

2015

The impact of nursing a significant other in the course of employment

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**The Impact of Nursing a Significant Other in the
Course of Employment.**

by

Tania Arnold

Bachelor of Nursing

Masters' Thesis

Presented to the School of Nursing and Midwifery of

Edith Cowan University

in Partial Fulfillment

of the Requirements

for the Degree of

Masters of Nursing

Edith Cowan University

July 2015

Edith Cowan University

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Tania Arnold

Abstract

This thesis describes the experiences of nurses and midwives working in metropolitan hospitals who cared for a significant other in their role of employment.

The absence of research directly related to this topic guided the exploration of individuals' experiences to establish base line knowledge relating to this phenomenon.

This study used descriptive research to provide information relating to the personal and professional effects on nurses who were required to, chose to or had no choice but to care for a significant other in their role of employment. An on-line survey gathered demographic, likert scale responses to evaluate impact on care, and personal narratives to describe and reflect on their experiences.

Nurses' recollections showed that nurses personalise the importance of patient outcomes, are distracted from the usual daily plan and alter their normal decision making processes. Personal effects included role confusion due to the concurrent nurse/patient/significant other relationships resulting in exhaustion and guilt. All of these effects lead to alteration in stress levels experienced by the nurse as a consequence of caring for a significant other in the role of employment.

Acknowledgements

Firstly I would like to acknowledge the people who encouraged me to commence my postgraduate studies. My colleague at the time, and friend Bev Ewens, who ignited my curiosity in research and threw me down a challenge. To my friends Alison and Terry de Jong, who so kindly encouraged me and were genuinely interested in my progress. To my father Herb Harris for instilling confidence, self-esteem and his love of learning and teaching in all four of his precious children.

Thank you to my supervisors Dr Deborah Sundin and Mrs Helen Godwin for their leadership. Their experience and advice were essential in guiding me through to the completion of my thesis.

I would like to express my appreciation to the executive at Joondalup Health Campus for granting me study leave to complete this study, and my colleagues for their support and understanding over the last two years.

To the nurses and midwives who responded to the survey and shared their recollections of caring for their significant other, without them there would be no findings to raise awareness and promote consideration of this phenomenon.

I would like to thank my dear friend Kirsty Freeman for her council and optimism when completing my Masters seemed impossible. Her perspective and reviews were of great benefit and her no nonsense attitude allowed me to refocus and complete the work required.

Lastly to my teenage girls Josie and Sophie who have grown up around my piles of articles and who have ignored any stress I projected as a result of my workload. Gorgeous girls who remain my main motivation for improving myself and our life.

CONTENTS

| | |
|--|----|
| Contents | iv |
| LIST OF TABLES | x |
| LIST OF FIGURES | x |
| CHAPTER ONE: Introduction | 1 |
| 1.1 Introduction | 1 |
| 1.2 Research Question and Problem | 1 |
| 1.3 Background | 2 |
| 1.3.1 Personal values..... | 3 |
| 1.4 Aims and Objectives..... | 4 |
| 1.4.1 Aim..... | 4 |
| 1.4.2 Objectives:..... | 4 |
| 1.5 Significance | 4 |
| 1.6 Conclusion | 5 |
| CHAPTER TWO: Literature Review | 7 |
| 2.1 Introduction | 7 |
| 2.1.1 Search Strategy..... | 7 |
| 2.2 Professional Boundaries..... | 8 |
| 2.3 Dual roles | 10 |
| 2.4 Duty of care..... | 11 |
| 2.5 Nurses as Informal Family Caregivers | 12 |

| | |
|---|----|
| 2.6 Nurses in the family member role | 13 |
| 2.7 Patient Vulnerability | 14 |
| 2.8 Confidentiality..... | 14 |
| 2.9 Clinical Decision Making | 15 |
| 2.10 Summary of the Literature | 16 |
| 2.11 Definitions..... | 17 |
| 2.12 Conclusion..... | 17 |
| CHAPTER THREE: Methodology | 18 |
| 3.1 Introduction | 18 |
| 3.2 Study Design and Rationale for the Method | 19 |
| Table 1. Descriptive design concept | 20 |
| 3.3 Population and Sampling | 21 |
| 3.3.1 Limitations..... | 21 |
| 3.4 Data Collection..... | 22 |
| 3.4.1 Survey Development..... | 22 |
| 3.4.2 The Tool..... | 22 |
| 3.4.3 Pilot Study | 23 |
| 3.5 Recruitment | 24 |
| 3.6 Data Analysis..... | 25 |
| 3.6.1 Demographics | 25 |
| 3.6.2 Likert Scaled Questions | 25 |

| | | |
|---|-------------------------------------|----|
| 3.6.3 | Written Accounts..... | 25 |
| 3.6.4 | Rigor | 26 |
| 3.7 | Ethical Considerations..... | 27 |
| 3.7.1 | Consent..... | 27 |
| 3.7.2 | Confidentiality and Privacy..... | 27 |
| 3.7.3 | Data storage | 28 |
| 3.7.4 | Dissemination | 28 |
| 3.8 | Conclusion..... | 28 |
| CHAPTER FOUR: FINDINGS..... | | 29 |
| 4.1 | Introduction | 29 |
| 4.2 | The Survey..... | 29 |
| 4.2.1 | Response rate..... | 30 |
| 4.3 | Demographics and Content | 30 |
| 4.3.1 | Designation..... | 31 |
| Figure 1: Respondents' Designation..... | | 31 |
| 4.3.2 | Highest Level of Qualification..... | 32 |
| Figure 2: Respondents' Highest Level of Qualification..... | | 32 |
| 4.3.3 | Experience | 33 |
| Figure 3: Respondents' Years of Professional Experience..... | | 33 |
| 4.3.4 | Relationship to the Patient..... | 34 |
| Figure 4: The Relationship Between the Respondent and Patient | | 34 |

| | |
|---|----|
| 4.3.5 Health Care Facility | 35 |
| Figure 5: The Type of Facility Where the Care Episode Occurred | 35 |
| 4.3.6 Reason the nurse was caring for their significant other. | 36 |
| Figure 6: Reason the Respondents Cared for the Patient..... | 36 |
| 4.3.7 Type of care provided | 37 |
| Figure 7: The Type of Care the Patient was Receiving in Hospital..... | 37 |
| 4.4 Quantitative Responses. | 38 |
| 4.4.1 Clinical decision making | 38 |
| Figure 8: Impact on Clinical Decision-making | 38 |
| 4.4.2 Ethical Decision Making | 39 |
| Figure 9: Impact on Ethical Decision-making..... | 39 |
| 4.4.3 Confidentiality..... | 40 |
| Figure 10: Impact on confidentiality..... | 40 |
| 4.4.4 Therapeutic Boundaries | 41 |
| Figure 11: Impact on the therapeutic boundaries | 41 |
| 4.4.5 Professional role..... | 42 |
| Figure 12: Impact on the professional role..... | 42 |
| 4.4.6 Personal Role..... | 43 |
| Figure 13: Impact on the personal role..... | 43 |
| 4.4.7 Professional Stress | 44 |
| Figure 14: Impact on the professional stress..... | 44 |

| | |
|--|----|
| 4.4.8 Personal Stress | 45 |
| Figure 15: Impact on personal stress | 45 |
| 4.5 Qualitative responses..... | 46 |
| 4.5.1 Nurses' Accounts | 46 |
| 4.6 Discussion of qualitative findings..... | 53 |
| Table 2: The impacts of caring for a significant other in the role of employment | 53 |
| 4.6.1 Obligation and Guilt | 54 |
| 4.6.2 Boundaries..... | 56 |
| 4.6.3 Role Confusion and personal relationships..... | 57 |
| 4.6.4 Trust and Confidentiality..... | 58 |
| 4.6.5 Decision-making and Distraction..... | 60 |
| 4.6.6 Pleasure and Exhaustion | 61 |
| 4.6.7 Stress | 62 |
| 4.7 Conclusion..... | 65 |
| Chapter 5: Discussion and Conclusions..... | 66 |
| 5.1 Introduction | 66 |
| 5.2 Demographic data..... | 66 |
| 5.3 Caring for a significant other in the role of employment. | 68 |
| Figure 16: The impact of caring for a significant other in the role of employment..... | 69 |
| 5.3.1 Obligation | 70 |
| 5.3.2 Role Confusion..... | 71 |

| | | |
|-------|---------------------------------------|----|
| 5.3.3 | Distraction | 73 |
| 5.3.4 | Decision-making | 74 |
| 5.3.5 | Personal Relationship | 76 |
| 5.3.6 | Stress | 78 |
| 5.4 | Recommendations | 79 |
| 5.4.1 | For Practice | 79 |
| 5.4.2 | For Education | 80 |
| 5.4.3 | For Future research | 80 |
| 5.5 | Strengths and Limitations | 81 |
| 5.6 | Conclusion | 82 |
| | References | 83 |
| | Appendix 1: Survey | 90 |
| | Appendix 2: Advertisement Flyer | 96 |

LIST OF TABLES

| | |
|--|----|
| Table 1. Descriptive design concept..... | 20 |
|--|----|

| | |
|---|----|
| Table 2: The impacts of caring for a significant other in the role of employment | 53 |
|---|----|

LIST OF FIGURES

| | |
|---|----|
| Figure 1: Respondents' Designation..... | 31 |
|---|----|

| | |
|--|----|
| Figure 2: Respondents' Highest Level of Qualification..... | 32 |
|--|----|

| | |
|--|----|
| Figure 3: Respondents' Years of Professional Experience..... | 33 |
|--|----|

| | |
|---|----|
| Figure 4: The Relationship Between the Respondent and Patient | 34 |
|---|----|

| | |
|---|----|
| Figure 5: The Type of Facility Where the Care Episode Occurred..... | 35 |
|---|----|

| | |
|---|----|
| Figure 6: Reason the Respondents Cared for the Patient..... | 36 |
|---|----|

| | |
|--|----|
| Figure 7: The Type of Care the Patient was Receiving in Hospital | 37 |
|--|----|

| | |
|---|----|
| Figure 8: Impact on Clinical Decision-making..... | 38 |
|---|----|

| | |
|---|----|
| Figure 9: Impact on Ethical Decision-making | 39 |
|---|----|

| | |
|--|----|
| Figure 10: Impact on confidentiality | 40 |
|--|----|

| | |
|---|----|
| Figure 11: Impact on the therapeutic boundaries | 41 |
|---|----|

| | |
|--|----|
| Figure 12: Impact on the professional role | 42 |
|--|----|

| | |
|--|----|
| Figure 13: Impact on the personal role | 43 |
|--|----|

| | |
|--|----|
| Figure 14: Impact on the professional stress | 44 |
|--|----|

| | |
|--|----|
| Figure 15: Impact on personal stress | 45 |
|--|----|

| | |
|---|----|
| Figure 16: The impact of caring for a significant other in the role of employment ... | 69 |
|---|----|

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The inspiration for this research was drawn from the author's attempts to write a departmental policy relating to nurses caring for a family member or loved one whilst working a shift in the operating department. Anecdotal stories of nurses caring for loved ones or midwives delivering their own grandchildren are occasionally heard. Concerns raised relating to this occurrence covers several areas. What ramifications would it have on the nurse and the care provided? Is it ethical to include a loved one in a nurses' caseload? Is it a breach of confidentiality? Is there a liability risk? Will, indeed can, the nurse remain objective? Will it impact on the care of other patients? Should hospitals allow it? Whose decision is it to monitor this occurrence? Once an initial literature review was conducted it became apparent that the current decision-making guidelines offered by the Nursing and Midwifery Board of Australia (2010) and used by individual nurses is not supported by research and do not directly speak to the issue of nurses caring for a significant other in the role of employment. Nurses base their beliefs related to this situation upon assumptions, guidance from their superiors or upon passionately defended personal preferences, not on evidence based practice

1.2 The Problem and the Research Question

Nurses and midwives, like many in the workforce, may be employed close to their place of residence. It is axiomatic then that the closest available health care for a family members may be that nurse's and midwife's own place of professional employment. As a result there exists the potential for nurses and midwives to be required to care for their loved ones in the course of their employment. The governing body for nurses and midwives in Australia, the Nursing and Midwifery Board of Australia (NMBA) recognises the risks associated with relationships between their professionals and patients by producing guidelines for the maintenance of professional boundaries (NMBA, 2010). Indeed, the NMBA has published two separate documents providing guidance for practice by nurses and midwives in this specific situation (NMBA, 2008, 2010). Nonetheless, the NMBA website does not currently provide its members with any information related to

the research behind these guidelines. It may well be that guidelines are not considered necessary because a problem has not been identified as yet. Nurses and midwives may not be challenged when required to care for family members and consequently, there is no potential impact on the quality of care for patients or the caring experience of the nurse or midwife. Contemporary research has not answered the questions raised here and especially not in Australia. Chapter two will present peripheral contemporary literature related to this topic. This study will begin to address that gap.

Research Question

“How does the experience of nursing a significant other in the course of employment impact Australian nurses and midwives?”

The phenomenon of interest for this study is nurses and midwives caring for a significant other (family member or loved one, someone identified as important to the nurse or midwife) in their professional capacity. The knowledge generated will provide information for the nursing community and other health care professionals with respect to current practices relating to caring for a significant other. In turn, this information should assist health care facilities, managers, and governing bodies in the development of policy and guidelines for safe patient care. The knowledge generated from this study may also influence managerial, professional and personal support for health professionals who find themselves in these situations.

1.3 Background

In the 21st century many procedures and practices in quality health care are supported by guidelines based upon best contemporary evidence. This is not yet so for nurses and midwives potentially or actually providing care for a significant other in their course of employment. Like the NMBA, the Australian Nurses and Midwifery Council (ANMC) guides individual professional conduct with the “...aim to protect the community by helping to prevent distress, confusion, harm or abuse of people being cared for by nurses” (ANMC, 2008 p.1). These guidelines require nurses and midwives to be informed about professional boundaries and work to establish and maintain those boundaries (ANMC, 2008). The ‘decision making tool’ produced to assist nurses and midwives navigate professional boundaries requires individuals to interpret these principles and

apply them to their own situation. There is no empirical literature to date that elucidates how nurses and midwives achieve this in specific situations. Neither is there specific evidence of the effectiveness of the guidelines when an emotional relationship already exists. Research related to physicians caring for their own family and friends, suggests that this creates several areas of concern.

It can be difficult to set clear boundaries, particularly when patients are family members. The result can be a conflict over roles, a poorly defined therapeutic relationship, and even a trespassing of boundaries (Mailhot, 2002, p. 546).

Studies relating to nurses caring for their significant others have predominantly focussed either on nursing staff who care for family members at home (McClunie-Trust, 2010; Mills & Aubeeluck, 2006) or health professionals who cross boundaries within their employment role by developing intimate relationships with a patient who they have met whilst in their care (Kaye, 2013; Peterson, 1992; Vere-Jones, 2008). Although these issues are heavily discussed in the literature relating to potential risk, there is limited empirical evidence considering the impact of an established relationship upon nurse's ability to work effectively within professional frameworks.

1.3.1. Personal values

I assisted with the care of my father at home during the last days before he passed away. Having experienced the emotional impact of analysing his needs and titrating appropriate medications to keep him comfortable, I am intrigued as to how other nurses and midwives are able to maintain their professional role and combine the intimate qualities that are unique to a close relationship, whilst carrying out their normal shift duties. I am aware of the difficulties and the pleasure associated with the act of caring for my Dad, but wonder how these are integrated into the work environment by nurses and midwives in a variety of circumstances.

