 181
31	If someone's been burnt when it's not their fault, I find that harder...most burns are because they've been stupid or...it's silly mistake...But when someone's been burnt from no fault of their own, I kind of feel a lot more for them...	4	30 – 34

Appendix 8

Significant statements and formulated meanings

All coded significant statements and corresponding formulated meanings relating to the objectives of the study are provided in the following tables.

Objective 1: To explore and describe the lived experience of burns nurses who care for patients with traumatic burns injury

Significant Statements	Formulated Meaning
I find it, it's a lot more intense than nursing I've done on other wards. 1 P7: L 8	Burns nursing is unique and specialised field of nursing requiring specialised skills in order to competently nurse and cope with the emotional and physical aspects of burns nursing. fm 1
You get to have quite an amazing relationship very quickly with a person who has suffered a large burn. It's a very intense time for them and as nurses we're automatically trusted so you have this quite amazing relationship with them which I think really helps. 2 P7: L 9 – 12	Rapid development of unique relationship between burns nurse and the patient with a severe burn injury grounded in trust assisting in the recovery process. fm 2
...the larger burns that have to go through dressings probably every second day, they have to have their outers changed which is still very, very painful, every day, every night, up to twice a day. 3 P7: L 27 – 30	Burns dressings are a very arduous procedure for the patient and the nurse, performed possibly several times a day becomes physically intensive. fm 3
You know, the dressings take an hour, hour-and-a-half, two hours...4 P7: L 32 – 33	Dressing wound for a severe burns injury patient takes several hours and is a physically and emotionally demanding, draining and exhausting task. fm 4
You do have the conflict of having to get on with it and do the dressing and the best thing you can do for a person is get on with it...stopping, drawing it out...just going to make it worse for them, so you've just kind of got to hold it together and get on with it and do it. 5 P7: L 71 – 75	Grounded in the reality that burns dressing need to be performed with the necessity to remain focussed in order to get through the procedure which engenders difficult emotions. fm 5
...you've just got to be able to get on with doing what you're doing...stopping, taking time out isn't	Staying extremely focussed is fundamental to burns procedures in order to reduce the stress

<p>an option, you've just got to be able to get on with it. 6 P7: 93 – 95</p>	<p>experienced by nurses and to alleviate the suffering and anxiety experienced by patients. fm 6</p>
<p>...people who self harm, it's so hard to work with them. If they're still depressed, if they still don't want to be alive, then you really notice the difference in nursing them, but it's exhausting trying to motivate them...7 P7: L 154 – 156</p>	<p>Self harm burns patients are emotionally exhausting and frustrating to nurse due to the lack of motivation and depressed state in which they remain. fm 7</p>
<p>I think it's definitely a reality check about what's important in life, um, and what's not...8 P7: 193 – 194</p>	<p>Nursing severe burns injury patients places the importance on life and gives nurses a different perspective on everyday life and events. fm 8</p>
<p>Okay, it's inflicting pain but we're all there by choice, we know, you know, if someone couldn't handle doing it then they wouldn't. 9 P7: L 159 – 160</p>	<p>Burns nurses need to be able to perform painful procedures that requires them to remain focused in order to cope and without the coping skills necessary it is not possible to give competent care. fm 9</p>
<p>...what I really like about it, well I really like wounds, looking after wounds. 10 P7: L 212</p>	<p>Managing severe burn wounds gives burns nurses a challenge to which they have an interest. fm 10</p>
<p>...it's definitely very emotional, lots of different emotions you're having to deal with and I've been doing this for quite a while and I feel like it's something you never get used to. 11 P3: L 10 – 12</p>	<p>Burns nursing is continually emotionally demanding and challenging that requires specific coping skills to be able to nurse these patients. fm 11</p>
<p>...it's very tough. But it's also very rewarding - can be a very rewarding experience. 12 P3: 13 – 14</p>	<p>Although challenging, nursing severe burns patients is a fulfilling and gratifying experience. fm 12</p>
<p>...seeing them mobilised for the first time...you feel like you're really making a difference when you actually see them taking those first steps. Then...because it is such a slow process...you sometimes you feel like, am I actually making any difference whatsoever? 13 P3: L 72 – 77</p>	<p>Frustration for the nurses that the recovery process is tedious and slow, questioning whether nursing care is actually contributing to the recovery process. fm 13</p>
<p>I think I'm a lot more patient...especially with burns patients, things tend to take a lot longer to achieve, so it's a very slow process when you're not used to that and you</p>	<p>The reality is that burns recovery is slow and the need for patience and realistic goals is critical when nursing severe burns patients. fm 14</p>

<p>want to see results quicker...whereas I think I'm a lot more patient and smaller achievements...14 P3: L 215 – 218</p>	
<p>Well it's very challenging...especially the large cases. 15 P6: L 9</p>	<p>Nursing severe burns injury patients is a very challenging, emotionally demanding and exhaustive experience. fm 15</p>
<p>It also depends whether they are young, married or not married, if they are very old. It depends...whether it's self inflicted, whether it's coming from an accident or whether it's because of stupidity...but you do take a different approach to the...severity of the burn and how you care for them. 16 P6: L 11 – 14</p>	<p>The mechanism of burn injury, type of patient involved and circumstances around the burn affects and influences how burns nurses react and care for their patients. fm 16</p>
<p>...you have to be strong, you have to be a bit...strong to get them to do things for you. It's no good to lure yourself into their misery and think, oh it's so sad for them, they can't do it, therefore you mustn't do it if you can't do it. 17 P6: L 69 – 72</p>	<p>Burns nurses need to maintain a level of detachment from the emotions of burns trauma in order to motivate patients to become independent. fm 17</p>
<p>...as long as you get them functioning, whether they're going to look terrible, it's sort of comes secondary, I look behind that. But I think to get them to function on their own is the most important thing. 18 P6: L 114 – 117</p>	<p>Placing the visible trauma aside and focussing on independence and function is fundamental to burns nursing. fm 18</p>
<p>You know you cannot avoid that pain, but the only thing you can do is just do it very quickly, so you need staff who can do it quickly instead of drag it on for many hours. 19 P6: L 229 – 231</p>	<p>Being grounded in the reality that pain is unavoidable and having specific skills to dress large burns patients with minimal trauma to both the staff and patients. fm 19</p>
<p>...often they come in and visit us afterwards. I think that's a nice outcome...and to follow up patients that you looked after for a long time, that they keep visiting the ward. I think that's very rewarding. 20 P6: L 246 – 248</p>	<p>Extremely rewarding and positive experience when long term burns patients return to the ward visiting in good health. fm 20</p>
<p>...well I'm careful that I don't get burnt. 21 P6: L 273 – 275</p>	<p>Fear and anxiety towards being burnt. fm 21</p>
<p>...so huge multidisciplinary care which is what's...great because you work as a big team of people all working towards the same goal. 22 P5: L 22 – 24</p>	<p>Burns nursing requires collaboration with an extensive multidisciplinary team that is focused on the management of severe burns injury patients. fm 22</p>

<p>I don't think you get used to it, I think when you get used to it it's probably time to give up. 23 P5: L 31 – 32</p>	<p>Burns nursing requires humanity and compassion and without these qualities it is not possible to nurse burns patients. fm 23</p>
<p>If it's something that has to be done and it has to be done quickly, I can go in and do it, as long as there's somebody else looking after the patient's...mental wellbeing, the pain...24 P5: L 245 – 247</p>	<p>Emotional detachment is crucial in order to remain completely focussed when performing burn dressings and delegation of psychological care to another team member. fm 24</p>
<p>...to make the nursing experience as positive as possible and as enjoyable for the staff in what's the majority of time is tragic circumstances...25 P5:L 331 – 332</p>	<p>Remaining positive in the face of adversity. fm 25</p>
<p>I couldn't do it without the team...because of the nature of the work...26 P5: L 368 – 369</p>	<p>Burns nursing is emotionally and physically exhausting and without the team support burns nurses give to one another it is not possible to care for severe burns patients and the many aspects of care. fm 26</p>
<p>...isn't like somebody's come in with appendicitis and it's straightforward...it's normally a very, a very sad accident...you get more involved with them. 27 P5: L 87 – 90</p>	<p>Burns nursing is complex in both the physical and emotional sense often involving intensive relationships with patients based on trust. fm 27</p>
<p>So because they're in for months you get to know them, you get to know their families and because of that then the whole team become very close. 28 P5 :L 149 – 150</p>	<p>Nursing teams unites and supports each other when there is a long stay severe burns patient. fm 28</p>
<p>I think I'm probably more hardened to it because I've seen so much of it and I have a quite a good idea of how things are going to play out and move on. 29 P5: L 173 – 174</p>	<p>Constant exposure to burns trauma desensitises nurses to patients' suffering. fm 29</p>
<p>I certainly think and I do believe that you either love working in burns and plastic surgery, or you don't like it and you wouldn't do it. 30 P5: L 183</p>	<p>There is a natural selection process for those who wish to work in burns and those who can not cope leave but those who stay are committed and passionate. fm 30</p>
<p>If someone's been burnt when it's not their fault, I find that harder...most burns are because they've been stupid or...it's silly mistake...But when someone's been burnt from no fault of their own, I kind of feel a lot more for them...31 P4: L 30 – 34</p>	<p>Burns as a result of unforeseen circumstances are more emotionally demanding to nurse due to the tragic circumstances that surround the injury. fm 31</p>

<p>...I've had situations where...I've been trying to remove a dressing that is very painful...trying to get more pain relief for them...nothing's working and then someone's come in and just ripped it right off and I've just stood back and almost been horrified. But then struggled, thinking well maybe that was the best thing because it got it over and done with really quickly. 32 P4: L 241 – 246</p>	<p>Having feelings of inadequacy and powerless during dressing changes resulting in questioning nursing care. fm 32</p>
<p>...I thought I was doing the right thing...stopping when they were in pain, but it was taking a hell of a long time to do...33 P4: L 265 – 267</p>	<p>Struggles between trying to do a burns dressing competently and attempting to keep the patient pain free. fm 33</p>
<p>...I would talk to him about all sorts of things. Like I shared my kids with him, I'd share my life with him so that we had something other than his injury to talk about. 34 P4: L 324 – 325</p>	<p>Self disclosure to burns patient to divert attention away from traumatic injury for both the nurse and the patient. fm 34</p>
<p>...it's made me a lot more suspicious of people, how their injuries occur, whether family were involved, it is, it's like, oh, you know, this burn injury doesn't correlate to that or was there something else going on that you haven't told me and stuff like that. 35 P2: L 472 – 475</p>	<p>Nurse becomes very suspicious of patients and their family in relation to the burn injury sustained. fm 35</p>
<p>...you try and get them to go down that track of what this injury means...and you try and be a bit more realistic with them because they just don't see it, they're blind. 36 P4: L 367 – 369</p>	<p>Grounding the patient in the reality of the injury sustained. fm 36</p>
<p>...I find burns nursing good too because...the dressings and all that is quite stimulating. It's challenging the brain, it's something extra other than normal nursing...you can be specialised in and...I just find it very rewarding. 37 P4: L 488 – 491</p>	<p>Burns nursing is exciting, more challenging than general nursing giving high levels of satisfaction and gratification. fm 37</p>
<p>...talking about how you feel, too, deciding when not to care for someone, like just to make them comfortable and let them die...is also a challenge with burns because they're so compos, you know, they can talk and everything. 38 P4: L 457 – 459</p>	<p>Importance of communicating feelings about withdrawing care and the challenge of communicating with burns patients that are dying. fm 38</p>
<p>...the fact too that...a lot of them do try and go out and kill themselves in other</p>	<p>Questioning whether treating burn suicide</p>

ways, you wonder if sometimes we're actually doing the right thing. 39 P4: L 455 – 456	patients is right if the patient wishes to die. fm 39
I find it hard to look after burns patients that have actually done it to commit suicide...because you know you put all this effort in to try and help somebody and you know they actually don't even want help to get better. 40 P4: L 431 – 434	Difficulty in nursing burn suicide patients due to the effort and commitment that nurses give to the patient that does not want to live. fm 40
...yes they've got a wound...or they've got a burn, but they're still a person. So I don't see the burn as the main thing. I see them as a person. 41 P4: L 408 – 410	Having humility and compassion in the face of a traumatic burns injury. fm 41
...people can have pretty horrific stuff and you just, you just accept it and...sort of more assess it and...do what you have to do. 42 P4: L 411 – 413	Burns nursing is extremely confronting that requires a level of acceptance and detachment in order to care for the patient. fm 42
...you're scared because you don't know what her life's going to be like outside the hospital...43 P1: L 47 – 48	Compassion for burns patients beyond discharge with feelings of apprehension and anxiety towards their progress and adjustment. fm 43
...I feel the faster I am causing, hopefully causing less pain, makes it a lot less painful for them, but I mean I still get scared if something happens. I don't think that will ever go away...44 P1: L 133 – 135	Performing burns dressings has an element of fear and anxiety towards causing pain to burns patients. fm 44
...what you see takes over everything and...you see it and then you think, oh my gosh, that's really bad and then you just have to stop and go, okay, you know what to do...45 P1: L 147 – 150	Remaining focussed and confident in the face of traumatic burns injury. fm 45
Not many people are as wary as you are when you light a barbeque and you're a burns nurse. 46 P1: L 167 – 168	Burns nurses exposure to burns injury affects behaviour and actions. fm 46
...you're not focussed on what happened to him, you focus on saving him, after it you think about what happened and how he got burnt, I mean the reason he got burnt was because he was also trying to commit suicide. 47 P1: L 204 – 206	Suicide attempt is not a focus during resuscitation process, however, after nurse reflects on how he was burnt and the suicide attempt. fm 47
...someone who you just came in and...you could see him and he had no chance at all, so it was kind of a bit shell	Severe burns trauma is extremely confronting to deal with the extent of the trauma. fm 48

shocking to walk into that situation. 48 P1: L 224 – 226	
...you just have to say to them, look it's going to be painful, we'll do everything we can to lessen the pain, but we can't stop it. 49 P1: L 267 – 268	Being honest and realistic to patients about painful burns procedures. fm 49
...I could definitely say I've hardened. 50 P1: L 436	Burns nursing causes nurses to become emotionally hardened to cope and manage the challenges of burns care. fm 50
...looking at him actually makes it really rewarding because he was in such a bad way on the ward and then seeing him now and he's quite happily talk about his experience. 51 P1: L 488 – 490	To see a severe burns patient make a significant recovery is extremely rewarding and satisfying. fm 51
...it's one of the areas only the people you work with can really understand... 52 P1: L 530 – 531	To fully comprehend and appreciate what burns nursing involves you have to be involved within the area of burns. fm 52
You definitely harden in some ways. 53 P1: L 444	Burns nursing causes you to toughen up to the reality of burns injury. Fm 53
It's hard because there's a lot going on. It's not just the dressings, it's not just the pain control. You're looking at nutrition. 54 P2: 13 – 14	Burns nursing is complex involving many different disciplines to be coordinated and involved. fm 54
You're not just supporting the burns patient, you're supporting their family. 55 P2: L 14 – 15	Burns nursing requires a holistic approach that incorporates supporting the family unit in order to assist in the physical and emotional rehabilitation. fm 55
...you've also got to collaborate with physios, OTs, nutrition...dieticians, doctors, pain teams...plus their family and social work...56 P2: L 15 – 17	Nursing burns patients requires a collaborative team approach incorporating many areas of healthcare in order to facilitate patients' recovery. fm 56
So you could provide a good level of care but not become so involved, even burnout which I think is probably the hardest thing I found...57 P2: L 38 – 39	A level of detachment is required to competently nurse severe burns patients so as not to endure the emotional and physical effects of burnout. fm 57
...just the physical work is really difficult. 58 P2: L 63	Burns nursing can be an extremely physically demanding and exhausting experience. fm 58
But it's just the emotional rollercoaster that you go through that you're putting a	Necessary painful procedures are extremely confronting and emotionally exhausting for