When I asked my immediate colleagues how they felt about nurses and midwives caring for a significant other at work, the responses were varied. One senior nurse said it was absolutely not allowed, and when asked for her rationale she informed me that her matron would never have allowed it. Another senior nurse informed me that she believed no one else would offer better care for them than she would as she had a personal

interest in the recovery of such a patient. Both of these staff members had many years in the nursing profession and both were adamant about their opinions. The more people I asked the clearer it became that nurses and midwives were acting on very different beliefs about potentially or actually caring for a significant other in their role of employment. There was clearly a need to investigate the experiences of nurses and midwives who had encountered this episode of care during their career as well as its impact on the professionals and their patients.

1.4 Aims and Objectives

1.4.1. Aim

To describe and understand the experience and impact of nursing a significant other for nurses and midwives.

1.4.2. Objectives:

1. Compile demographic information relating to the respondents that complete the survey, including nursing designation, highest qualifications and years of experience.
2. Explore the individual's recollection of the episode of care.
3. Describe the circumstances surrounding the episode of care, including, what was the relationship between nurse/midwife and patient, what type of care facility did it take place in, what type of care was provided and was it by choice or necessity?
4. Describe the impact nursing a significant other in the role of employment had on the nurse/midwife.

1.5 Significance

A review of the literature outlines the impact on health professionals who had nursed a significant other. These included nurses who were providing family care in the home, nurses who had critical ill family members, physicians who had family members requesting care, opinions and medication scripts. This study aimed to establish if the

issues discussed in the literature are similar to those experienced by nurses and midwives who care for a loved one during the course of employment. Ultimately using this knowledge has the potential to enhance practice and decision-making. Specifically it is hoped an enhanced knowledge base to support nurses and midwives who care for their significant other, would support best practice, through the development of a tailored guideline based in empirical evidence.

The findings from this study will contribute to the body of professional knowledge, as minimal information is currently available. This research into nurses and midwives caring for a patient who falls into the category of significant other, with in their role of employment, will highlight the actual effects this experience has had on the nursing respondents in this study. Currently nurses and midwives use their intuition, historical and personal beliefs to make decisions regarding the appropriateness of nursing a significant other. Nurses and midwives who care for their own family members fall outside the frameworks provided by the Nursing and Midwifery Board. The information gained from this study will provide personal experiences that outline aspects of this phenomenon that currently aren't available for consideration. It is important to individual nurses and midwives to inform them of the potential benefits and/or complications associated with this phenomenon when faced with this experience themselves to assist with decision-making processes. Any potential risk to patients or staff due to this phenomenon will allow the governing bodies to address any issues that come to light to protect the nursing profession and the community members in their care. The findings from this study may prompt future larger studies, considering causality, correlation and comparison, which may be used for guideline reviews by state and federal health agencies.

1.6 Conclusion

This chapter presented the background information relating to nurses and midwives who care for a significant other in their role of employment. It has provided a link between this topic and outlines for professional boundaries between nurse/midwife and patient. The introduction of concepts addressed in associated studies have been included to guide this study. The research question and the objectives of this study have been provided and a discussion around the significance of the research included. Chapter two will review the current governing body guidelines and several topics that are considered

noteworthy in the absence of research into this particular occurrence. Chapter three will discuss the methodology used to conduct this study and Chapter four will present the finding from the study utilizing graphs, tables and the analysis of the findings. Conclusions drawn from the study will be will present in Chapter five along with recommendations and suggestions for further research opportunities.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature review conducted to determine the existing body of knowledge, identify any knowledge gaps and establish a theoretical framework to underpin the proposed study. Literature was also included that was considered to be associated with the research topic due to the dearth of primary research related to the specific topic of 'nurses and midwives who have cared for a significant other in their role of employment'.

Search Strategy

The question directing the literature search was: *"How does the experience of nursing a significant other in the course of employment impact Australian nurses and midwives?"*

A search of the electronic databases from 2008-2014 was conducted to elicit contemporary research, theoretical literature and policies by nursing and healthcare organisations. The following databases were searched: PROQUEST, CINAHL, MEDLINE and GOOGLE Scholar. The search terms used to cover the topic of interest were: nurs*, care, caring, own family, dual role, boundary violations, loved ones and significant other. Terms were used with Boolean logic to ensure a comprehensive result. The selection criteria included: peer-reviewed journals and publications in English language. Due to the paucity of literature relating to the topic in the previous 5 years the time restriction on the search was lifted.

The majority of articles found related to three major groups: -

1. Relationships established between patients and nurses after their introduction at the point of care. Many of these involve therapeutic boundary violation issues between mental health nurses and their patients.
2. Nurses caring for a family member outside of their role of employment. The majority of the literature focused on palliative care in the home.

3. The needs, stresses and related challenges for other health professionals working in dual roles, including social workers in rural areas and physicians who's own family members sort health care advice.

The papers referred to above were judged as not directly relevant to the topic or research question however they were retained for their contextual relationship to the topic and the hope of demonstrating the significance of this study. The literature cited included authoritative work on health professionals experiencing dual roles. Reference lists of retrieved papers were hand searched for relevant literature not identified via the electronic database search. Ultimately, no relevant research papers directly related to nurses caring for a significant other in the role of employment were found. Literature associated with the topic searched were included with 14 of the pieces being published over ten years ago. One of the most informative was a study of physicians conducted in 1991 (La Puma et al., 1991). This paper is referenced in many recent articles. This paucity of empirical evidence in this area highlights a gap in the contemporary knowledge base. The following review introduces concepts that have been recognised in studies conducted surrounding professional boundaries, relationships and intimacy in the medical and psychology fields as well as the phenomenon of nurses who have cared for a significant other as a family member outside their professional role. These concepts, their definitions and the surrounding supporting research are discussed here to provide a background for this study.

2.2 Professional Boundaries

Professional boundaries are limits that delineate where a professional therapeutic relationship ends and a personal relationship begins (NMBA, 2010). Nurses and midwives are expected to be "... aware that dual relationships may compromise care outcomes and always conduct professional relationships with the primary intent of benefit for the person receiving care" (NMBA, 2008, p. 4). These guidelines present one common theme: to encourage nurses and midwives to reflect on their responsibilities by identifying boundary crossings and violations (NMBA, 2008) in an attempt to make a decision to do the least harmful thing, and have the most beneficial outcome for the patient (Paternelj-Taylor & Yonge, 2003). When the nurse/midwife providing care is a

significant other there is already an established personal relationship, which needs to be considered in specific guidelines.

Professional boundary crossing is discussed extensively in the literature (Baron, 2008; Holder & Schenthal, 2007; Hudspeth, 2006; Pugh, 2007). The treatment of patients who are known to the clinician on a personal level has been researched in the mental health and social work sectors. An exploration of the extent and impact of professional boundary crossings was conducted to evaluate the effects of dual relationships (Endacott et al., 2006). This study involved interviews with 52 mental health workers from rural, metropolitan and regional areas. Data revealed that boundary crossings were common and unavoidable, causing participant health care professionals, "... greater stress when the boundary crossing affected their partner and/or child" (Endacott et al., 2006, p. 987). This study highlighted that participants from smaller communities inevitably experienced increased accountability for care outcomes for individuals within their social circles. This was linked to a perceived limitation on their own capacity to deliver quality health care. At the same time, ease of social interaction was impaired for all concerned once 'patient' and the health care professional had shared intimate information (Endacott et al., 2006).

Addressing the issue of dual relationships Baca (2011) explains that boundary violations often occur when the nurse/midwife confuses his or her own needs with the needs of the patient and this becomes tricky when "...to a degree the patient relinquishes control in order to form trust" (Baca, 2011.p. 196). When nursing a significant other there is the additional blurring of lines between the nurse's clinical decision making and the desired outcome of the role associated as a significant others. Patient-nurse relationships that are established within a clinical setting are represented in the literature; however none of them acknowledges the situation where the relationship exists prior to the hospitalization. The development of a therapeutic relationship alongside an already set personal relationship adds complications not addressed in the literature relating to informal care provided by a nurse /midwife significant other.

The medical profession have addressed the effects of dual roles when treating significant others (Eastwood, 2009; Evans, Lipton, & Ritz, 2007; La Puma, Stocking, La Voie, & Darling, 1991; Mailhot, 2002; Schneck, 1998). There is a possibility of risk with concerns voiced by physicians treating significant others about either the patient not feeling

comfortable sharing intimate information or the physician failing to ask certain questions for the same reason. This raises questions about whether patients seeking treatment from family physicians are getting the most appropriate treatments for their individual needs. A survey of 465 physicians found 99% had experienced a significant other informally asking them for medical advice (La Puma et al., 1991). They reported significant others and friends bypassing the official consultation by requesting health care services during social encounters or contacting them at home for advice or scripts. This could be considered convenient and cost effective for the significant other, however was reported to cause the physician discomfort, especially when the request is related to more serious health concerns. Two hundred and sixty-two participants reported refusing a significant others' requests but a staggering one hundred and three said they had agreed to provide care even when they felt uncomfortable about the decision. This is of great concern because it suggests that health care professionals are not necessarily governed by their own concerns when making ethical decisions about the appropriateness of providing care. The above concerns may transfer into the ethical decision making processes in nurses and midwives. If nurses and midwives feel pressured to provide care for their significant other or are simply preoccupied by any discomfort of caring for a significant other this may affect decision making and quality of care that is being provided. An understanding of nurses' and midwives' reflections on these experiences may lead to a better understanding of and suggest changes to the current practice and guidelines around professional boundaries in general.

2.3 Dual roles

Mills and Aubeeluck (2006) recorded nurses' accounts of conflict between wanting the best possible treatment for their loved one, yet not having the confidence to make the decisions needed. Off duty nurses in this study were caring for family members at home. Their innate nursing qualities such as empathy and compassion heightened the demand they felt on themselves in the role as family nurse due to their intimate connection to their patient. Having a health professional's understanding of illness, treatment options and being able to communicate with doctors at a professional level meant nurses were well informed, but with having those discussions came the "chilling and frightening realisation of the reality of the health status" (Crunden, 2010).

Whilst the nurse caring for a significant other is informed and has the patients' best interests at heart, the literature emphasizes the role conflict that develops when the personal relationship takes on a new structure (Crunden, 2010; Feeg, 2006; La Puma et al., 1991). The professional is described as being in conflict with their professional and personal care giver roles, which in turn makes it harder to make decisions and initiate health driven care whilst constantly battling the power balance between the professional role and private role of loved one. The familiarity and trust that develop between a nurse and a client in the professional setting, can lead to the professional having feelings of importance and control. Holding the power to make treatment decisions in addition to the change in the personal relationship could easily confuse the integrity of the nurse- patient relationship and may lead to boundary violations both professionally and personally (Baron, 2008; Holder & Schenthal, 2007; Mailhot, 2002; Peternelj-Taylor & Yonge, 2003). Holder and Schenthal (2007) recognised "...nurses... must be increasingly aware of patterns of boundary crossings and the potential or real harm that may come to patients and nursing staff" p.28. These boundary lines may be even more difficult to recognise in a dual relationship between nurse and a significant other patient.

2.4 Duty of care

Duty of care is described as a legal obligation to safeguard others from harm while they are in your care (Collins, 2014). The Nurses Code of Conduct covers duty or care within the nursing community with several statements relating to standards of professional and broader health care.

"Nurses are responsible for ensuring the standard of their practice conforms to the standards developed and agreed by the profession, the object of enhancing the safety of people in their care as well as their partners, family members and other members of the person's nominated network. This also applies to the nurses' colleagues."(2008. p.2)

It is pertinent to mention the inclusion within the Code of Conduct of a nurse's family members and wider social network when considering the experiences of dual relationships. For the NMBA to include non-patient socially connected people within the

professional duty of care guidelines beg the question, “What happens when that known community or family member becomes a patient in your care?”

2.5 Nurses as Informal Family Caregivers

There are many potential complications associated with significant others nursing their loved ones (Crunden, 2010; Mills & Aubeeluck, 2006). Caring for a significant other, when caring is also your profession has been shown to create issues with role confusion, resentment and exhaustion due to the dual roles. (Gottlieb, 1996; Mills & Aubeeluck, 2006; Ross, Rideout, & Carson, 1994).

Nurses caring for their significant others in the home describe the role of nurse and the role of significant other being intertwined (Salmond, 2011). Not being able to separate the two raises questions about the effects this may have for nurses caring for significant others in their role of employment. Salmond’s study of 22 nurses caring for family members outside of their role of employment identified six challenges for these nurses. These were: masking heightened emotional turmoil; assuming the in-charge role; assessing and monitoring; seeking information and meaning; advocating; and letting go to assume family and self roles. Questions surrounding these reported challenges of nurse family members being mirrored in health care settings are yet to be investigated.

When patients have chronic or ongoing debilitating illness they are often stabilized and discharged home until the need for medical intervention and hospitalisation is needed again. During these times nurses are often called upon to assist with the family members care at home. A qualitative study conducted by Mills and Aubeeluck (2006) identified issues experienced by nurses providing informal care for their significant others. Three of the four themes that emerged were linked to the negative or concerning effects on the nurses caring for their significant other and involved both professional and personal issues. The care was seen to affect their own quality of life due to the reduction of time to engage in normal social activities and relaxation time. This in turn brought on feelings of guilt about selfish thoughts for wanting relief from the constant demands on time and energy from their loved one.

From a professional viewpoint, the nurses in the above study reported feeling concerned about the personal and professional boundaries associated with the informal

care arrangement. Nurses did not relinquish their professional ethical responsibilities whilst engaging in family care giving. This led to role confusion and the added responsibility of becoming the family guide, researching and communicating with the specialists.

Having a qualification in healthcare creates an internal conflict when making decisions and initiating health driven care whilst constantly battling the power balance between that and the private role of loved one (Crunden, 2010; Feeg, 2006; Gottlieb, 1996; Mailhot, 2002; Mills & Aubeeluck, 2006). The findings from this study are considered significant as the experiences of the home care nurses may be transferable to the hospital setting.

Many nurses reported positive aspects associated with caring for their own significant others (Mills & Aubeeluck, 2006). They reported being able to provide care and utilise their professional skills, which brought comfort to their significant other and even enabling the significant other to pass away in their own bed because the family member nurse could deliver appropriate care in the home. The professional skills and knowledge they held were directly linked to the ability to offer higher acuity care in the home.

2.6 Nurses in the family member role

Salmond (2011) suggested, "... that their nurse role identity was intertwined with their family member role identity and could not be separated" (2011, p. 12). Twenty-two nurse participants reported feeling the need to be fully informed even when the information was both confronting and not understood by their wider family members. This in turn led to feelings of isolation. The nurse family members acted as leaders, interpreting information and reassuring the other family members, often playing down the seriousness of the situation they fully understood themselves. Nurse family members needed to be closely involved in the care planned and care choices to decrease their own anxiety about the possible outcome. Being an active care advocate reassured them the best care would be provided. They were often evaluating the care given and gauging the competency of the staff to alleviate their own fear (Salmond, 2011). In this case, nurses whose relative was receiving care in their place of employment felt included in the team

and were perceived by the nurse family member to be provided with extra monitoring and attention than they believed the average patient would receive.

2.7 Patient Vulnerability

The existence of patient vulnerability has been highlighted by the media coverage of legal action taken over boundary violations and abuse in the healthcare system (Holder & Schenthal, 2007). Nurses and midwives need to be vigilant about boundaries and the warning signals that identify boundary crossings and aim to prevent harm to the patient. A study of patients who had recently been discharged from hospital found patient feelings of vulnerability were directly related to their inability to maintain control of their own lives and to protect themselves against threats to their physical and emotional wellness (Irurita, 1999).

The NMBA acknowledges patient vulnerability in their Code of Professional Conduct with the statement “An inherent power imbalance exists within the relationship between people receiving care and nurses that make the persons in their care vulnerable and open to exploitations” (NMBA, 2008, p. 1). Although nurses are familiar with assisting patients with intimate tasks, (Rose, 1998) embarrassment and inhibitions experienced by clients, caring for a significant others can constrain the interactions that would normally take place between the nurse and patient. Vivaldelli (2007) highlights the fine line between appropriate nurse-patient interaction and boundary violation. Nik-Sherina and Ng (2006) elaborates on these findings by reporting the cultural sensitivities with many significant others finding hierarchical, gender roles and family expectations cause discomfort and barriers to delivering appropriate health care reporting “...personal emotions may cloud clinical objectivity”(p. 3). These findings may be experienced when nursing care is delivered by a patient’s significant other.

2.8 Confidentiality

Maintaining confidentiality has been seen as a challenge when dual roles of carer and relative was experienced by doctors surveyed in relation to requests by significant others to provide care (Nik-Sherina, 2006). Family members asking about their relative’s health status caused concern for the doctor both by using the relationship to access information they would not have acquired from an unknown doctor and the potential of

being perceived as withholding information from the family. These ethical issues weighed heavily on the study participants' minds.

The blurred boundaries may cause a breakdown of confidentiality at the time of treatment or in the future as the information stays with the significant other even after the doctor-patient relationship returns to a private one (Nik-Sherina, 2006). Dual relationships caused conflict and unnerved the health professional when they were encouraged to continue treating their loved one when they were not confident about the appropriateness of the interactions. Doctors reported feeling bullied into continuing care of their relatives even when they did not want to treat the patient due to their dual relationship (Nik-Sherina, 2006).

When a significant other was admitted to one nurse's place of employment she expressed unease with her colleagues potentially gaining too much personal information about her private life via the significant other's admission to her own ward (Salmond, 2011). This was something that she could not control due to a significant other being nursed on her own ward. The author does not discuss how this affected the staff morale and patient/staff member's confidentiality and the ability to keep a private life private? The effects on the nurse in this situation would support the need for further research into the phenomenon of nurses caring for their significant others in their role of employment.

2.9 Clinical Decision Making

Doctors reported feeling anxious about the potential for misdiagnosis or incorrect management of care and especially clinical outcomes when providing care for significant others (Nik-Sherina and Ng, 2006). The risk of blame being placed on the doctor for what could be seen as inadequate or wrong treatment from other family members, indicated doctors may make decisions differently than if the patient was a stranger. The fear of having question placed on their professional abilities and the risk of causing family conflict, meant doctors were more likely to give advice or suggestions rather than actual treatment as a way of reducing their involvement (Nik-Sherina and Ng, 2006).

The literature reviewed in this chapter suggests that even with the best intentions and professionalism, a nurse who encounters a significant other in their care will be affected in some way. Crunden (2010) shares his experiences of seeing his critically ill wife

in the intensive care unit. He describes feeling like he was on autopilot. His thought processes shut down to protect him from the reality that he knew as an experienced nurse. He explains feeling powerless and trying to block out the physical symptoms he knew were life threatening to delay the reality of how serious his wife's health status really was. If a nurse experiences these same coping strategies while caring for a significant other in their role of employment, this could lead to delaying or misinterpretation of clinical symptoms. The risk of this occurring highlights the need for further studies into this phenomenon and its impact on clinical decision-making outcomes.

2.10 Summary of the Literature

Nurses and midwives have multiple roles including personal, professional and community member. In this review the pre-existence of an association between the patient and the nurse/midwife is the main factor differentiating this phenomenon from other professional boundary examples. The relationship already established may have the potential to alter the interactions between nurses/midwives and their patients when there is a pre-existing deep relationship. Nurses and midwives need to be mindful of the implications of proceeding to deliver care to patients who fit into any of the category of 'significant other'.

Registration guidelines provide nurses and midwives, employers and the public with the standards expected within the health care system. They highlight the concerns of the nurse-patient relationship; however the nurse/midwife is left to use their own professional judgement to ensure that their behaviour and interactions with the patient meet the professional standards for both health care and the therapeutic relationship. As pointed out by several studies, this judgement is effected when a healthcare professional is responsible for the care of a significant other (Crunden, 2010; Feeg, 2006; Hudsperth, 2006; La Puma et al., 1991; Mailhot, 2002; Nik-Sherina, 2006).

Professional boundary awareness is of particular importance for nurses and midwives who are contemplating nursing their own significant other in their role of employment. The nursing profession needs members who have the ability to make judgments about boundaries with the best interests of the clients in mind. Research and

learning from others who have experienced nursing a significant other in the role of employment may enhance this knowledge base.

2.11 Definitions

Drawing on the reviewed literature, the following definitions will be applied throughout this thesis:

- Boundary crossing: brief ventures across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet the therapeutic needs or care needs of the patient.
- Boundary violations: occur when the nurse/midwife confuses their own needs with the needs of the person in their care. This may be through ignorance or malice.
- Dual relationship: a relationship in which a nurse/midwife is concurrently participating in two or more roles at one time with a patient. Such dual relationships may be benign or harmful.
- Significant other: a person who a nurse/midwife identifies as very important in his/her life. It could be a spouse, partner, parent, child, sibling or friend.
- Therapeutic relationship: a relationship based on plans and goals that are beneficial in intent and outcome

(ANMC, 2008; NMBA, 2008, 2010)

2.12 Conclusion

Nurses and midwives are self-governing when it comes to caring for a significant other in their role of employment. They are asked to consider the risks associated with the practice particularly the ethical ramifications. A thorough search of published literature has demonstrated a gap in empirical knowledge relating to the experiences of nurses and midwives caring for a significant other in the role of employment. This chapter has introduced and discussed literature that sits on the boundaries of this particular topic. Examples of health professionals other than nurses, examples of rural practitioners and of nurses who care for a loved one in their private lives have been included. This chapter has outlined the deficit of knowledge related to how caring for a significant other in the role of employment effects nursing staff.

In the following chapter the methods used to explore nurse's and midwives' perceptions will be explained.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter describes the methodology and method used to address this study's aim and objectives. First, the philosophical values guiding the study are outlined. Next, the respondents, the selection and recruitment will be discussed. Following this, the development of a survey tool, the collection and analysis of the data are discussed in detail. Finally, academic rigour, safety and accountability will be addressed as they relate to this study.

Methodology is the study of research methods and their philosophical foundations (Schneider, Whitehead, & Elliott, 2007). It has two sub-branches, 'Ontology', which is concerned with the existence of things, and 'Epistemology' which is the study of how we know that things exist (Polit & Beck, 2007). Researchers work within a particular knowledge community or paradigm, and share that group's intellectual and value assumptions (Sundin-Huard & Fahy, 2008). The results of that researcher's work is useful and makes sense based upon the relevant paradigm's beliefs about the purpose of their project, the appropriate methods for the study and the forms evidence should take (Richardson-Tench, Taylor, Kermode & Roberts, 2010).

There are two broad approaches to research, qualitative and quantitative. Qualitative research aims to describe and/ or understand phenomena and social issues. It tends to "... generate data that comprises words and pictures" (Moule & Goodman, 2013. P. 171). Quantitative research aims to gauge the size of phenomena described in qualitative research or measure and develop logical explanations for the relationships between data, to "...generate research data that can be analysed numerically using statistical techniques" (Moule & Goodman, 2013. P. 172). These approaches are increasingly combined to achieve both these aims in the one study. This study aims to describe the experience of nurses and midwives who have cared for their significant other in their role of employment, not only in terms of the nurses' and midwives' personal experiences of the events, but also in terms of their perceptions of the event's impact/s on the care provided.

3.2 Study Design and Rationale for the Method

The purpose of descriptive research is to observe, describe and document aspects of a situation (Polit & Beck, 2007). The aim of this study was to collect information relating to experiences of nurses and midwives who have cared for a significant other in their role of employment. The scarcity of empirical knowledge about this topic makes the use of a descriptive research method an ideal choice, as descriptive research is useful when little is known about a phenomenon (Schneider, 2013). This study describes the respondents experiences through their narrative accounts and their responses to a Likert scale designed to illuminate the impact of their experiences on their nursing care,

Descriptive research design allowed for the collection of the individual's experience of the phenomenon, as it was recalled and expressed by the respondents. This information is a narrative of the perceived experience, not what may have caused the situation or effect. The existence of the phenomenon in this study is acknowledged in governing body's documents and included in academic and practical setting education for nurses and midwives with little reference to research into the effects of such events (NMBA, 2010). Descriptive research provides a base line knowledge relating to the experiences of respondents who had cared for a significant other in their role of employment. Table 1 provides themes highlighted from the literature were used as concepts to direct development of the survey tool used to gauge the impact of the phenomenon on respondents.

Table 1. Descriptive design concept

| Descriptive design concept modified from Burns and Grove (2010, p.238) | | |
|--|--|---|
| RESEARCH QUESTION <i>“How does the experience of nursing a significant other in the course of employment impact Australian nurses?”</i> | | |
| MEASUREMENT | DEFINITIONS | INTERPRETATION |
| Concept 1 – Clinical Decision Making | <p>The process of evaluating available information and reaching a care option based on that information and the individual desires and beliefs of the patient.</p> <p>Mosby's Medical Dictionary, 8th edition. 2009, Elsevier.</p> | Interpretation of the meanings associated with survey reported information and hypothesis development for future research |
| Concept 2 – Patient Confidentiality | <p>The ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure.</p> <p>http://medical-dictionary.thefreedictionary.com/confidentiality</p> | |
| Concept 3 – Ethical Decision Making | <p>Clinical decision making that considers moral values and including the principles of autonomy and beneficence.</p> | |
| Concept 4 – Therapeutic Boundaries | <p>Professional boundaries in nursing are defined as limits which protect the space between the professional's power and the client's vulnerability; that is they are the borders that mark the edges between a professional, therapeutic relationship and a non - professional or personal relationship between a nurse and a person in their care.</p> <p>NMBA, 2010</p> | |
| Concept 5 – Stress Personal/ Professional | <p>Anything that causes wear and tear on the body's physical or mental resources. Personal and professional stressors may be independent or intertwined in this situation.</p> <p>Mosby's Medical Dictionary, 8th edition. 2009, Elsevier.</p> | |
| Concept 6 – Role confusion | <p>The presence of contradictory and often competing role expectations.</p> <p>Mosby's Medical Dictionary, 8th edition. 2009, Elsevier.</p> | |

3.3 Population and Sampling

Participants recruited for this study included nurses and midwives who had cared for their significant other during their course of employment. The sites for recruitment were three hospitals in Perth, Western Australia. These hospitals were chosen for convenience due to the time constraints of Master's studies and included hospitals affiliated with the hospital the researcher was employed at.

The inclusion criteria were:

- a) Midwives, Registered Nurses or Enrolled Nurses
- b) Currently employed in one of the three participating hospitals
- c) Have nursed a significant other in their paid employment as a nurse or midwife in their current or previous employment (no time frame was applied)

Statistical data on the frequency of this phenomenon has not been collated therefore the sample size cannot be estimated by a power analysis. An electronic survey was chosen to allow for qualitative insight and a quantitative paradigm to collect information from a broad target group in a relatively short time frame (Richardson-Tench, 2010). This process of data collection enabled the researcher to collect information that describes experiences and interprets their meaning (Grove & Burns, 2010). Surveys are economical, timely and can reach a large population (Polit & Beck, 2007) therefore suitable for collecting information from participants recruited for this study. Participants had an opportunity to describe their experiences responding to survey questions and by writing freely any additional information. The survey was self administered and could be completed at a time and place suitable to the participant.

1.3.1. Limitations

A disadvantage of data collected via a written survey is that the researcher cannot observe the participants' reaction to the questions and there is an inability to verify information presented (Moule & Goodman, 2013). The inability to probe deeper or prompt the participant to elaborate on areas of interest or encourage participants to further explain specific content risks the collection of superficial data. Interviewing

participants would have allowed for observation of human behaviour and feelings that are expressed during the human interaction, which may enhance the content of the words used to explain the experience (Polit & Beck, 2007).

The positive side to using a survey over interviews was the ability to record the frequency and statistical information a widespread data collection technique could offer. In this instance the desire to collect extensive rather than intensive data supported the use of a survey.

The return rate could not be calculated due to the unknown prevalence of the phenomenon. The researcher proceeded knowing that a lack of data may support the fact that there are no specific guidelines needed to govern this area other than mindfulness of the nurse/midwife.

3.4 Data Collection

3.4.1. Survey Development

An electronic survey was chosen as the most appropriate tool for this study as it could be administered to a large group of nurses and midwives in a short time. Making the survey accessible to the wider group via the online survey increased the chance of accessing nurses and midwives who had experiences to share. Without knowledge of the frequency of the phenomenon it was important to gain a snapshot of the extent to which nurses and midwives have cared for a significant other at work.

The electronic survey was administered using the Qualtrics Research Suite (2014) accessed via the university Intranet. This is a password-protected site and each user has an individual account and password to protect the survey tool and data.

3.4.2. The Tool

The survey tool, as can be seen in appendix 1, included four sections.

- Section one included information statements relating to the study aim, process, risks, contact details of the researchers and informed the participants of the consent and withdrawal process. A tick box was used at the bottom of the information page as

verification of consent to be included in the study. Potential participants could not progress past this page without ticking this box.

- Section two was the collection of demographic information to contextualise the participant's experience. Information was collected about the participant including designation, qualification and years of experience. Information relating to the care episode included relationship to the patient, facility type; type of care provided and why they cared for their significant other were also collected.
- Section three required participants to rate their responses on a five point Likert scale from 'much better' to 'much worse'. The questions related to caring for a significant other in the role of employment as opposed to nursing a stranger. The concepts of interest underpinning this survey were identified in the literature review as ethical and clinical decision-making, confidentiality and therapeutic boundaries. Two further concepts of importance, which tangentially affected patient care, were impact on the role as nurse/midwife and significant other, and on personal and professional stress levels associated with the care episode. These concepts and a précis of their definitions can be found in Table 1.
- Section four of the survey invited the participant to record an example of one of their own experiences of caring for a significant other in their role of employment. The participants were asked an open-ended question: 'tell us about your experience in written form. This section, allowing the individual to narrate, describe and possibly reflect upon their experience, provided rich contextual data.

3.4.3. Pilot Study

A pilot survey was distributed to invite feedback relating to the survey tool and adjustments to improve the final product, with the aim to collect more accurate data. The pilot survey was sent electronically to 6 clinicians who were either nurses or midwives, and include a member each from the University and Hospital Ethics Committees. The pilot survey results were used to modify the survey tool during the development process. These measures were taken to confer credibility and dependability on the study results.

Feedback requested from the participants included:

- Is it clear what the survey is trying to achieve?
- Are the questions easy to comprehend and answer?
- Is the wording appropriate?
 - Are there any areas of inquiry that have been overlooked?
 - Is the ranked scale easy to understand and plot?

The demographic information was extended to include areas that were predicted to be of benefit when analysing the results. These included level of qualification and the type of care carried out. The wording used to describe the scaled questions were altered to clarify the options and reduce participant confusion. Alternatives for the five ranking choices were tested by the pilot participants with the final scale of 'much better', 'better', 'same', 'worse' and 'much worse' used to accommodate both improved and reduced perception of effects on the themes. By having a two directional scale it allowed for the participant to acknowledge both good and bad effects, preventing the researcher from leading the participant's responses.