person through pain and you're doing it intentionally but not wanting to...59 P2: L 71 – 72	burns nurses. fm 59
...the psychological issues that this patient also transfers to you as well. It makes you angry and it makes you upset that you have to deal with this and it's not particularly your issue. 60 P2: L 73 – 75	Dealing with burns patients' emotions is draining and exhausting eliciting anger and frustration of having to face these emotions. fm 60
I would hate to think of someone being burnt and then having to die by themselves, which I think puts a lot of pressure on the nursing staff. 61 P2: 469 – 471	Dying patients without family support is stressful for the burns nurse. fm 61
...you dread going into it knowing that you could look after them. 62 P2: L 112	The care of burns patients is sometimes fraught with fear, anxiety and emotion towards the care of specific patients that require intensive physical and emotional care. fm 62
You know you're going to be put through an emotional rollercoaster and not only that but you're going to be physically exhausted from everything that you have to do for the patient. 63 P2: L 113 – 115	Burns nurses experience a range of emotions whilst caring for their patients that are extremely challenging, demanding and exhausting emotionally as well as physically draining. fm 63
You're comparing yourself to other people and other nurses, would they have done this, what would they have done...I suppose it also causes you a lot of reflection...64 P2: L 161 – 163	The trauma of burns injury causes burns nurses to continually reflect on their practice as a nurse. fm 64
...there were times when his family came in and you could see happiness and you could see, yep, this patient is going to make it through. And then there would be other times when he would be crying and there was nothing you could say, there was nothing you could do that would make this situation any better. 65 P2: L 182 – 186	Feelings of hope and positivity towards patients recovery verses feelings of hopelessness unable to alleviate pain and suffering. fm 65
...you form a friendship with the patient, not the normal friendship say you'd have with someone outside because you obviously have that nurse/patient relationship, that there is a friendship there...66 P2: L 206 – 208	A unique friendship and bond develops between the burns patient and nurse with professional boundaries. fm 66
But most of the time it's seeing the patient smile and just thinking, yeah, it's been a good day...67 P2: L 217	Seeing the patient smile gives the nurse satisfaction and gratification for care she has

	delivered. fm 67
...you're still compassionate but you lose a lot of your compassion. 68 P2: L 232	Nursing burns trauma patients requires a level of emotional detachment in order to give competent emotional and physical care without losing your humanity. fm 68
It's something you dread. You go through the day knowing that it's coming up and that you're going to have to do it regardless. 69 P2: L 360 – 361	Anxiety, fear and apprehension are emotions that burns nurses often feel prior to large burns procedures. fm 69
...consulting with pain team as well is a big thing...70 P2: L 369	Team collaboration is the key to burns nursing and without the support, competent care can not be given. fm 70
...the patients have a right to be angry and resent what they're having to go through. But you kind of feel angry at them that if they don't do this treatment then it's going to get worse for them and trying to explain that. 71 P2: L 438 – 441	Anger and frustration are emotions experienced by burns nurses towards patients that are non compliant, traumatised and angry at their level of function. fm 71

Objective 2: To identify stressors and strategies used by burns nurses to cope with negative traumatic events in relation to patient care.

Significant Statements	Formulated Meaning
As far as what you have to do to people, um, like inflicting a great deal of pain sometimes; that can be really hard. And I guess you learn how to deal with that.....72 P7:L 19 – 21	Infliction of pain on patients during burns dressings and procedures is extremely challenging and requires specific coping mechanisms to learn how to cope. fm 72
...it causes me quite a bit of anxiety doing burns dressings, especially big ones. 73 P7: L 54 – 55	Nurse experiences levels of anxiety during large burns dressings. fm 73
...he was just screaming at the top of his lungs... and I found that really hard to deal with... I found it really hard to concentrate on what I was doing, it was causing me quite a bit of anxiety...74 P7: L 80 – 84	Patient vocalising his pain through continual screaming makes it difficult to manage and focus on the task required and a source of anxiety for the burns nurse. fm 74
...you think, gosh why, especially if they're young ones and they haven't lived their life, yes, it's very distressing. 75 P6: L 266 – 267	Burns trauma is extremely confronting and distressing for the burns nurse especially the very young burns victims that have not experienced their life as yet. fm 75
...and actually having to stop through the dressing because it was too traumatic for the patient and too traumatic for myself... 76 P3: L 26 -27	Burns dressings is not only traumatic for the patient but transfers onto the burns nurse as a distressing experience. fm 76
...because it is such a slow process, you know, you sometimes you feel like, am I actually making any difference whatsoever? 77 P3: L 75 – 77	The rehabilitation process for burns patients is extremely tedious and slow which is frustrating for the burns nurse in putting great effort and seeing little progress. fm 77
...you don't feel like you're being fully supported, sometimes it can get a little too much when you're - you don't really have anyone to...sort of fall back on because of staff shortages...78 P3: L 90 – 92	Feelings of a lack of support for burns staff are upsetting especially with staff shortages. fm 78
And I do get upset if my...patients are getting upset about...how they will, if they are ever going to get back to some kind of normality and how people...in the outside world...are going to look at them with their scarring...79 P3: L95 – 98	Burns nurse is distressed by patient's emotions and empathises with patient about returning to a sense of normality. fm 79
...but I do worry just how they will cope when they are outside of the safety of the	Burns nurse feeling concerned and apprehensive about patients with severe

<p>burns unit. 80 P3: L 101 – 102</p>	<p>burns trauma return to society after a long admission. fm 80</p>
<p>...try to leave my work at work, but when you've had a really bad day on the ward you do tend to bring it home with you. 81 P3: L 121 – 122</p>	<p>Bad experiences for the nurse on the burns ward tend to affect home life, unable to detach from the stress and anxiety of burns nursing. fm 81</p>
<p>...I came out of dressings, it was like, what am I doing to this patient...this is wrong, this is not how it should be done. I'm traumatising them and myself and they're going to be dreading their next dressing because of what's just happened...82 P3: L 201 – 204</p>	<p>Burns dressings can be extremely traumatic experience for the nurse that leaves them troubled and distressed about the experience and how this will affect the patient's next dressing change. fm 82</p>
<p>...if I'm in a dressing for two hours and I have three other patients who may need things, I feel that I'm not - there's not enough of me to go round. Um and I worry that I'm not giving the proper amount of care to all of my patients.83 P3: L 251 – 254</p>	<p>Having several large burns dressings to complete is a lengthy procedure that is emotionally and physically exhausting and leaves the nurse feeling inadequate about the care given. fm 83</p>
<p>It's stressful, it's emotional, it's - I can see how nurses, burns nurses get burnt out, because it is a highly stressful, emotional job. 84 P3: L 263 – 264</p>	<p>Burns nursing is a highly stressful and emotional job that can leave burns nurses feeling burnt out. fm 84</p>
<p>I don't feel I have much to give. I don't have...anything to give my patients...you can give and give and then you end up with nothing left to give. 85 P3: L 269 – 271</p>	<p>Burns nursing is emotionally exhausting, demanding and draining that leaves the nurse feeling she is unable to give anymore to the patient. fm 85</p>
<p>I also feel if someone is burnt in a situation that is close to mine, that that's more upsetting. 86 P4: L 34 – 35</p>	<p>The burns nurse finds nursing severely burnt patients in situations that are close to her challenging and considerable more upsetting. fm 86</p>
<p>...people that have been burnt in a traumatic situation, like the Bali bombings, I found that very stressful...it just wasn't something you could um, chat about, it was so traumatic. You couldn't make it light. You couldn't banter about it or anything, it was too serious, you know? People had lost their friends and stuff, so I actually found that looking after</p>	<p>Burns victims that have been burnt in mass disasters are difficult for the burns nurse to communicate with due to the sensitive and tragic circumstances that surround the patient. fm 87</p>