3.5 Recruitment

An email sent from the reserchers ECU emailaccount to the Nurse Unit Managers and the Staff Development Nurses at the hospitals included in the study for distribution to their staff. This email requested the following process be carried out:-

- The attached flyer be printed and displayed on notice boards and in communication books on all wards (see appendix 2).
- The electronic flyer be forwarded to all staff on email
- The survey flyer was mentioned at unit meetings. An A3 copy of the flyer was distributed to the main tea rooms around the various hospital sites. These copies had tear off tabs at the bottom with the link to the electronic survey. Staff were encouraged to take a tab with a copy of the URL/ link so that they could complete the survey at a time and place convenient to them.

- The survey was open for twelve weeks, with 3 separate reminder emails distributed to facilities..

3.6 Data Analysis

Data analysis aimed to shed light on the experiences of nurses and midwives caring for a significant other in their role of employment. The survey results were collated using the Qualtrics Research Suite (2014) program. By using the analysis features of the program the risk of data entry errors was reduced by removing the need to transcribe the data from the written form to an electronic form or from one database to another.

The respondent's accounts were coding for common words, themes and ideas. These were listed and reconsidered until all the commonalities fit into sub groups. These sub groups were then evaluated against the Literature Review and in collaboration with the researcher's supervisors the final concepts were established. The final concepts are visible in Table 2.

3.6.1. Demographics

The demographic data from the survey was collated and analysed using descriptive statistics. These included age groups, levels of experience, type of qualification, reason the care was provided by the nurse/midwife, type of care provided to the patient and the nurses/midwives relationship to the patient.

3.6.2. Likert Scaled Questions

Likert scales (developed from the reviewed literature) provided information related to the self-perceived effects on nurses/midwives in relation to the issues identified in the literature review including confidentiality, clinical decision making, ethical decision-making, role confusion and stress. These have also been presented as descriptive statistics.

3.6.3. Written Accounts

The respondents written accounts of their own experiences were collected, coded and thematically analysed by Constant Comparative Analysis. During this process data was sorted to identify common threads throughout the accounts. Each story was analysed and

concepts were underlined. The accounts were then compared against each other until the main concepts inherent in the overall study highlighted. These concepts were analysed to ascertain any overarching themes.

All of the findings have been used to present the impact nursing a significant other in the role of employment had on the respondents and their nursing.

3.6.4. Rigor

Rigour in research refers to the measures taken to ensure the strength and value of the findings of a particular project (Shenton, 2003). These measures have differences and similarities depending upon the approach.

Trustworthiness in qualitative research refers to the rigor of the research and comprises the four constructs of: credibility (truth value), transferability (applicability), dependability (reliability) and confirmability (auditability) (Guba and Lincoln 2005, Shenton 2004). For the quantitative researcher, validity and reliability are considered important to the strength and value of the study (Polit & Beck, 2007). For the qualitative researcher, credibility is strengthened as the researcher builds a rapport with the participants in an effort to enhance the potential 'truth value' of the information imparted (Streubert & Carpenter, 2011). This strategy is not available to the researcher using surveys. In this study an attempt to counteract this limitation, the survey was piloted before use. A pilot survey was distributed to invite feedback relating to the survey tool and adjustments to improve the final product, with the aim to collect more accurate data. The pilot survey was sent electronically to 6 clinicians including a member each from the University and Hospital Ethics Committees. The pilot survey results were used to enhance the credibility and validity of the survey tool during the development process.

Transferability of the data will be limited to health care professionals in Western Australia as the data was only collected in this state due to the time constraints attached to Master's studies. The development of the tool used to collect data the steps of data collection and analysis are clearly laid out in this chapter four, conferring dependability/ reliability on the findings of this study.

3.7 Ethical Considerations

The ethics proposal for this research study involved a review process by peers and faculty members. The final version was approved by of the University's and Hospitals Human Research Ethics Committees.

3.7.1. Consent

Data was collected for this study via an online survey. The first page of the survey contained an information/ consent section outlining the aims, potential benefits and, reassurance that participating in the study was entirely voluntary and that no identifying material would be recorded (see appendix 1). Respondents were informed in this section that by proceeding and completing the survey acknowledged their consent to be included in the study. Withdrawal from the study could be activated by closing the survey before finalising the last page and progressing to the thank you page.

3.7.2. Confidentiality and Privacy

Respondents were able to complete the survey at a time convenient to them, in an environment that suited them by accessing the survey link on a computer. Their privacy was maintained by the anonymous online survey technique. Respondents were not required to identify themselves when completing the survey, maintaining their anonymity and the confidentiality of their experiences.

The respondents were given the opportunity to include their email address if they wished to receive an email with a copy of the study results. Email addresses supplied for this correspondence will be deleted after the distribution of findings on the successful completion of the researcher's studies. This will limit the possibility of any electronic disruption of respondent privacy and confidentiality once the findings have been forwarded to the requesting respondent

When Respondents used people's names in the written account of their experience the names were substituted with Respondent A-G. Although individuals may recognise their shared experience, other details such as names of institutions or towns were to be changed to ensure stories are not readily recognisable to the wider community, however this was not necessary as these were not included in the nurses and midwives accounts.

3.7.3.Data storage

All data was stored in a folder in the researcher's password protected university Qualtrics account and when required, moved to a password-protected file on the researcher's hard drive. These systems are only accessible by the researcher utilising a secure password. The laptop used for analysis of the collected data was also password protected and when not in use was kept in a locked cabinet, accessible to the researcher, in the researcher's office. All hard copy material generated during the study was kept locked in the same cabinet when not in use. Hard copy material will be shredded after seven years as per the National Health and Medical Research Council (NHMRC) requirements; electronic files will be deleted at the completion of the project (NHMRC, 2007).

3.7.4.Dissemination

It is expected the results of this research will be published in peer-reviewed journals and presented at conferences. All respondents and healthcare facilities will be de-identified in these publications to maintain confidentiality.

3.8Conclusion

This chapter discussed the benefits and limitations of study design and for using a descriptive research model for this study into the experiences of nurses/midwives caring for a significant other in the role of employment. Explanations of the development and administration of the survey tool and the ethical considerations regarding the study were discussed. Written dialogue describing the nurses' and midwives' experience of caring for a significant other were recorded as well as basic demographic data, self-assessments of effects on confidentiality, clinical decision making, ethical decision making, role confusion and stress. The administrative responsibilities including confidentiality of the respondents, data storage, use and disposal of the collected data were explained.

In Chapter four the findings from the survey will be presented for each section. Tables of the results will support the information.

CHAPTER FOUR: FINDINGS

4.1 Introduction

In this chapter the findings from the distributed survey will be presented. In line with the research question, *“How does the experience of nursing a significant other in their role of employment impact Australian nurses?”* This study aimed to investigate the perceptions of nurses and midwives who have cared for their significant other in the course of employment. This chapter presents the findings from the survey including demographic data of the cohort, their rated responses to questions about the impact of issues highlighted by the literature review together with the qualitative data that emerged from an opportunity to share their experience in written format.

The chapter commences with presentation of the demographic data relating to the respondents in this study. This is followed by results from the remainder of the survey in two sections: quantitative, and then qualitative results. The quantitative section provides the nurses’ and midwives’ Likert scales ratings of their perceptions of their experiences and their impact when nursing a significant other in their professional role. This data is illustrated and explained with graphs. The qualitative data from the surveys is then presented as narratives incorporating concurrent analysis.

4.2 The Survey

This study sought information from midwives, registered and enrolled nurses and nurse practitioners who were currently employed in one of three Australian metropolitan hospital and had nursed a significant other in their professional capacity. Under the constraints of timelines and in the interests of feasibility, five sites in Western Australia were invited to participate. Only three accepted. Ethical clearance was gained from the Edith Cowan University Human Research Ethics Committee, where the researcher is enrolled as a student, and from all health care facilities involved in the study.

4.2.1. Response rate

The Qualtrics Research Suite (2014) survey detailed in chapter three (see appendix 2) was made available to potential Respondents via a Uniform Resource Locator (URL) provided within information sheets, emails, and flyers. The survey was distributed to ward managers and staff development nurses via email as outlined in section 3.5 and advertised using flyers.

The number of nurses and midwives employed at participating sites at the time of this study was 1314 registered nurses/midwives/practioners and 288 enrolled nurses. Within this cohort it is unclear as to the number of those who have experienced the phenomenon and who would have met the inclusion criteria. Although the response rate was lower than anticipated, the depth of information available from the completed surveys gives an insight into the experiences and issues associated with caring for a significant other in the role of employment.

The survey was commenced by 28 individuals who met the inclusion criteria, however only 15 went on to complete the survey questions. Nine respondents provided a written account of their individual experiences in the last section of the survey.

4.3 Demographics and Content

This section will present data relating to the respondents' individual characteristics and the clinical settings for their experiences.

4.3.1.Designation

Designation refers to the respondent's qualifications and role. The majority of the respondents who completed this question were registered nurses who made up 80 % (n=12) of the total number (n=15). Enrolled nurses made up 13% (n=2) and midwives represented 7% (n=1). There were no nurse practitioners represented in the findings.

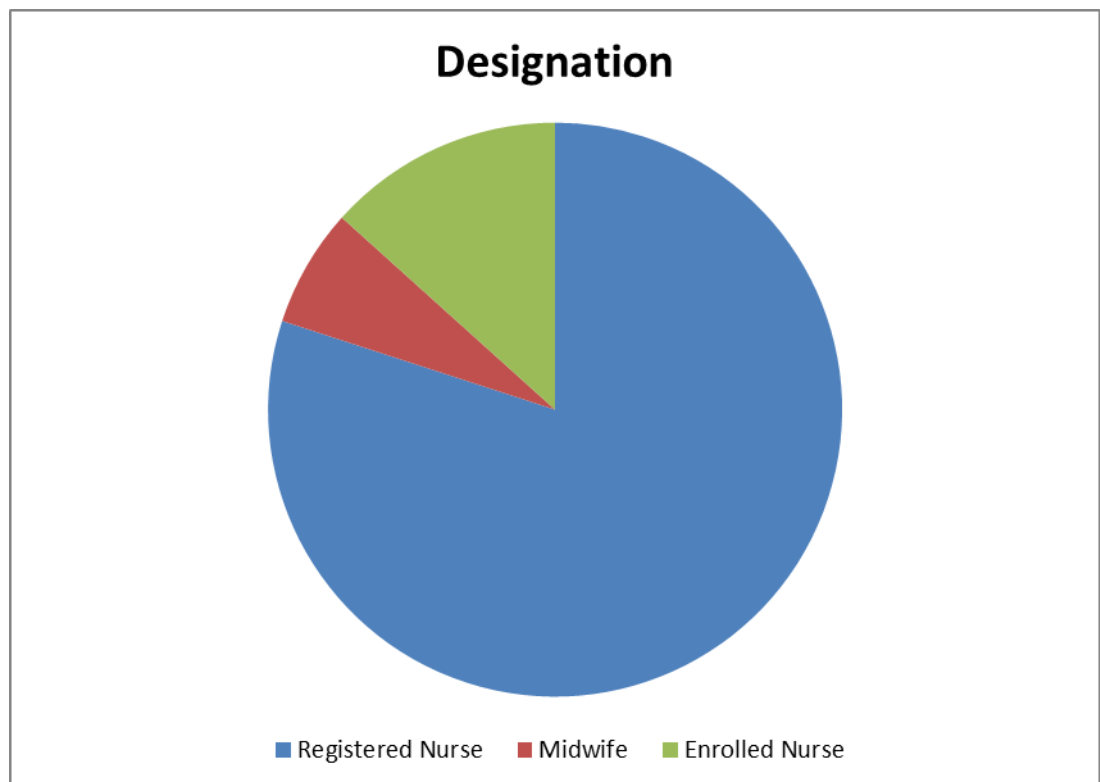


Figure 1: Respondents' designations

4.3.2.Highest Level of Qualification

Fifteen out of 28 respondents answered this question. Of these, 46% (n=7) achieved university based nursing/midwifery degrees as their highest level of education. Respondents with post graduate qualifications included one master's, 7% and one PhD, 7%. The remainder of the group was represented by hospital trained 20% (n=3), and diploma qualified nurses 20%, (n=3).

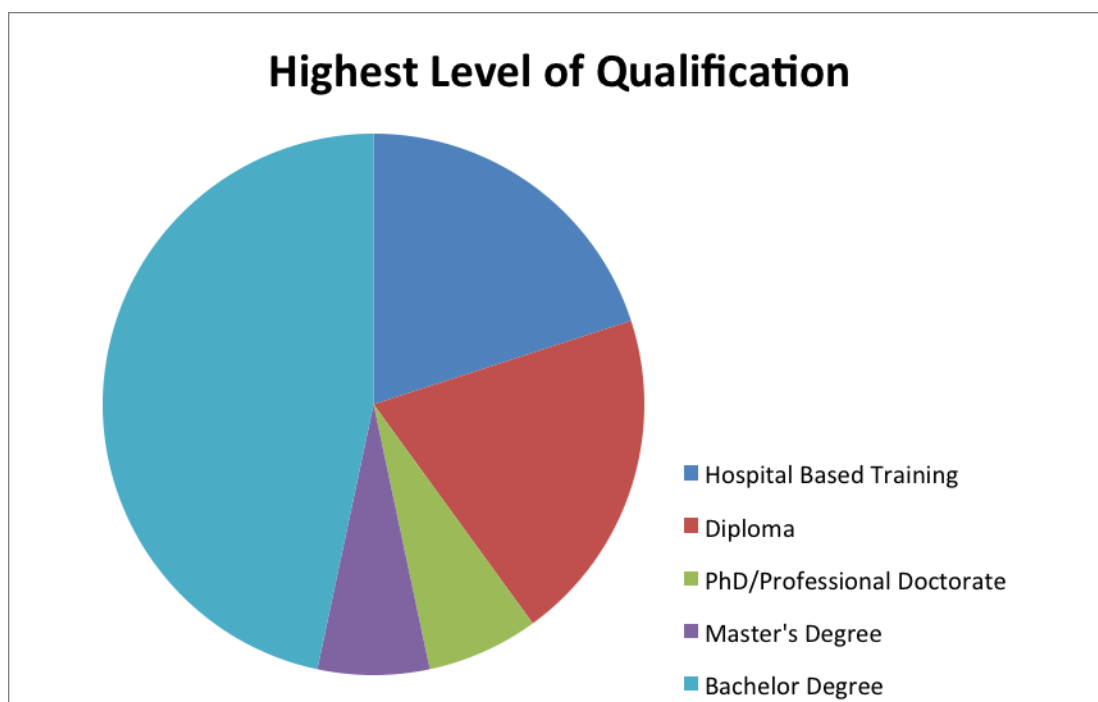


Figure 2: Respondents' highest level of qualification

4.3.3.Experience

Fourteen out of 28 respondents answered the question regarding the number of years of experience they had. The largest proportion of respondents, 53% (n=8) had been nursing for over 16 years at the time of completing the survey. The next career bracket was from 11 to 15 years with 33% (n=5) reporting themselves in this bracket and lastly 13% (n=2) of respondents were in the 1 to 5 years career bracket. There were no respondents with less than one year experience or in the 6 to 10 year bracket option.