them very difficult. 87 P4: L 40 - 47	
Makes you feel a bit vulnerable because you know...it can happen to people that are close to me, means it can happen to me. 88 P4: 63 – 64	Burns trauma is confronting in that it makes the nurse feel vulnerable that it could happen not only to loved ones but themselves. fm 88
...inside you just get stressed, like adrenalin keeps going when you don't need it and you just can't keep going at a hundred miles an hour. And to me, it starts manifesting in...well not feeling to well almost.... not being able to make decisions properly and...the well oiled machine isn't just running properly anymore. 89 P4: L 208 - 213	Burns nurses can feel severely stressed and burnt out manifesting in the inability to make competent decisions about patient care and function as a valuable member of the burns team. fm 89
Even where when we do Keta-Midazolam where I know they're going to forget it and they're still in extreme pain, I mean it's easier because I know they're not going to remember it, but um, even that is still quite traumatic. 90 P4: L 250 – 253	The pain associated with dressing burns patients is very traumatic for the burns nurse to experience even when patients can not recall the pain of the dressing due to the medications it still remains a traumatic experience for the nurse. fm 90
...it took four hours to do his dressing and by the end of the four hours...I just walked out...of the room, went away thinking that ...it was probably the most awful I've ever been through... 91 P1: L 87 – 93	Burns dressings are an arduous, demanding and exhausting task that can take many hours and leave the nurse feeling emotionally drained and experience a sense of awfulness. fm 91
...I felt horrible, but everything I was suppose to be there to help and it wasn't helping and by the end of it I just felt like I couldn't do anything, it was awful. 92 P1: L 109 – 111	The nurse is left with distressing feelings of dismay, hopelessness and inadequacy unable to alleviate patient's suffering. fm 92
...you're watching someone, a severely burnt body, pretty much die and...that's what you get thrown into, it's a bit of a shellshock. 93 P1: L 229 – 233	Burns nursing sometimes involves caring for fatal burns injury that leaves the nurse shell shocked. fm 93
...you do get a little bit upset when you see their faces and...you hope...when you first see someone, you go, I hope it goes back to their normal face... 94 P1: L 358 – 360	Nursing patients with facial burns is upsetting with the uncertainty of their face ever returning to the pre injury state. fm 94
...the hardest thing was the learning to find a way to detach because otherwise you were taking it home with you, you were thinking of it 24/7, you were getting angry at him (the patient), you were	Learning to emotionally detach is important for the nurse's mental well being otherwise she was continually thinking about the patient becoming angry at the patient and

getting angry at yourself that you couldn't stop thinking about it. 95 P2: L 64 – 67	herself for not being able to detach from the scenario. fm 95
...I suppose inadequacy that you know you're going to get through the end of the day, the patient isn't really going to appreciate what you've done. 96 P2: L 115 – 117	A need for appreciation from the patient is important and valued by the burns nurse, without appreciation for the physically exhausting effort has lead to feelings of inadequacy. fm 96
Inadequacy because you can't control his pain, anger that you can't control his pain and anger that he's screaming and yelling and like showing other visitors and other patients that you're putting him through this...97 P2: L 127- 129	Feelings of inadequacy and anger are experienced by the burns nurse related to the lack of control over patient's level of pain experienced. fm 97
...it's sad, it's just a horrible, horrible feeling that you're having to do this to someone and that someone is having to suffer this way and that there's - you've done and you've tried almost everything and you just, also a sense of hopelessness as well because you have done and tried everything and you can't think of any way to fix it. 98 P2: L 134 – 138	Having to inflict pain and suffering upon a patient in the course of trying to help and being unable to alleviate their suffering fills the nurse with feelings of hopelessness and futility. fm 98
...they're just screaming to stop and to stop hurting them and it's awful to have to keep going. 99 P2: L 146 – 148	The screams of burns patients pleading to stop the dressing is distressing for the nurse and challenging to continue and still remain focussed to complete the burns dressing. fm 99
And that's a horrible feeling when you're feeling that you're not supported by your work people or that people are doing that judgment of you and your practice. 100 P2: L 333 – 335	Distressful feeling experienced when the burns nurse perceives she is not supported and her practice is in question. fm 100
...it's horrible...knowing that you're not going to be able to control their pain regardless of what you do, knowing that they're going to hate it for you and they're going to swear at you and they're going to, in some cases, even lash out at you which you hate them doing... 101 P2: L 370 – 373	Experiencing feelings of powerlessness and inadequacy with the inability to control the patient's pain adequately and then the nurse having to deal with the patient's anger. fm 101
It's just this horrible inadequacy that I can't do my job properly, that this patient is showing this emotion and this level of pain that you're angry at them, that you're	Patient's level of pain and emotion during a dressing change leaves the burns nurse experiencing feelings of inadequacy and

<p>sad for them. Um, it kind of goes against everything in nursing: you're supposed to help these people and fix these people but you can't. 102 P2: L 398 – 402</p>	<p>frustration about her role as a primary care giver. fm 102</p>
<p>I find I reach burnout a lot quicker here because you're dealing with a lot more emotionally where not necessarily you do on other surgical wards. 103 P2: L 463 - 465</p>	<p>The nurse experiences burnout earlier due to the high levels of emotions experienced with nursing severe burns injury patients. fm 103</p>
<p>...anger I feel sometimes the doctors do not care or do not care enough...104 P2: L 493</p>	<p>Feelings of anger towards the medical staff for not expressing compassion or too little is upsetting for the burns nurse. fm 104</p>
<p>...I felt horrible, but everything I was suppose to be there to help and it wasn't helping and by the end of it I just felt like I couldn't do anything, it was awful. 105 P1: L 109 – 111</p>	<p>Experiencing levels of frustration, inadequacy and hopelessness towards difficult burns dressings. fm 105</p>

Objective 3: To describe the level of commitment and motivation displayed by burns nurses.

Significant Statements	Formulated Meaning
<p>...it's not really an option not to do dressings. It's not an option not to do physio</p> <p>145 P7: L 152 – 153</p>	<p>Being grounded in the reality of the injury assists burns nurses to be dedicated and committed towards burns care. Fm 145</p>
<p>So obviously you want them to get better very quickly and you do your utmost to get them there. 146 P6: L 26 – 27</p>	<p>Passion, motivation and commitment to nursing severe burns injury patients is fundamental towards a positive patient recovery. fm 146</p>
<p>...especially if it is a younger person who's got a young family, you want to get them as quick as possible back to their - maybe you put in extra effort in getting them back. 147 P6: L 28 – 30.</p>	<p>A young patient with a family is a motivational aspect towards a rapid recovery for the burns nurse. fm 147</p>
<p>You try and convince them to go that bit extra when they do their physio or their daily living skills or whatever, you just push them that little bit extra. 148 P6: L 72 – 74</p>	<p>Dedication and commitment towards the care and rehabilitation of someone with a burns injury involving emotional engagement and encouragement with the patient. fm 148</p>
<p>...when you think of the outcome, you think it's a necessity to have the physio and the OT and you know that in the end the patient and the staff will all be pleased because there will be a functional individual again. 149 P6: L 234 – 236</p>	<p>Burn nurse's commitment and dedication to physiotherapy and occupational therapy in order for patients to return independence. fm 149</p>
<p>I think looking after burns patients ...it's what I'm passionate about, I'm very committed to burns and how burns patients are looked after... 150 P5: L 109 – 110</p>	<p>Passion and commitment is the fundamental driving force to nursing severe burns patients. fm 150</p>
<p>...I think you have to have a certain amount of passion to be looking after burns patients. 151 P5: L 185 – 186</p>	<p>Passion is a core characteristic that enables burns nurses to nurse severe burns patients. fm 151</p>

<p>...the long process in trying to get them back to able to attend to their activities of daily living, the mobilising, the helping them with feeding and trying to get them to be able to be a little more independent with these aspects. 152 P3: L 57 – 60</p>	<p>Burns rehabilitation is a long process of encouraging independence requiring patience and persistence from the burns team. fm 152</p>
<p>...I get a lot of satisfaction out of...making them smile, making it less stressful for them and being able to help them mentally as well as physically. 153 P4: L 51 – 53</p>	<p>Nursing burns patients gives nurses gratification, satisfaction and the motivation to making patients experience as positive as possible. fm 153</p>
<p>... I just want to up the knowledge and actually I feel like I want the challenge to get a big burn down there again so I can try and do a better job next time. 154 P4: L 104 – 106</p>	<p>Motivation and commitment towards current best practice in the management of burns trauma. fm 154</p>
<p>If they need to get up and walk and it hurts, you don't just say, well there, there, it's okay, don't worry about it, because they need to do it. 155 P4: L 301 – 303</p>	<p>Motivating and encouraging the patient to push through the pain towards recovery. fm 155</p>
<p>...I'll try and do little things that are special for people, like...wash their hair or...little things like that, try and...take their TED stockings off when you wash them, just do little things that are extra to make them feel special. 156 P4: L 397 – 400</p>	<p>A show compassion and empathy towards the patient during a traumatic time in their life. fm 156</p>
<p>...I don't know if you would still go to the nth degree for them...(Why is that?) Because they don't want you to and you don't get the appreciation for doing that. 157 P4: L 473 – 477</p>	<p>Appreciation for commitment to care and effort is a motivational aspect. fm 157</p>
<p>...helping someone dress, I would probably rarely do that now unless they really needed to, but before you'd be quite happy to slip something on someone for them because... they</p>	<p>The role of encouraging independent functioning is fundamental to the care of burns patients. fm 158</p>