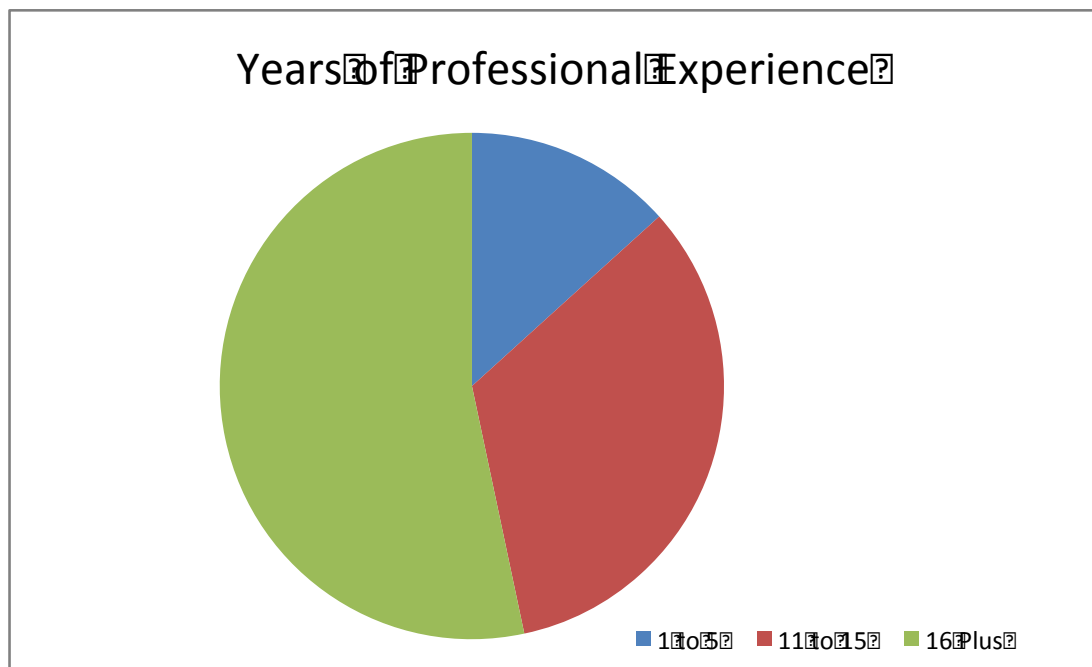


Figure 3: Respondents' years of professional experience

4.3.4. Relationship to the Patient

There were 14 responses to the question related to their relationship with the significant other they nursed. Respondents who cared for their spouse made up 13% (n=2), 7% (n=1) cared for their mother, 7% (n=1) cared for their father and 13% (n=2) cared for their own child. Twenty percent (n=3) of respondents reported caring for a grandparent while the remaining significant relationships were made up of best friend, mother-in-law, sister-in-law and nephew all attracting a 7% (n=1) portion. There were 13% (n=2) of personal relationships not described in detail.

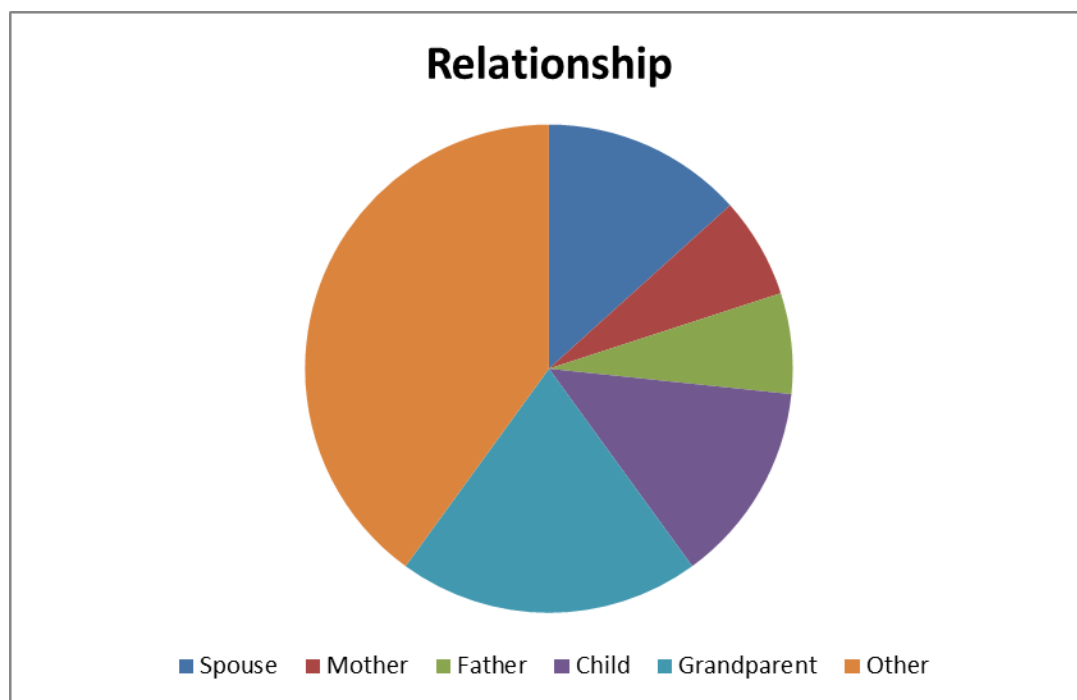


Figure 4: The relationship between the respondent and patient

4.3.5. Health Care Facility

Respondents were asked to describe the facility they were employed in when the episode of care took place. There were fourteen responses to this question. Metropolitan hospitals were the highest listed at 86% (n=12) followed by Rural hospitals with the remaining 14% (n=2).

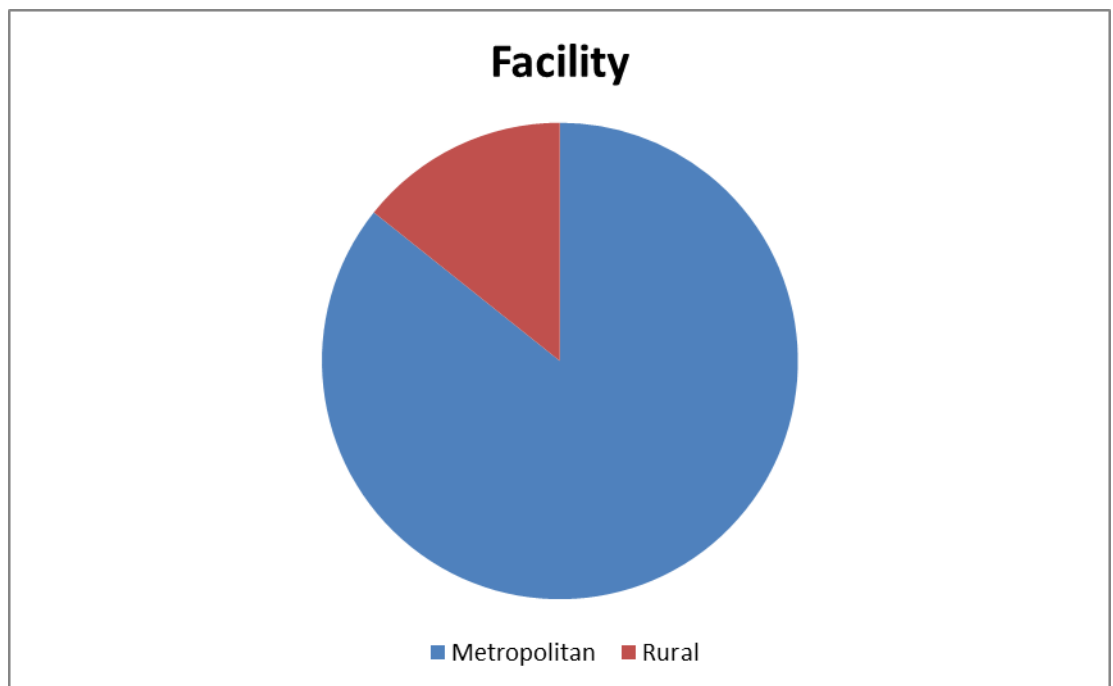


Figure 5: The type of facility where the care episode occurred

4.3.6. Reason the respondent was caring for their significant other.

Respondents were asked to list the reason(s) they had cared for a significant other in their role of employment. There were fourteen responses to this question with 57% (n=8) reporting it was their own choice. Twenty one percent (n=3) of respondents listed their significant other requested the care be provided by them and 14% (n=2) listed staffing needs to be their reason. Seven percent (n=1) of respondents listed the reason as a combination of all the options listed on the survey.

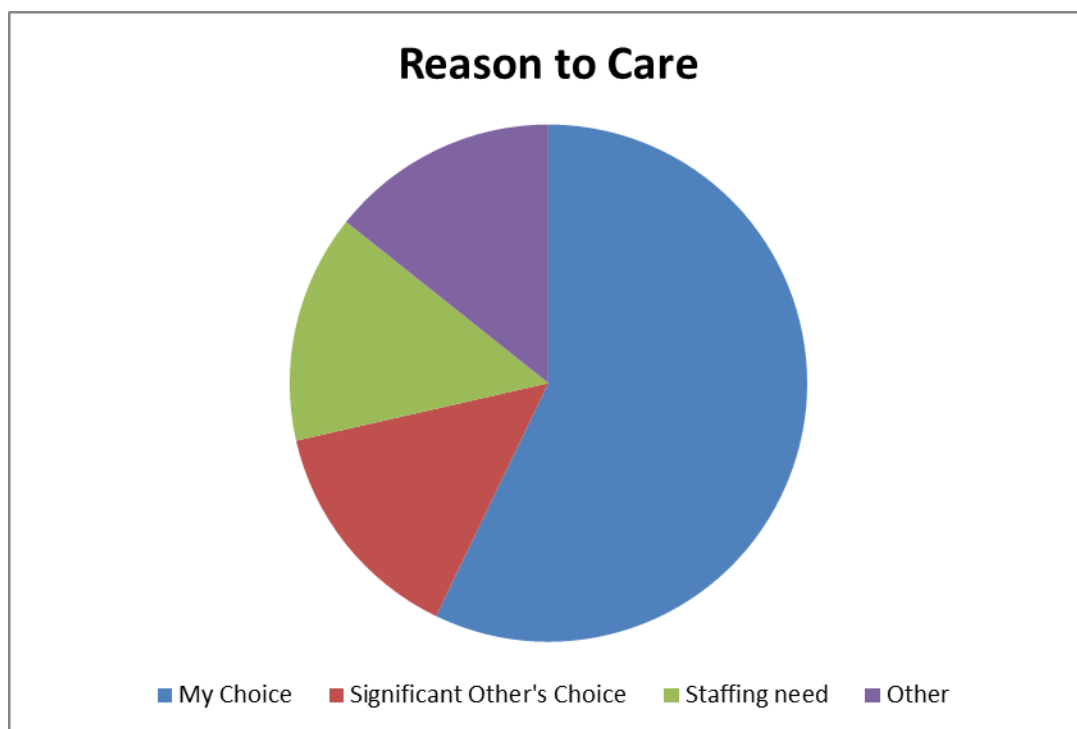


Figure 6: Reason the respondents cared for the patient

4.3.7.Type of care provided

When asked what type of the patient care was receiving 36% (n=5) described the care as acute. The next highest represented group were patients admitted for elective surgery with 29% (n=4) belonging to this category. Fourteen percent (n=2) of patient were receiving obstetric care and 7% (n=1) each were listed as palliative, emergency and rehabilitation.

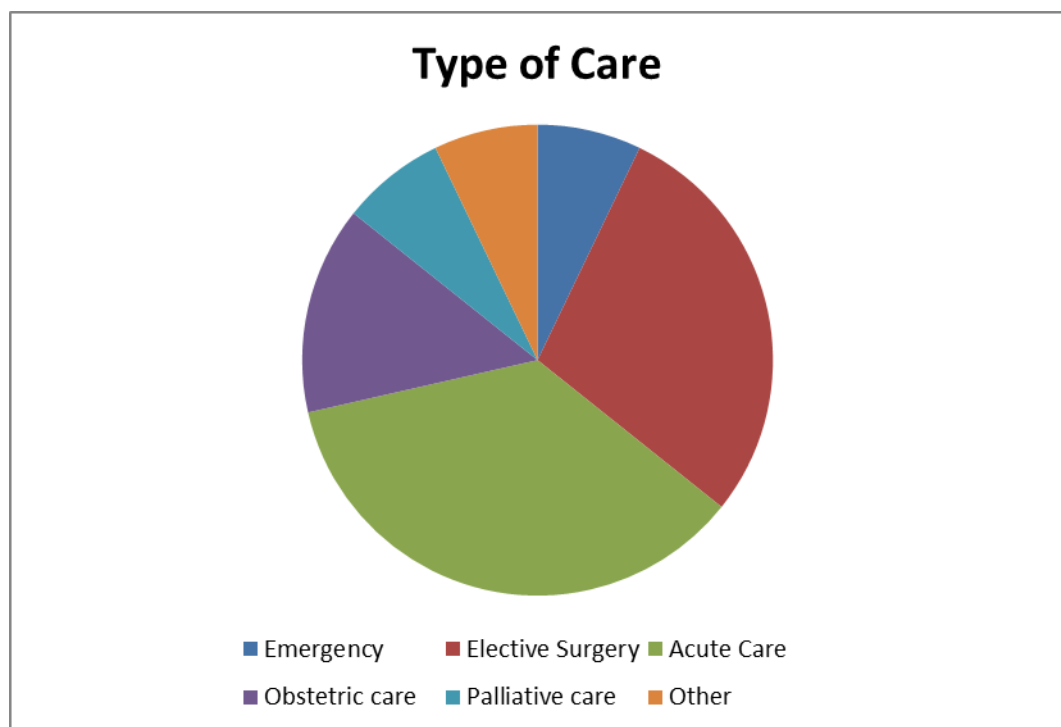


Figure 7: The type of care the patient was receiving in hospital

4.4 Quantitative Responses.

Respondents were asked to rate the impact of several factors on their experience of nursing a significant other in their role of employment. The options available on the scale consisted of Much Worse, Worse, About the Same, Better, *Much Better*.

4.4.1. Clinical decision making

When asked to assess the impact of caring for a significant other on their ability to make clinical decisions 71% (n=10) of respondents listed the effect as *About the Same*. Fourteen percent (n=2) of respondents each chose *Better* and *Much Better* from the options.

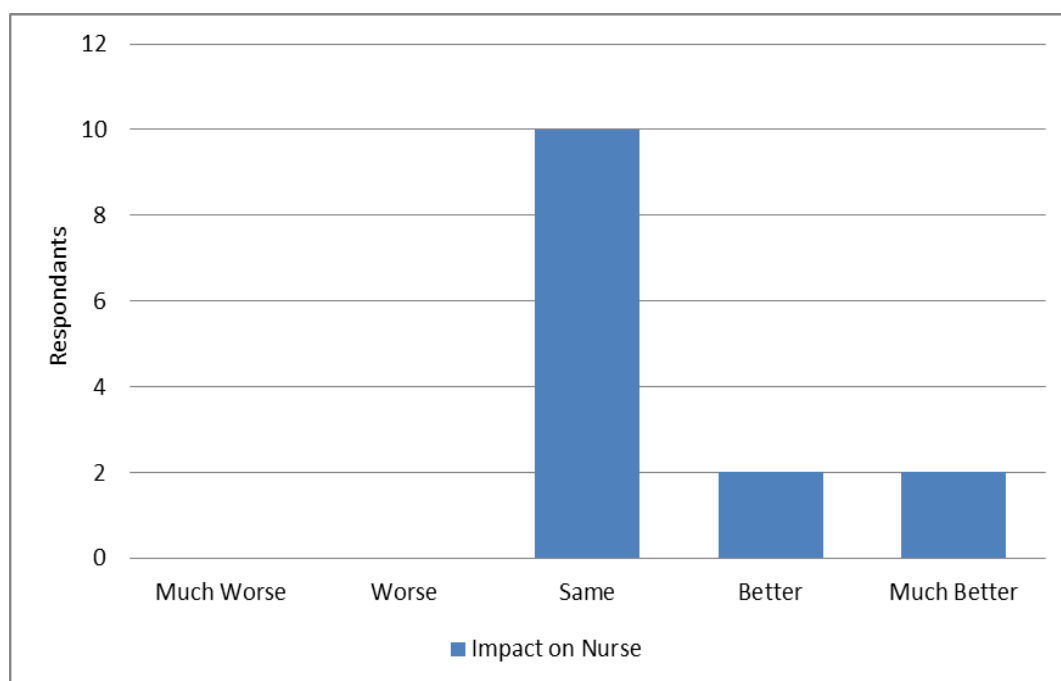


Figure 8: Impact on clinical decision-making

4.4.2.Ethical Decision Making

When asked to assess the impact of caring for a significant other on their ability to make ethical decisions relating to the patient 71% (n=10) of respondents listed the effect as *About the Same*. Seven percent (n=1) each chose *Better* and *Much better* from the ranking options and 14% (n=2) listed their effect as *Worse*.