<p>needed the help, but now... it takes a little bit longer... now you say, you need to do it for yourself and then you just remind them that when they're going home, they have to do it for themselves...158 P1: L 318 – 323</p>	
<p>...they're saying oh can I not put the splint on today and then they look at you quite pleadingly and...when I first started I probably would have said, fine, don't put your splint on, but now, I wouldn't ever let anyone get away with not wearing a splint overnight unless it was broken. (And why?) Pretty much and then we still try and fix something up...159 P1: L 383 – 389</p>	<p>The need to remain strict, disciplined and at times firm with nursing burns patients to achieve the goal of independent functioning. fm 159</p>
<p>...it was quite rewarding to see him there because it just shows that eventually the work that we do, most of the time it leaves a happy ending. 160 P1: L 493 - 495</p>	<p>Patients that have a good outcome is very rewarding and gratifying for the nursing staff. fm 160</p>
<p>Like I definitely love the job and if left now, I would be very unhappy...161 P1: L 505 – 506</p>	<p>Burns nurses are very passionate about their work and receive great gratification, satisfaction and motivation from nursing burns patients. fm 161</p>
<p>...everyone's there because they want to be, no one's really there because they have to be. 162 P1: L 540 – 542</p>	<p>Nurses caring for burns patients have the ability to manage and cope with the challenges that come with nursing severe burns patients. fm 162</p>
<p>...the patient often just wants to lie there and you're a bit of a bully and it's like no, come on, use your hands, eat, stuff like that. And, you know, if you don't eat I'm going to put a tube down your nose so you also become a little bit of a bitch... 163 P2: L17 -20</p>	<p>A level of harshness and discipline towards burns care is necessary in order to facilitate in the rehabilitation of burns patients. fm 163</p>
<p>Whether you like it or not, you're kind of going to have to do it. 164 P2: L 53</p>	<p>Commitment and a sense of reality are essential to facilitate the recovery as a result of severe burns injury. fm 164</p>
<p>...showing that you know why I'm doing the stuff, I do care and I'm</p>	<p>Showing commitment and dedication towards the</p>

<p>trying to make this experience better for you in any way that I can...165 P2: L 204 – 205</p>	<p>alleviation of burns trauma of patients that have are suffering emotional and physical loss. fm 165</p>
<p>...no do this for yourself and the family, no back away, and you come across as the bitch who is - and you try to explain to them, well I'm trying to help you...166 P2: L 420 – 422</p>	<p>A huge level of frustration is experience in caring for patients and their families during the rehabilitation process towards independence requiring setting specific goals and boundaries. fm 166</p>
<p>...this isn't forever, suck it up, deal with it, come on, let's get through it. 167 P2: L 460 – 461</p>	<p>Giving patients motivation and courage to get through the traumatic injury towards rehabilitation. fm 167</p>
<p>I like the adrenalin and the challenges that you have to face. 168 P2: L 615</p>	<p>Nursing severe burns patients is extremely challenging and confronting that requires a high level of motivation in order to cope with those challenges. fm 168</p>
<p>...what motivates me is keeping up to date and moving forward with things that are happening. Um, it's a very specialised subject so making sure that as many people as possible get the education, so the earlier the care starts the better the outcomes. 169 P5: L 123 -127</p>	<p>Burns is a highly specialised area of nursing that requires continual education which is a motivational force that drives burns nurses to always strive to improve the outcomes for the patients. fm 169</p>
<p>...It's standing up and saying, enough's enough, we can't do this. 170 P5: L 208 – 209</p>	<p>Burns nursing requires strong patient advocacy for people who have sustained traumatic burns injuries leaving them physically and emotionally traumatised and unable to say enough. fm 170</p>

Objective 4: To identify the psychological and sociological needs of nurses working with patients that has sustained a severe burns injury.

Social or psychological	Significant Statements	Formulated Meanings
Psychological	You need other things in your life, so get out and get some exercise, get out and do something completely different. Just having that escape...from work. 106 P7: L 135 – 136	The necessity to have other interests in life to escape from the stresses of burns nursing. fm 106
Psychological	...at home on the burns ward people are employed 0.9, so work nine days in a fortnight. That's a really good way around it. You just have that little bit extra time off because it is really intense, you know. 107 P7: L 137 – 140	Rostering burn nurses on a 9 day fortnight gives the nurses extra time away from the intensity of nursing burns patients which is important for their well being. fm 107
Psychological	...it's really draining and we tend to rotate working with people (patients)...You just have to... 108 P7: L 177 – 178	Burns nursing is extremely draining that there is a necessity to rotate the patient load so the nurse is not caring for the same patient constantly. fm 108
Sociological	And so I think talking to colleagues is really important...109 P7: L 113	Expressing thoughts and feelings with other members of the burns team is important and an essential form of support. Fm 109
Sociological	...having colleagues in there just to help you...it just seems emotionally supportive to have someone else in there go through it with you. 110 P7: L 114 – 115	Having assistance from colleagues is emotionally supportive during difficult burns dressings and care. fm 110
Psychological	They get sick and tired of you, you get sick and tired of them. But of course you can't show that, so what you do is you take turns in looking after those patients because you	Rotating the care of burns patients for the well being of the nursing staff and the burns patients. fm

	must never get tired of looking after burns patients. 111 P6: L 55 -58	111
Psychological	If you look after the same patient for a long time you might get burnout and you might not provide as efficient as nursing care could be. I think that it's important that you discuss with the other staff who looks after whom and how often. 112 P6: L 132 – 135	Collaboration and communication among nursing team in care of burns patients to avoid nurses becoming burnt out and emotionally exhausted. fm 112
Sociological	Oh you take time out. You take holiday if you can...113 P6: L 139	The necessity for burns nurses to take time out or time off when experiencing feelings of burnout. fm 113
Psychological	...you go and see a counsellor...we did have a counsellor come to us to the ward when we had a specific patient or a long term stay and we did have a counsellor or a psychiatrist involvement in where we could all sit and talk about our feelings and I think that really helps. And maybe we should have a bit more of that sometimes. 114 P6: L 140 – 144	The importance of talking about feelings and issues related to the nursing of specific or long term burns patients with a professional counsellor or psychiatrist assists with nursing patients and the well being of the nurse. fm 114
Sociological	...go for a walk or go out, have a glass of wine, see some friends, go and do something positive. 115 P6: L 179 – 180	Doing something positive to turn your mind away from the stress of nursing burns patients. fm 115
Psychological	...I'm very good at, um, at close off my work life when I get home and not talking too much about it. 116 P6: L 191 – 192	Nurse is able to detach and separate from the emotions of burns nursing and her private life. fm 116
Psychological	If it is really nasty...you just go out, have a cold drink, get your thoughts together, put some happy music on, that often helps...If somebody's really in pain, well I think sometimes it's good just to leave the room for a little while. 117 P6: L 212 – 215	Knowing when to take time out from a traumatic painful dressing experience and take time to consolidate your

		thought before returning. Fm 117
Psychological	...I just absolutely try and lock it out (screaming) and get on with my work and get it over and done as quickly as possible. ...118 P6: L 228 – 229	Blocking out the pain and trauma that the patient is suffering in order to remain focussed and complete the dressing swiftly. Fm 118
Psychological	I think you cope, the longer you work there, the more coping skills you develop...119 P6: L256 -257	The longer burns nurses work with and experience burns trauma the more coping skills develop. fm 119
Sociological	The staff members are very good...I feel I can talk to most of them about any concerns or if I find things are getting a little bit too much. 120 P3: L 108 – 110	The importance of a supportive team to debrief with about concerns nurse may have. Fm 120
Psychological	I try and do exercise and stress relieving stuff like yoga. 121 P3: L 131 – 132	Nurse uses exercise and yoga as a form of stress relief from nursing patients with traumatic burns injury. fm 121
Psychological	You know you cannot avoid that pain, but the only thing you can do is just do it very quickly, so you need staff who can do it quickly instead of drag it on for many hours.122 P6: L 229 – 231	Being grounded in the reality that pain is unavoidable therefore being competent and quick is essential for both the patient and nurse. fm 122
Psychological	...I have to try and think that it is for...their own...benefit and that it will hopefully get them to be more independent...that when I do get upset about seeing them in pain, I have to think about...the bigger picture and that everything I'm doing, even though it does create some pain. 123 P3: L 161 – 166	A holistic perspective on patients' pain and treatment assists in the delivery of nursing care. Fm 123
Sociological	...debrief at home about either frustrations or...issues...with my partner who has nothing to do with the medical profession,	Debriefing about frustrations and issues of

	so that's quite a good take on that, he doesn't have to, haven't been involved, he is a different stabilising I suppose to my life. 124 P5: L 72 – 80	concern with an outsider who is not involved with the dynamics of the ward adds a different perspective to the situation. fm 124
Psychological	Exercise, that's how I...get rid of frustrations or upset I think. 125 P5: L 81	Exercise is a form of relieving the frustration and stress of burns nursing. fm 125
Sociological	I think we all support each other. We have um, differences of opinions and are comfortable with each other I think to vocalise those which means I think we work as a very close team. 126 P5: L 136 – 139	Extremely supportive and close team that is respectful of each other. Fm 126
Sociological	...without the team you can't...without the support of your peers...you can't, I don't think you can do burns nursing... I think we're very close as a group on the unit and...I think it's pretty unique to, certainly to burns...127 P5: L 142 – 145	Valuing and recognising the importance of the team support in the field of burns nursing. fm 127
Sociological	And one of the really nice things I think is that if there are issues or somebody finds it difficult looking after that patient, everybody rallies around and if it's a particularly difficult patient, then we share the load. 128 P5: L 150 – 153	Burns nurses supporting other colleagues that are experiencing difficulties with nursing a particular difficult burns patient. fm 128
Psychological	...I can switch off to a certain amount of pain or shouting or screaming...129 P5: L 240	Disengaging with the patient's pain or screaming is a mechanism to focus on the task. fm 129
Psychological	...when I switch off...for that time, so for the...30 minutes that I'm in there, knowing that somebody else is...looking after the patient and I can go in and see it as a task rather than...as a whole and I can do it...it's a coping mechanism for that 30 minutes...130 P5: L 252 – 257	Switching off to the patient's pain and focussing on the task of the dressing is used as a coping mechanism. fm 130
Sociological	...helping a junior member of staff get through a particularly unpleasant experience, we're talking about it, we're	The importance of debriefing and discussing

	discussing it and we're going through it in detail. So that, I think, possibly helps me as well. 131 P5: L 338 – 340	confronting experiences with other members of the burns team. fm 131
Psychological	...we've had the employees assistant person in to talk about and coping mechanisms or strategies and debriefing and things that have been difficult to deal with, but also we've had the psychiatrist in who's doing services or discussions with staff about how to deal with difficult patients or put in boundaries or um, to let the nurses know what's, what it's alright for them to say. 132 P5: L 352 – 357	The need for professional psychological services for the nursing team that debriefs, discussing coping strategies and the placing of boundaries to protect the burns nurses' emotional well being. fm 132
Sociological	I find the nurses you're working with are actually very important because you do need support...I think if you didn't have the support of a good team around you, you would find it very difficult...133 P4: L154 – 156	Support from the burns nursing team is extremely important for the well being of the nurses and without a strong support network it is not possible to nurse severe burns injury patients. fm 133
Sociological	I know just chatting to staff and going through things, I'm sure it's a debriefing type of process that just naturally goes on, on a ward. 134 P4: L 159 – 161	Sharing and discussion with nursing colleagues is an important support and debriefing process. Fm 134
Sociological	...one of the times I cried...at work there was a lot of staff support there. You know, they understood exactly why and...they helped me debrief in a way that you can't do when you're by yourself. 135 P1: L 551 – 554	The importance of supporting and debriefing with nursing colleagues during a traumatic experience. fm 135
Psychological	And one of the things you have to find is one, you need a good support base and some way to de-stress and detach yourself while still showing compassion. But it's more the detachment, so you don't take it home with you. 136 P1: L 34 – 37	The importance of having a strong support system and the ability to detach from the stresses of burns nursing so as it does not interfere with nurses' private life. fm 136
Sociological	...so it's more talking to the other nurses as well, you're first up going how do you	The importance of supporting and discussing

	detach and to the point you're almost bitching about the patient going, I can't believe this and yeah, it's more coping abilities. 137 P2: L 67 – 70	with other nurses about effective coping strategies used to nurse patients with traumatic burns injury. fm 137
Psychological	...the main coping strategy you have is finding the balance between showing compassion and good nursing care to the point where you're also detached. 138 P2: L 92 – 94	A key coping strategy is being able to remain detached whilst delivery compassionate competent nursing care. fm 138
Psychological	...but there's also that sort of detachment of, you know, this is the boundary and we're not crossing that at all. And you have to, to get on with your life. 139 P2: L 237 – 239	Detaching by setting professional boundaries as a form of protection from the distress and trauma that burns nurses' experience. fm 139
Psychological	But I think if you're a burns nurse, you're a burns nurse and if you can't find that level of compassion and detachment then you're not going to make it and you're going to reach burnout. 140 P2: L 245 – 247	A career as a burns nurse is a process of natural selection in which those who can not cope reach burnout and do not make it. fm 140
Sociological	...it's always good to have a de-stressing or even a debriefing consult and the ward gets that, we feel that and unfortunately it usually involves alcohol, but you need to go out to the pub, you need to discuss it, you need to say, you know, this is crap, I can't believe it and blah, blah, blah, blah, blah. 141 P2: L 259 – 263	Debriefing or distressing at the pub is way that burns nurses can vent their frustrations and emotions about issues that cause them considerable stress and anxiety. fm 141
Sociological	...but socially it's - it does affect your relationships with people and tension and often you just have to talk about it and you have to get it off your chest so you can move on... 142 P2: L 264 – 266	Debriefing and discussing about feelings and emotions is critical for burns nurses mental well being. fm 142
Psychological	They will (the nurses) take over the patient when they think you've had enough. 143 P2: L 281	Burns nurse come together to assist their colleagues in times of

		need. fm 143
Psychological	...I'm very much of a, you get in, you do your job, you get out mentality which may not be the best for the patient or the family at the time, but that's my coping mechanism, that's how I get through it. 144 P2: L 454 – 456	Pragmatic mentality of getting in doing the job and getting out to survive and cope as a burns nurse. fm 144

Appendix 9

Development of formulated meanings and associated cluster and emergent themes

**Numbers indicate coded formulated meanings*

Formulated meanings	Theme cluster	Emergent theme
<p>14*. The reality is that burns recovery is slow and the need for patience and realistic goals is critical when nursing severe burns patients. 18*. Placing the visible trauma aside and focussing on independence and function is fundamental to burns nursing. 36*. Grounding the patient in the reality of the injury sustained. 49*. Being honest and realistic to patients about painful burns procedures. 144*. Pragmatic mentality of getting in doing the job and getting out to survive and cope as a burns nurse. 159*. The need to remain strict, disciplined and at times firm with nursing burn patients to achieve the goal of independent functioning. 163*. A level of harshness and discipline towards burns care is necessary in order to facilitate in the rehabilitation of burns patients.</p>	Pragmatism	Virtues of burns nurses
<p>10*. Managing severe burn wounds gives burns nurses a challenge to which they have an interest. 146*. Passion, motivation and commitment to nursing severe burns injury patients is fundamental towards a positive patient recovery. 150*. Passion and commitment is the fundamental driving force to nursing severe burns patients. 151*. Passion is a core characteristic that enables burns nurses to nurse severe burns patients. 154*. Motivation and commitment towards current best practice in the management of burns trauma.</p>	Passion	