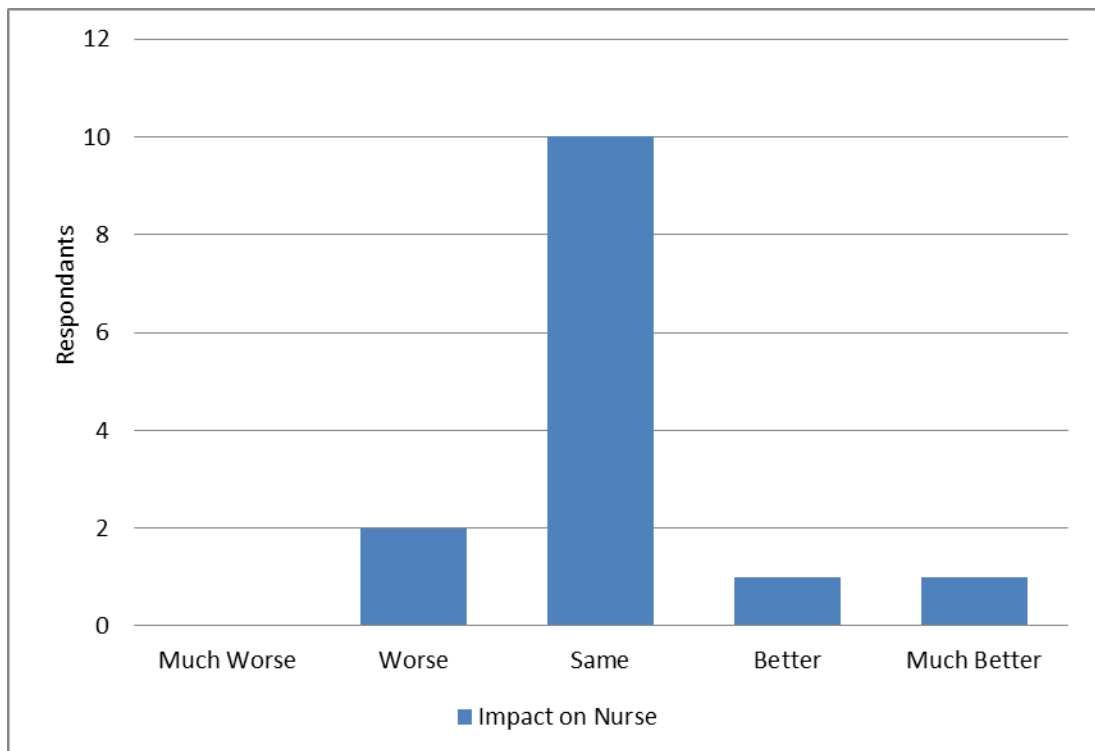


Figure 9: Impact on ethical decision-making

4.4.3. Confidentiality

When asked to assess the impact of caring for a significant other on their ability to maintain confidentiality of the patient 57% (n=8) of respondents listed *About the Same*. Twenty-nine percent (n=4) of respondents chose *Worse* from the ranking options and 14% (n=2) listed their effect as *Better*.

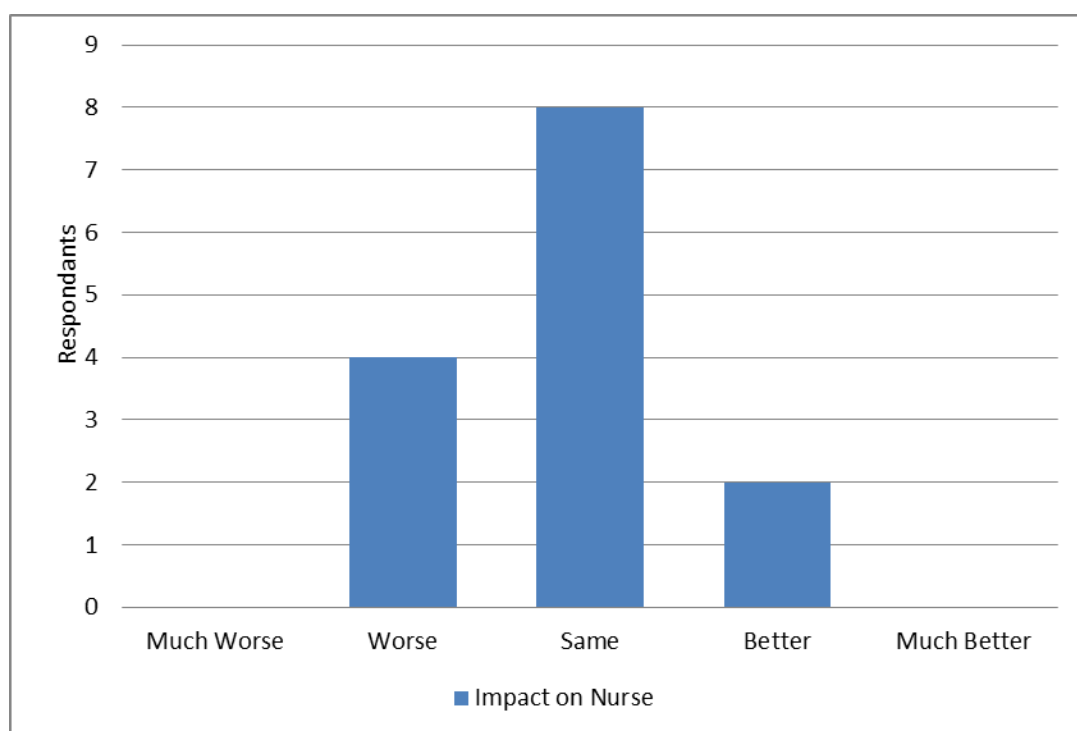


Figure 10: Impact on confidentiality

4.4.4. Therapeutic Boundaries

When asked to assess the impact of caring for a significant other on their ability to maintain therapeutic boundaries with the patient 38% (n=5) of respondents chose *Worse* and 8% (n=1) chose *Much Worse*. Thirty-one percent (n=4) of respondents chose *About the Same* effect. Fifteen percent (n=2) of respondents chose *Better* and 8% (n=1) chose *Much Better* from the scaled options. Overall 56% (n=6) reported a negative impact and 23% (n=3) of respondents reported a positive impact on their abilities to maintain therapeutic boundaries.

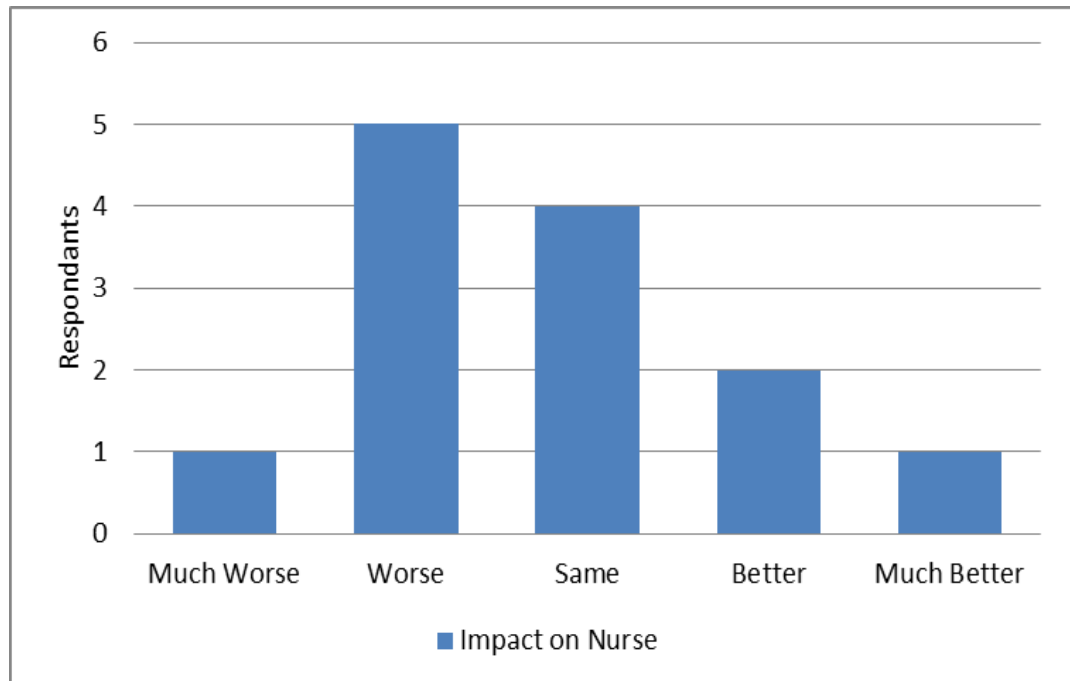


Figure 11: Impact on the therapeutic boundaries

4.4.5. Professional role

When asked to assess the impact of caring for a significant other on their professional role 36% (n=5) of respondents each listed *About the Same* and *Better*. Twenty-one percent (n=3) of respondents chose *Worse* and seven percent (n=1) chose *Much better* from the ranking options.

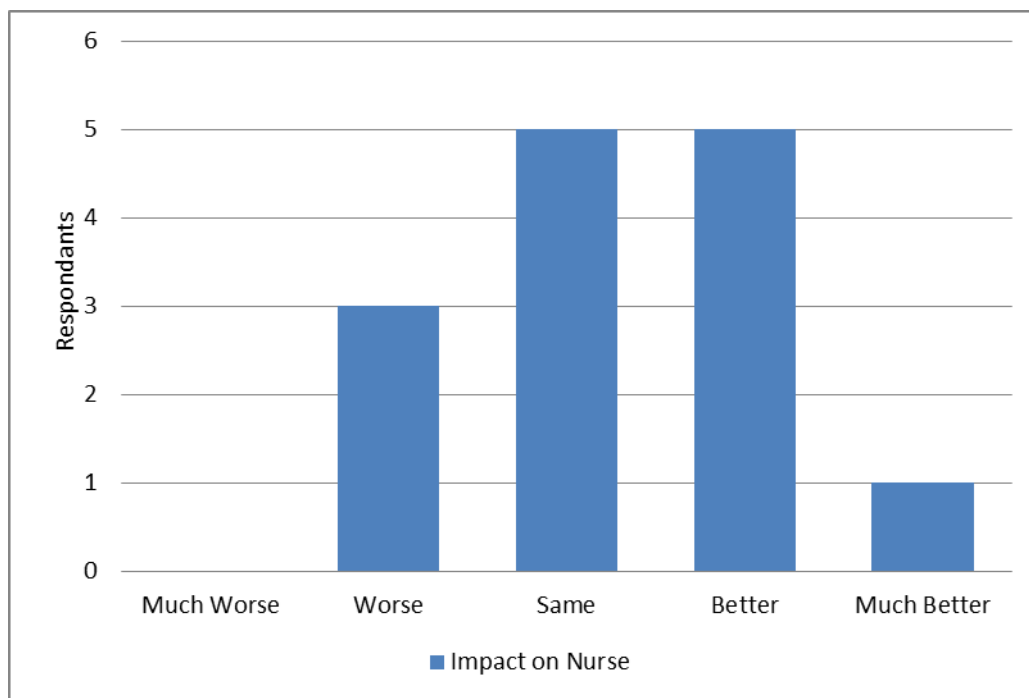


Figure 12: Impact on the professional role

4.4.6. Personal Role

When asked to assess the impact of caring for a significant other on their personal role 50% (n=7) of respondents listed *Better* and 7% (n=1) listed *Much Better*. Fourteen percent (n=2) of respondents reported a negative impact on their personal role by choosing the *Worse* option. Overall the response indicated the majority of respondents had a positive or unchanged impact on their private role.

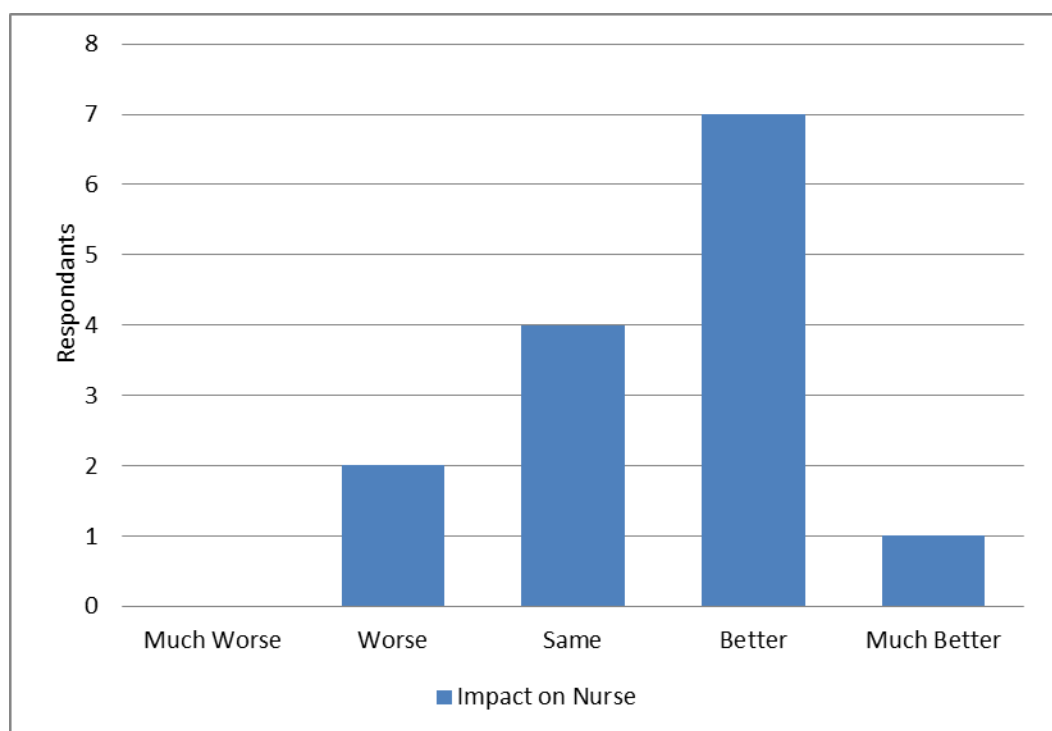


Figure 13: Impact on the personal role

4.4.7. Professional Stress

When asked to assess the impact of caring for a significant other on their professional role 43% (n=10) of respondents listed *About the Same*. Twenty-one percent (n=3) of respondents listed the impact as *Better* and 36% (n=5) chose *Worse*. The choices of *Much Worse* or *Much Better* were not represented in this question.