Formulated meanings	Theme cluster	Emergent theme
<p>145*. Being grounded in the reality of the injury assists burns nurses to be dedicated and committed towards burns care. 148*. Dedication and commitment towards the care and rehabilitation of someone with a burns injury involving emotional engagement and encouragement with the patient. 149*. Burn nurse's commitment and dedication to physiotherapy and occupational therapy in order for patients to return independence. 152*. Burns rehabilitation is a long process of encouraging independence requiring patience and persistence from the burns team. 155*. Motivating and encouraging the patient to push through the pain towards recovery. 158*. The role of encouraging independent functioning is fundamental to the care of burns patients. Motivating and encouraging the patient to push through the pain towards recovery. 164*. Commitment and a sense of reality are essential to facilitate the recovery as a result of severe burns injury. 165*. Showing commitment and dedication towards the alleviation of burns trauma of patients that have are suffering emotional and physical loss. 167*. Giving patients motivation and courage to get through the traumatic injury towards rehabilitation. 170*. Burns nursing requires strong patient advocacy for people who have sustained traumatic burns injuries leaving them physically and emotionally traumatised and unable to say enough.</p>	Commitment and dedication	
<p>39*. Questioning whether treating burns suicide patients is right if the patient wishes to die. 47*. Suicide attempt is not a focus during resuscitation process, however, after nurse reflects on how he was burnt and the suicide attempt. 64*. The trauma of burns injury causes burns nurses to continually reflect on their practice as a nurse.</p>	Reflection	Making meaning

Formulated meanings	Theme cluster	Emergent theme
<p>8*. Nursing severe burns injury patients places the importance on life and gives nurses a different perspective on everyday life and events. 16*. The mechanism of burn injury, type of patient involved and circumstances around the burn affects and influences how burns nurses react and care for their patients. 35*. Nurse becomes very suspicious of patients and their family in relation to the burn injury sustained. 147*. A young patient with a family is a motivational aspect towards a rapid recovery for the burns nurse.</p>	Perception	
<p>2*. Rapid development of a unique relationship between burns nurse and the patient with a severe burn injury is grounded in trust assisting in the recovery process. 27*. Burns nursing is complex in both the physical and emotional sense often involving intensive relationships with patients based on trust. 34*. Self disclosure to burns patients in order to divert attention away from traumatic injury for both the nurse and the patient. 66*. A unique friendship and bond develops between the burns patient and nurse with professional boundaries.</p>	Interactions	Unique bonds
<p>38*. Importance of communicating feelings about withdrawing care and the challenge of communicating with burns patients that are dying. 87*. Burns victims that have been burnt in mass disasters are difficult for the burns nurse to communicate with due to the sensitive and tragic circumstances that surround the patient.</p>	Empathetic communication	
<p>84*. Burns nursing is a highly stressful and emotional job that can leave burns nurses feeling burnt out 85*. Burns nursing is emotionally exhausting, demanding and draining that leaves the nurse feeling she is unable to give anymore to the patient. 89*. Burns nurses can feel severely stressed and burnt out manifesting in the inability to make competent decisions about patient care and function as a valuable member of the burns team. 103*. The nurse experiences burnout earlier due to the high levels of emotions experienced with nursing severe burns injury patients.</p>	Feelings of stress	Burnout

Formulated meanings	Theme cluster	Emergent theme
<p>15*. Nursing severe burns injury patients is a very challenging, emotionally demanding and exhaustive experience. 31*. Burns as a result of unforeseen circumstances are more emotionally demanding to nurses due to the tragic circumstances that surround the injury. 44*. Performing burns dressings has an element of fear and anxiety towards causing pain to 48*. Severe burns trauma is extremely confronting to deal with the extent of the trauma. 59*. Necessary painful procedures are extremely confronting and emotionally exhausting for burns nurses. 61*. Dying patients without family support is stressful for the burns nurse. 62*. The care of burns patients is sometimes fraught with fear, anxiety and emotion towards the care of specific patients that require intensive physical and emotional care. 63*. Burns nurses experience a range of emotions whilst caring for their patients that are extremely challenging, demanding and exhausting emotionally as well as physically draining. 69*. Anxiety, fear and apprehension are emotions that burns nurses often feel prior to large burns procedures. 73*. Nurse experiences levels of anxiety during large burns dressings. 74*. Patient vocalising his pain through continual screaming makes it difficult to manage and focus on the task required and a source of anxiety for the burns nurse. 75*. Burns trauma is extremely confronting and distressing for the burns nurse especially the very young burns victims that have not experienced their life as yet. 76*. Burns dressing is not only traumatic for the patient but transfers onto the burns nurse as a distressing experience 82*. Burns dressings can be extremely traumatic experience for the nurse that leaves them troubled and distressed about the experience and how this will affect the patient's next dressing change. 90*. The pain associated with dressing burns patients is very traumatic for the burns nurse to experience even when patients can not recall the pain of the dressing due to the medications it still remains a traumatic experience for the nurse. 93*. Burns nursing sometimes involves caring for fatal burns injury that leaves the nurse shell shocked.</p>	Emotional exhaustion	Traumatic caring

Formulated meanings	Theme cluster	Emergent theme
<p>3*. Burns dressings are a very arduous procedure for the patient and the nurse, performed possibly several times a day becomes physically intensive. 4*. Dressing wound for a severe burns injury patient takes several hours and is a physically and emotionally demanding, draining and exhausting task. 58*. Burns nursing can be an extremely physically demanding and exhausting experience. 91*. Burns dressings are an arduous, demanding and exhausting task that can take many hours and leave the nurse feeling emotionally drained and experience a sense of awfulness.</p>	Physical exhaustion	
<p>32*. Having feelings of inadequacy and powerlessness during dressing changes resulting in questioning nursing care. 83*. Having several large burns dressings to complete is a lengthy procedure that is emotionally and physically exhausting and leaves the nurse feeling inadequate about the care given. 92*. The nurse is left with distressing feelings of dismay, hopelessness and inadequacy unable to alleviate patient's suffering. 97*. Feelings of inadequacy and anger are experienced by the burns nurse related to the lack of control over patient's level of pain experienced. 98*. Having to inflict pain and suffering upon a patient in the course of trying to help and being unable to alleviate their suffering fills the nurse with feelings of hopelessness and futility. 101*. Experiencing feelings of powerlessness and inadequacy with the inability to control the patient's pain adequately and then the nurse having to deal with the patient's anger. 102*. Patient's level of pain and emotion during a dressing change leaves the burns nurse experiencing feelings of inadequacy and frustration about her role as a primary care giver. 105*. Experiencing levels of frustration, inadequacy and hopelessness towards difficult burns dressings.</p>	Inadequacy	Powerlessness

Formulated meanings	Theme cluster	Emergent theme
<p>7*.Self harm burns patients are emotionally exhausting and frustrating to nurse due to the lack of motivation and depressed state in which they remain. 13*. Frustration for the nurses that the recovery process is tedious and slow, questioning whether nursing care is actually contributing to the recovery process. 33*. Struggles between trying to do a burns dressing competently and attempting to keep the patient pain free. 40*. Difficultly in nursing burns suicide patients due to the effort and commitment that nurses give to the patient that does not want to live 60*. Dealing with burns patients' emotions is draining and exhausting eliciting anger and frustration of having to face these emotions. 65*. Feelings of hope and positivity towards patients recovery verses feelings of hopelessness unable to alleviate pain and suffering. 71*. Anger and frustration are emotions experienced by burns nurses towards patients that are non compliant, traumatised and angry at their level of function. 77*. The rehabilitation process for burns patients is extremely tedious and slow which is frustrating for the burns nurse in putting great effort and seeing little progress. 166*. A huge level of frustration is experience in caring for patients and their families during the rehabilitation process towards independence requiring setting specific goals and boundaries.</p>	Frustration	
<p>79*. Burns nurse is distressed by patient's emotions and empathises with patient about returning to a sense of normality. 80*. Burns nurse feeling concerned and apprehensive about patients with severe burns trauma return to society after a long admission. 94*. Nursing patients with facial burns is upsetting with the uncertainty of their face ever returning to the pre injury state.</p>	Apprehension	

Formulated meanings	Theme cluster	Emergent theme
21*. Fear and anxiety towards being burnt. 46*. Burns nurses exposure to burns injury affects behaviour and actions. 86*. The burns nurse finds nursing severely burnt patients in situations that are close to her challenging and considerable more upsetting. 88*. Burns trauma is confronting in that it makes the nurse feel vulnerable that it could happen not only to loved ones but themselves.	Vulnerability	
29*. Constant exposure to burns trauma desensitises nurses to patients' suffering. 50*. Burns nursing causes nurses to become emotionally hardened to cope and manage the challenges of burns care. 53*. Burns nursing causes you to toughen up to the reality of burn injury.	Toughening up	Resilience
30*. There is a natural selection process for those who wish to work in burns and those who can not cope leave but those who stay are committed and passionate. 52*. To fully comprehend and appreciate what burns nursing involves you have to be involved within the area of burns. 140*. A career as a burns nurse is a process of natural selection in which those who can not cope reach burnout and do not make it.	Natural selection	
5*. Grounded in the reality that burns dressing need to be performed with the necessity to remain focussed in order to get through the procedure which engenders difficult emotions. 6*. Staying extremely focussed is fundamental to burns procedures in order to reduce the stress experienced by nurses and to alleviate the suffering and anxiety experienced by patients. 45*. Remaining focussed and confident in the face of traumatic burns injury. 99*. The screams of burns patients pleading to stop the dressing is distressing for the nurse and challenging to continue and still remain focussed to complete the burns dressing.	Emotional toughness	

Formulated meanings	Theme cluster	Emergent theme
<p>9*. Burns nurses need to be able to perform painful procedures that requires them to remain focused in order to cope and without the coping skills necessary it is not possible to give competent care. 11*. Burns nursing is continually emotionally demanding and challenging that requires specific coping skills to be able to nurse these patients. 25*. Remaining positive in the face of adversity. 72*. Infliction of pain on patients during burns dressings and procedures is extremely challenging and requires specific coping mechanisms to learn how to cope. 119*. The longer burns nurses work with and experience burns trauma the more coping skills develop. 162*. Nurses caring for burns patients have the ability to manage and cope with the challenges that come with nursing severe burns patients. 168*. Nursing severe burns patients is extremely challenging and confronting that requires a high level of motivation in order to cope with those challenges.</p>	<p>Coping with the challenges</p>	
<p>81*. Bad experiences for the nurse on the burns ward tend to affect home life, unable to detach from the stress and anxiety of burns nursing. 106*. The necessity to have other interests in life to escape from the stresses of burns nursing. 107*. Rostering burn nurses on a 9 day fortnight gives the nurses extra time away from the intensity of nursing burns patients which is important for their well being. 113*. The necessity for burns nurses to take time out or time off when experiencing feelings of burnout. 115*. Doing something positive to turn your mind away from the stress of nursing burns patients. 116*. Nurse is able to detach and separate from the emotions of burns nursing and her private life. 117*. Knowing when to take time out from a traumatic painful dressing experience and take time to consolidate your thought before returning. 121*. Nurse uses exercise and yoga as a form of stress relief from nursing patients with traumatic burns injury. 125*. Exercise is a form of relieving the frustration and stress of burns nursing.</p>	<p>Regrouping and recharging</p>	

Formulated meanings	Theme cluster	Emergent theme
<p>17*. Burns nurses need to maintain a level of detachment from the emotions of burns trauma in order to motivate patients to become independent. 24*. Emotional detachment is crucial in order to remain completely focussed when performing burns dressings and delegation of psychological care to another team member. 42*. Burns nursing is extremely confronting that requires a level of acceptance and detachment in order to care for the patient. 57*. A level of detachment is required to competently nurse severe burns patients so as not to endure the emotional and physical effects of burnout. 68*. Nursing burns trauma patients requires a level of emotional detachment in order to give competent emotional and physical care without losing your humanity. 95*. Learning to emotionally detach is important for the nurse's mental well being otherwise she was continually thinking about the patient becoming angry at the patient and herself for not being able to detach from the scenario. 118*. Blocking out the pain and trauma that the patient is suffering in order to remain focussed and complete the dressing swiftly. 129*. Disengaging with the patient's pain or screaming is a mechanism to focus on the task. 130*. Switching off to the patient's pain and focussing on the task of the dressing is used as a coping mechanism. 138*. A key coping strategy is being able to remain detached whilst delivery compassionate competent nursing care. 139*. Detaching by setting professional boundaries as a form of protection from the distress and trauma that burns nurses' experience.</p>	Emotional detachment	

Formulated meanings	Theme cluster	Emergent theme
<p>28*. Nursing teams unite and supports each other when there is a long stay severe burns patient. 108*. Burns nursing is extremely draining that there is a necessity to rotate the patient load so the nurse is not caring for the same patient constantly. 110*. Having assistance from colleagues is emotionally supportive during difficult burns dressings and care. 111*. Rotating the care of burns patients for the well being of the nursing staff and the burns patients. 112*. Collaboration and communication among nursing team in care of burns patients to avoid nurses becoming burnt out and emotionally exhausted. 128*. Burns nurses supporting other colleagues that are experiencing difficulties with nursing a particular difficult burns patient. 133*. Support from the burns nursing team is extremely important for the well being of the nurses and without a strong support network it is not possible to nurse severe burns injury patients. 134*. Sharing and discussion with nursing colleagues is an important support and debriefing process. 135*. The importance of supporting and debriefing with nursing colleagues during a traumatic experience. 136*. The importance of having a strong support system and the ability to detach from the stresses of burns nursing so as it does not interfere with nurses' private life. 137*. The importance of supporting and discussing with other nurses about effective coping strategies used to nurse patients with traumatic burns injury. 143*. Burns nurse come together to assist their colleagues in times of need.</p>	Peer nursing support	The necessity for support and unity

Formulated meanings	Theme cluster	Emergent theme
<p>22*. Burns nursing requires collaboration with an extensive multidisciplinary team that is focused on the management of severe burns injury patients. 26*. Burns nursing is emotionally and physically exhausting and without the team support burns nurses give to one another it is not possible to care for severe burns patients and the many aspects of care. 54*. Burns nursing is complex involving many different disciplines to be coordinated and involved. 56*. Nursing burns patients requires a collaborative team approach incorporating many areas of healthcare in order to facilitate patients' recovery. 70*. Team collaboration is the key to burns nursing and without the support, competent care can not be given. 109*. Expressing thoughts and feelings with other members of the burns team is important and an essential form of support. 126*. Extremely supportive and close team that is respectful of each other. 127*. Valuing and recognising the importance of the team support in the field of burns nursing.</p>	<p>Multidisciplinary team collaboration</p>	
<p>114*. The importance of talking about feelings and issues related to the nursing of specific or long term burns patients with a professional counsellor or psychiatrist assists with nursing patients and the well being of the nurse. 124*. Debriefing about frustrations and issues of concern with an outsider who is not involved with the dynamics of the ward adds a different perspective to the situation. 132*. The need for professional psychological services for the nursing team that debriefs, discussing coping strategies and the placing of boundaries to protect the burns nurses' emotional well being.</p>	<p>Professional support</p>	

Formulated meanings	Theme cluster	Emergent theme
<p>120*. The importance of a supportive team to debrief with about concerns nurse may have. 131*. The importance of debriefing and discussing confronting experiences with other members of the burns team. 141*. Debriefing or distressing at the pub is way that burns nurses can vent their frustrations and emotions about issues that cause them considerable stress and anxiety. 142*. Debriefing and discussing about feelings and emotions is critical for burns nurses mental well being.</p>	<p>Informal support</p>	
<p>78*. Feelings of a lack of support for burns staff are upsetting especially with staff shortages. 100*. Distressful feeling experienced when the burns nurse perceives she is not supported and her practice is in question. 104*. Feelings of anger towards the medical staff for not expressing compassion or too little is upsetting for the burns nurse.</p>	<p>Lack of support</p>	

**Numbers indicate coded formulated meanings*