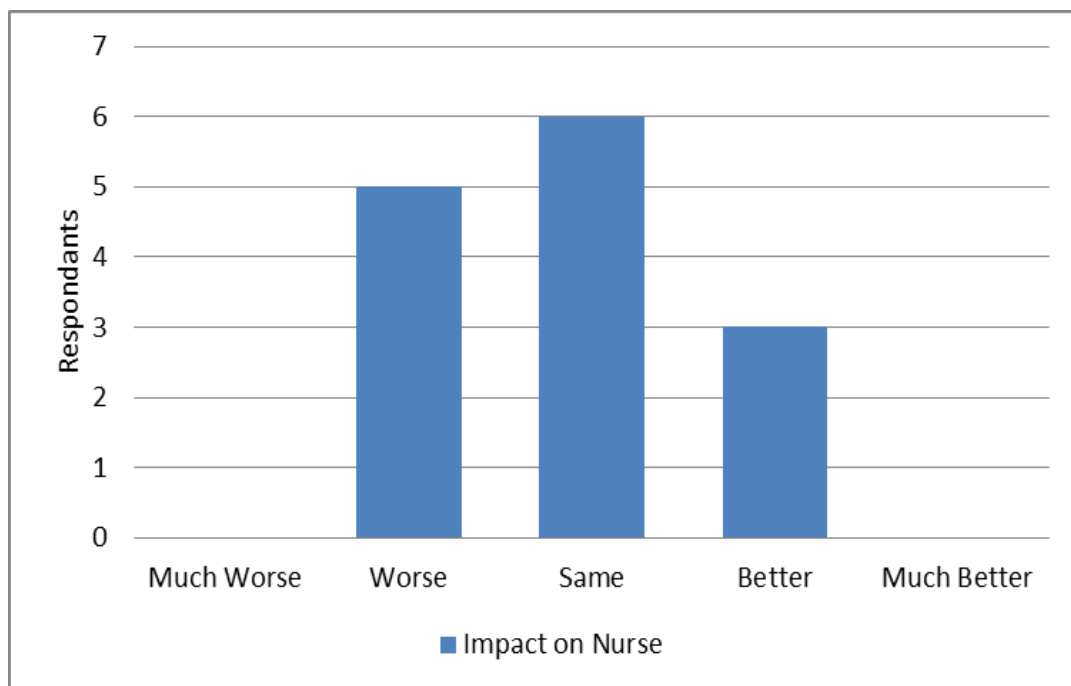


Figure 14: Impact on the professional stress

4.4.8. Personal Stress

When asked to assess the impact of caring for a significant other on personal stress levels 36% (n=5) of respondents reported their private stress levels as *Worse*. Twenty-nine percent (n=1) of respondents each chose *Better* and *Much Better* from the ranking options and 14% (n=4) of respondents each listed *About the Same* and *Better*, whilst seven percent (n=1) listed their private stress as *Much Better*.

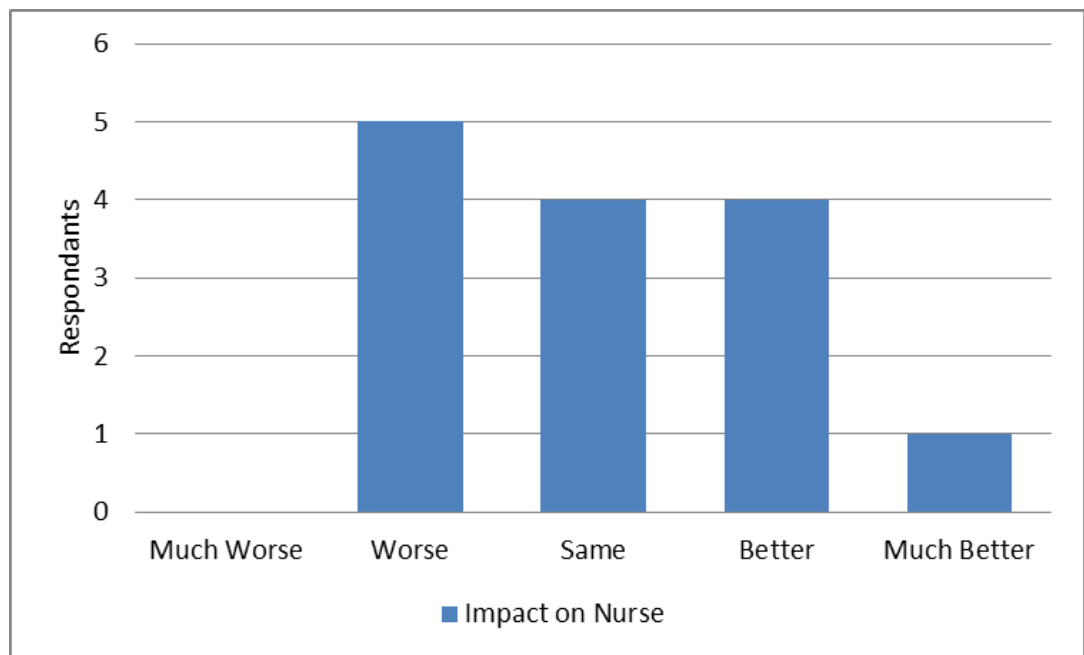


Figure 15: Impact on personal stress

4.5 Qualitative responses

The following section presents the respondents' accounts of their experiences caring for a significant other in their role of employment. Each account includes concurrent analysis, which is then followed by a list of the concepts illuminated during analysis to be associated with the impact of this phenomenon.

4.5.1. Respondents' Accounts

At the end of the survey, the respondents were invited to record an example of their experience of nursing a significant other in their role of employment. Nine out of twenty-eight respondents provided accounts. One of the responses did not include information related to the topic and so this account was excluded. Two respondents who provided their accounts were not the primary carers; nonetheless, they were working at the hospital and supported the patient on the day. Their accounts did include data relevant to the research question and so these have been included for consideration here. Respondents have been assigned an alphabetical code to maintain anonymity.

The respondents' verbatim accounts follow (***presented in bold italics***), interspersed with concurrent analysis (in normal font). Emerging concepts are identified throughout the accounts (underlined) and then listed below each account.

4.5.1.1 Respondent A's account.

I was assisting during the delivery of my friend's first baby. She insisted I assist because she was nervous and trusted my judgement. Respondent A suggests that her friend's anxiety gave her little choice but to care for her friend. This suggests she felt an obligation to remain with, and care for her friend, and yet: ***I felt guilty being so involved with the patient emotionally as my colleagues went about their usual business.*** She expressed guilt related to the possible work load added to her colleagues and the increased involvement she had with her patient. ***I was also preoccupied with the emotional moments and had to keep reminding myself to concentrate on the tasks at hand.*** Respondent A indicated a personal distraction affected her level of concentration. ***I was glad to be present and my friend was relaxed and loved sharing the experience with***

me later, but next time I would assist her off shift, not on! Respondent A acknowledged her personal pleasure in being involved in the care and that she believed the personal relationship helped the patient relax, however there was increased stress relating to the dual roles. *My colleagues did ask me why I was caring for someone I knew, which did make me evaluate whether or not it was the right thing to do, and how it would have affected the situation and the friendship had there been any complications with the birth.* A's reflection on her professional obligations in this situation suggests some concern, and about the potential impact of her involvement on both decision making and her friendship should there have been any complications.

Concepts identified:

Obligation, Guilt, Distraction, Pleasure (personal), Personal Relationship, Concern, Decision-making, stress (increased)

4.5.1.2 Respondent B's account

My personal stress level was lower because I was able to spend time with her [the client] and keep an eye on how she was going while I was at work. Respondent B expresses decreased personal stress levels related to involvement with her daughter's care. *My stress level at work however, increased due to being worried about her while I had to attend to my other patients.* She did acknowledge increased professional stress due to obligation[s] to attend to her other patients and leave her daughter alone. *With regards to confidentiality this was a bit difficult to answer because I had the authority as a parent to discuss my child outside of work.* Respondent B contemplated confidentiality issues but decided there were none in this instance as the patient was her child. *Also, because she [the patient] was a young child it was difficult to maintain boundaries like not give her cuddles or give her a kiss if she asked or needed because she was too young to understand that it is outside therapeutic boundaries.* She did recognise she had difficulty maintaining appropriate physical boundaries. These aspects of respondent B's account suggest she was experiencing role confusion.

Concepts identified:

Stress (Personal decreased), Stress (Professional increased), Obligation, Confidentiality, Boundaries (Physical), Therapeutic boundaries, Role Confusion

4.5.1.3 Respondent C's account.

I talked more openly to other people about my dad's progress because he was my dad and I knew he would be ok with me talking about him. Respondent C reported sharing information about her father without realising she was admitting to a breach of confidentiality. ***I think I overstepped my therapeutic boundaries because I gave my opinion on what I thought was best for him because I knew him. I wouldn't be so forthcoming in giving other patients my opinion on what I thought they should do, I would give them the info and let them decide without providing my personal opinion.*** She was aware that she was providing her personal opinion about what was best for her father and even made decisions on his behalf. This suggests that she was aware of her role confusion caused by caring for her father. ***I think the care was better because I knew my dad and if there was a problem I could get to the issue quicker as you have the trust there.*** Respondent C believed the established trust between herself and her father improved her decision-making.

Concepts identified:

Concern, Confidentiality, Therapeutic Boundaries, Role Confusion, Trust, Decision-making (improved)

4.5.1.4 Respondent D's account.

Since my significant other is my grandmother the care is more intense. My parents relied on me all the time as no one in the family is in the medical field. Respondent D reported feeling an obligation to care for her grandmother due to the expectations of her family members. ***It was hard sometimes especially when I need to work as well after looking after her.*** Respondent D's words suggest she felt a level of physical stress. ***I did personal hygiene care, making sure her pressure area care is intact,***

oral care, feeding her via nasogastric tube, but I couldn't do all this without the help of my family. I needed to look after myself as well, especially my back. I have to teach them the proper manual handling. There is evidence here of emotional and physical stress on Respondent D which suggest exhaustion of her reserves. *It was hard to see your loved one suffering but we thought before she passed away we have given her the best care we could offer. She was at peace and comfortable pain free with the help of syringe driver.* As well as the increased stress respondent D verbalised previously, she expressed pleasure at having been able to offer her grandmother a peaceful death.

Concepts identified:

Obligation, Stress (increased), Pleasure, Exhaustion

4.5.1.5 Respondent E's account.

My grandmother kept pressing her call bell and giving me a pout when I entered her room. She kept asking why I hadn't checked on her, and that she was lonely. I had to tell her over and over that I had five other patients who needed showers and medication, and to be rolled, gotten out of bed. She didn't get it. Respondent E appeared stressed at her grandmother's demands and distracted from her responsibilities to her other patients. *She thought I should have been with her for my whole shift. I wanted to show her what a great nurse I was, but she was very demanding.* Respondent E's need to impress her grandmother increased her personal and professional stress. She also felt an obligation to provide the best care her grandmother but found her demands exhausting. *I felt bad for my other patients and was getting quite short by the end of the shift.* E's words suggest she was finding this situation untenable by the end of the shift. It seems her grandmother's demands on her time, caused her both guilt and concern that her other patients were being neglected. These feeling increased her frustration with her grandmother further increasing to her stress. Respondent E tells us: *I was worried my colleagues would think I was neglecting my other patients. I found myself discussing my grandmother with my colleagues and this probably wasn't fair, as I was giving my personal opinion, not just about her care.* Respondent E realised she breached confidentiality by discussing her opinion and personal information with her colleagues. *I*

was emotionally exhausted by the end of the shift. Caring for her grandmother left her emotionally depleted. *This made me feel guilty, and when my mum rang to ask me how she was going that night I felt guilty talking about her care.* E's own words demonstrate that the tension between professional, personal and family boundaries was a source of stress and guilt. *I was really torn when she [nurse's mother] said the whole family were relieved I was looking after her.* Respondent E felt an obligation to care for her grandmother from her family, added to her stress. *I didn't want to look after her again but felt pressured by the family. She was in for 11 days and I did care for her on 4 shifts, even though I didn't want to.* Respondent E's perceived continued obligation to look after her grandmother increased her personal stress. *I felt a bit cold towards Gran for a few months after that.* The experience of looking after her grandmother in the role of employment temporarily altered the personal relationship. *Looking back now I suppose it is something I could have handled better. Not stressed, just treated her like every other patient and shared my time between them all. I should have said, "I won't be back for at least an hour Gran". Experience and reflection are grand.* Respondent E's reflection on how she could have handled the situation better, suggests an element of role confusion.

Concepts identified:

Guilt, Distraction, Exhaustion, Neglect, Stress (increased), Confidentiality, Concern, Personal Stress, Obligation, Personal Relationship (negative effect)

4.5.1.6 Respondent F's account.

Respondent F thought herself fortunate to have cared for her sister-in-law during her shift and expressed her pleasure when she wrote, *My sister-in-law had said throughout the pregnancy that she hoped I would be there to care for her... and I was! The opportunity to care for my sister-in-law during her labour was purely a matter of chance that I was rostered on, but it was also a privilege. I cared for her as I do for all my women in labour, with the same level of attention, respect and privacy - when my mother rang I didn't release any information.* Respondent F displayed self-awareness about maintaining confidentiality, as well as professional and therapeutic relationships when she emphasised treating her patient as she would normally. *In many ways caring*

for someone you know well in labour makes my job easier. This relationship decreased her professional stress. *I know how she [sister-in-law] usually responded to the world around her, so when she experienced pain I had an understanding as to what was her "norm", not something that I know with women I have never met before.* Respondent F found having a personal knowledge of this patient allowed her to provide appropriate care and assess the patients' needs easier. This reduced her stress during the care episode and quite probably enhanced the quality of care provided to her client. *I also believe that she laboured better feeling secure in my presence, she felt safe with having a familiar face as a care giver.* She believed her sister in-law coped better due to the established trust from their personal relationship. *I think my levels of personal stress were a little higher than usual, as I think I put a lot of pressure on myself to perform normally... making sure I wasn't seen to be treating a family member any differently to other women.* F's professional awareness and desire to maintain normal practices did increase the level of stress she felt compared to caring for a normal patient. In contrast to the earlier statement about finding the care episode 'easier', F suggests here that, contrarily, she is now experiencing increased concern about potential judgement by her colleagues. This suggests an element of role confusion leading to increase in professional stress level. *Also there was a sense of pressure from my family to make sure everything would go as they expected... lucky for me it did.* Respondent F expressed a level of obligation to her family to care for her sister in-law and a level of relief indicating that she had increased stress about possible outcomes during the care episode. *Working in a rural setting doesn't always allow you the option of asking another staff member to take over of you. It's not like we have excess staff rostered on, or extra staff we can call in.* She reveals that it is not always possible to choose not to care for a particular patient due to the staff restriction in a rural facility. *We are used to caring for our families, our neighbours, our kids school teachers, it is part and parcel of working in a rural hospital.* Respondent F indicates that this is accepted practice in rural areas and was looking forward to the next care episode, *Can't wait for them to have their next baby... hope I get to care for them again!*

Concepts identified:

Pleasure, Stress (increased and decreased), Trust, Confidentiality, Concern, Role confusion, Personal relationship, Obligation

4.5.1.7 Respondent G's account.

My spouse was admitted to our combined ICU/ CCU for his first episode of chest pain. He had no prior history, but my husband was overweight and had smoked heavily up until 5 years previously. He had an uncle with a history of a 'heart attack' in his forties. My husband had significant 'classic' pain, some ST elevation, but no rise in his enzymes. He was in the unit overnight only - transferred to the hospital in town with a cardio-thoracic unit for angiograms and later stents. I was the RN 'in charge' of the ICU side of the unit so not directly caring for my spouse. Respondent G was coordinating the unit her husband was admitted to and although not his primary carer was in-charge of the staff member who was. *While I was concerned about my husband's level of pain, I confess my experience of his low thresh-hold to pain might have affected my assessment and clinical decision-making related to his pain so it is just as well I was not directly involved in his care.* 'G's' reflection on her personal knowledge caused concern that it may have affected her clinical decision-making.

Concepts identified:

Concern, Decision-making

4.6 Discussion of qualitative findings

The following section discusses the concepts that were identified in analysis of the respondents' accounts and offers a tentative explanation of the process(es) inherent in their stories and impacting their experiences nursing a significant other. These concepts are summarised in the table 2. This table demonstrates the intensity of the impact of these experiences on the respondents and provides the reader with a link or trail from respondents' accounts to the discussion and interpretation to follow. The concepts in table one have been organised to loosely reflect the temporal flow of the events recounted by the respondents.

Table 2: The impacts of caring for a significant other in the role of employment

| Concept | Respondents | | | | | | |
|--|-------------|---|---|---|---|---|---|
| | A | B | C | D | E | F | G |
| Obligation/ Guilt | X | X | | X | X | X | |
| | X | | | | X | X | |
| Boundaries: Physical | | X | | | | | |
| Therapeutic | | X | X | | | | |
| Role confusion/ Personal relationship | | | X | | | X | |
| | X | X | | | X | X | |
| Trust/ Confidentiality | | | X | | | X | |
| | | X | X | | X | X | |
| Decision-making/ Distraction | X | | X | | | | X |
| | X | | | | X | | |
| Pleasure | X | | | X | | X | |
| Exhaustion | | | | X | X | | |
| Stress: | | | | | | | |
| Concern | X | | X | | X | X | X |
| Stress (increased) | X | X | | X | X | X | |
| Stress (personal ↑) | | X | | | X | X | |
| Stress (personal ↓) | | X | | | | X | |
| Stress (professional ↑) | X | | | | | | |
| Stress (professional ↓) | | | | | | X | |

4.6.1.Obligation and Guilt

Obligation involves a feeling of duty, commitment or responsibility to a person or group (Oxford dictionary, 2015). Throughout these accounts, a number of the respondents revealed this sense of obligation to care for their significant other. A, for example, seems to have had no choice (from her own perspective at least): ***She insisted I assist because she was nervous and trusted my judgement.*** E, though, felt the obligation imposed by family expectations: ***My parents relied on me all the time as no one in the family is in the medical field'***, while imposing some of her own: ***I wanted to show her what a great nurse I was, but she was very demanding.*** At the same time, these accounts demonstrated the impact obligation may have on a nurse when she cares for a significant other in the role of employment.

A level of guilt often accompanied senses of obligation. Guilt may be defined as having committed a wrong or failed in an obligation (Oxford Dictionary, 2015). For the respondents, this sense of guilt grew from their perceived obligations to the patient, the patient's family, their colleagues and other patients the nurse is caring for.

Respondents A, B, D, E and F all reported feeling obliged to provide care for their significant other when that person was admitted to their place of employment. Some respondents felt an internal obligation where they themselves chose to care for their significant other. Others seemed to perceive themselves as bullied into caring for a significant other. E confessed, ***I didn't want to look after her again but felt pressure from my family.*** This external feeling of obligation lead to distraction from her professional role. ***I felt bad for my other patients and was getting quite short by the end of my shift.*** E's distractions also increased her concern for her how her peers viewed her. ***I was worried my colleagues would think I was neglecting my other patients.*** Respondent B also felt stress relating to her obligation to care for her allocated patients and not wanting to leave her daughter to do so quote; ***My stress levels at work increased due to being worried about her while I had to attend to my other patients.*** From a duty of care point of view this is a serious concern and raising questions as to about the appropriateness of this staffing arrangement.

The sense of obligation (whether internally or externally imposed) appeared to reduce the decision-making capacity of the nurse/midwife. Instead of considering professional boundaries guidelines (NMBA, 2010) they allowed themselves to be coerced into caring for their significant other when they might have otherwise chosen not to. Respondent E goes as far as to say. ***She was in for 11 days and I did care for her on 4 shifts. Even though I didn't want to.*** This kind of external obligation/coercion may have had impact on all types of decision making, from caring for their significant other against their desire, errors in clinical care or lack of concentration due to increased stress. Respondent A experienced similar pressure from her best friend ***She insisted I assist because she was nervous and trusted my judgement.*** These examples present evidence of nurses and midwives making uncharacteristic decisions due to obligation rather than using their professional judgement.

Respondents reported feelings of guilt relating to an increased level of emotional involvement with her patient and distracted from their nursing care. A was concerned about what her colleagues may think. ***I felt guilty being so involved with the patient emotionally as my colleagues went about their business.*** Respondent E also mentions a level of guilt in relation to several different issues during her grandmother's admission. She felt guilty for spending too much time attending to her grandmother, for feeling annoyed by her grandmother's behaviour and for breaching her confidentiality. ***I was worried my colleagues would think I was neglecting my other patients. I found myself discussing my grandmother with my colleagues and this probably wasn't fair, as I was giving my personal opinion, not just about her care.*** E also confessed to feeling guilty for discussing her grandmother's care with her mother after her shift, an occurrence that would not have occurred if the three had not been related.

Initially, decisions lead by obligation had ramifications of guilt experienced specifically to caring for a significant other. Obligation and guilt relating to caring for a significant other were evident from their self-reflection. One common account was fear of judgement from colleagues and other patients. This suggests a self-awareness of the differences between caring for a significant other and caring for a stranger, and that there is a noteworthy impact on the nurses and midwives, and the care they provide.

4.6.2. Boundaries

“Professional boundaries in nursing are defined as limits which protect the space between the professional’s power and the client’s vulnerability” (NMBA, 2006, P.1). The ability to develop, set and maintain professional boundaries may be effected by an established personal relationship. Respondents expressed a difficulty maintaining physical and therapeutic boundaries due to their personal relationships. Nurses and midwives are informed of their responsibility to “... establish and maintain boundaries in their professional relationships with persons receiving care; and where necessary communicate these to that person” (NMBA, 2006. P. 3)

Respondents gave examples of how this was difficult for physical and therapeutic boundaries. B explains***because she was a young child it was difficult to maintain boundaries like not giving her a cuddle or giving her a kiss when she asked or needed because she was too young to understand it was outside therapeutic boundaries..*** This was the only example of physical boundary concerns. Although affection is socially acceptable behaviour between mother and daughter, this nurse was aware that it was inappropriate between a paediatric patient and nurse to interact in this way and felt uncomfortable. Due to the age of the child it was unrealistic to expect a sick child to refrain from physical comfort from her parent. When combining the personal and the professional roles it is difficult for observers to understand all the aspects of the situation leaving the nurse concerned about perceived boundary violations.

The basic rights for all patients include being informed of all care options and making individual choices relating to treatment (Australian Commission on Safety and Quality in Healthcare, 2009). Respondent C expressed overstepping therapeutic boundaries when she said ***I gave my opinion on what I thought was best for him because I knew him.*** Boundary Violations occur when nurses and midwives confuse their needs with those of their patient (NMBA, 2006.) C acknowledged that she would not behave in this way with other patients when she said ***I wouldn’t be so forthcoming in giving my personal opinion on what I thought they should do, I would give them the info and let them decide without providing my personal opinion.*** It is possible that the nurse in this situation confused what she wanted for her Dad with her assumptions about what choice he would have made for himself. Coercing, encouraging or withholding care options to

meet the desires of the nurse, who in this case is also the daughter of the patient breaches the patient's right to be involved in care decision making. This patient was potentially denied this opportunity and his autonomy, instead received care that the daughter wanted for her father, because she was in a position of power as his nurse.

4.6.3. Role Confusion and personal relationships

The Nursing and Midwifery Board of Australia explains the existence of dual relationships as a situation in which the nurse/midwife and the patient have a pre-existing relationship prior to the care episode. They also explain that role confusion means the health professional role and the personal roles are at risk of poor delineation (2008).

Respondents' accounts demonstrated caring for a significant other in the role of employment has an effect on their normal professional capacity and as a consequence may impacted their personal relationship. Respondent A acknowledged ***I was preoccupied with the emotional moments and had to keep reminding myself to concentrate on the tasks at hand.*** Her account shows an awareness of her difficulty managing the competing roles. The excitement of a new baby shifted focus away from the health care of the patient. A's professional reflection suggests she realised the risks associated with this scenario. ***I was glad to be present and my friend was relaxed and loved sharing the experience with me later, but next time I would assist her off shift, not on!*** Respondent B's account provided evidence of role confusion when caring for her daughter during a shift. By her own admission she struggled with concentrating on her nursing role under the circumstances. ***My stress level at work however, increased due to being worried about her while I had to attend to my other patients.*** B's words suggest the personal relationship may have impacted the care received by her other patients as she was preoccupied with caring for her own daughter.

Respondent E recalls feeling pressured by her family and her grandmother who was her patient. She states ***I didn't want to look after her again but felt pressured by the family. She was in for 11 days and I did care for her on 4 shifts, even though I didn't want to.*** E was found it difficult to maintaining her nursing role during her shifts. She was taking direction from her family members, as a daughter and granddaughter rather than making professional decisions as a nurse. Clinical decision-making and concentration on the care she was providing were potentially compromised due to role confusion. Being coerced

into caring for her grandmother against her better judgement not only impacted her professional role it affected F's personal relationship. ***I felt a bit cold towards Gran for a few months after that.*** This had a negative effect on the nurse and her personal relationship as a result of role confusion associated with caring for a significant other in the role of employment.

The respondents to this survey did not report if the patients experience any unexpected adverse outcomes. Respondent A's reflection addressed the potential effects on the personal relationship when caring for a significant other. ***My colleagues did ask me why I was caring for someone I knew, which did make me evaluate whether or not it was the right thing to do, and how it would have affected the situation and the friendship had there been any complications with the birth.*** If there were undesirable effects on the patient's health during the episode of care this could have had long lasting negative effects on the personal relationship between the nurse, patient and the extended family. It is important to remember that the personal relationship continues after the patient is discharged and therefore should be a major consideration when a significant other requires care.

4.6.4.Trust and Confidentiality

Trust is the firm belief in the reliability, truth or ability of someone or something (Oxford Dictionary, 2015). Maintenance of trust is important for the rapport needed to gain important personal information from a patient to assess their health care needs. Confidentiality relates to the nondisclosure of certain information except to another authorised person (NMBA, 2010). In the health care setting this would translate to sharing information obtained in the role of nurse/midwife with other health care professionals who require the information to provide the best care for the patient. and midwives are required to treat personal information gained in a professional capacity as confidential and never use it to advantage themselves (NMBA, 2008).

The pre-established trust between nurse and significant other was reported to improve patient assessment and decision-making. Respondent C supported this when she reported, ***I think the care was better because I knew my dad and if there was a problem I could get to the issue quicker as you have the trust there.*** Respondent F supported this

when she said, ***In many ways caring for someone you know well in labour makes my job easier. I know how she usually responded to the world around her, so when she experienced pain I had an understanding as to what was her "norm", not something that I know with women I have never met before.*** Decision-making requires the evaluation of information. Knowing the patient personally may increase speed and accuracy of the decision making process. There is a risk nonetheless of the nurse making assumptions about the patient that may not be accurate.

Nurses found the personal knowledge of their significant other challenged their ability to maintain confidentiality. Respondent B was caring for her daughter at work and explained... ***With regards to confidentiality this was a bit difficult to answer because I had the authority as a parent to discuss my child outside of work.*** If this nurse was not caring for her daughter on her shift she may not have had access to the level of information a parent would have nor would she have had the level of personal information as an unknown nurse. It raised the question of whether or not a nurse in Respondent B's situation has the awareness of where the boundary lies with confidential information and or the ability to apply it when the roles are intertwined. Respondent C showed a limited understanding about confidentiality by saying ***I talked more openly to other people about my dad's progress because he was my dad and I knew he would be ok with me talking about him.*** This is a dangerous assumption as the patient may have been unhappy or unaware that he was having his personal details discussed in the professional setting. Familiarity has the potential to blur the boundary for what is confidential due to the personal involvement with their patients.

In contrast Respondent E was aware she had breached her grandmother's confidentiality when she said ***I found myself discussing my grandmother with my colleagues and this probably wasn't fair, as I was giving my personal opinion, not just about her care.*** She highlights the difficulty in keeping private and professional information separate when debriefing with colleagues and that when caring for a stranger this level of personal information would not be under scrutiny. Respondent F showed an awareness of patient confidentiality and demonstrated a commitment to adhering to it. ***I cared for her as I do for all my women in labour, with the same level of attention, respect and privacy - when my mother rang I didn't release any information.*** Her ability

to treat her significant other within the same framework as a patient she did not know personally shows a high level of accountability.

4.6.5. Decision-making and Distraction

“Decision-making is complex and dependent on a range of inter-related factors” (NMBWA, 2007. P.4) Nurses and midwives are responsible for making many decisions during the course of their shift. These include individual assessment and evaluation of treatment options, policies that guide practice and scope of practice of the individual professional. There is a risk that familiarity, and the related hesitation, may prevent the nurse/midwife from taking the time to correctly question and analyse these patient’s needs. This could culminate in the form of distraction, defined as something that prevents someone from concentrating on what’s at hand (Oxford dictionary, 2015). This was evident in the reflections shared by respondent G ***While I was concerned about my husband's level of pain, I confess my experience of his low thresh-hold to pain might have affected my assessment and clinical decision-making related to his pain so it is just as well I was not directly involved in his care.*** Distraction associated with personal information may decrease the nurse’s ability to correctly and safely judge the patient’s situation and may in fact lead to detrimental outcomes or reduced quality of care.

Respondents E and A both reported caring for their significant other was a distraction. E expressed frustration with her grandmother who ***...kept pressing her call bell and giving me a pout when I entered her room. She kept asking why I hadn’t checked on her, and that she was lonely.... she didn’t get it. She thought I should have been with her for my whole shift.*** The patient was unable to see her granddaughter in the role of nurse and her behaviour and expectations were distracting the respondent from her professional role. This frustration was not within the control of the nurse and became a distraction for the whole of the shift.

Respondent A reported an awareness of her distraction. ***I was preoccupied with the emotional moments and had to keep reminding myself to concentrate on the tasks at hand.*** Her distraction came in the form of emotional involvement with the joyous arrival of a friend’s new baby. This created a situation where she was conscious of her distraction from her professional capacity and had to regularly remind herself to perform the roles of the nurse. In a situation where there was an impending crisis, or deterioration of either

mother or baby identification of this and corrective actions may have been delayed. Carrying out the two different roles, friend and nurse, was difficult and that retrospectively both roles were needed.

Not all respondents perceived a negative effect on decision making when caring for a significant other. Respondent C believed caring for her dad made her a more effective nurse. ***I think the care was better because I knew my dad and if there was a problem I could get to the issues quicker.*** She reported the established knowledge of patient added to timely and appropriate care decisions.

4.6.6. Pleasure and Exhaustion

Respondents reported emotional consequences as a result of caring for a significant other in the role of employment. Concepts identified in the respondent's accounts were pleasure and a level of exhaustion directly due to the personal relationship. Exhaustion is described as feeling tired or weak, whilst pleasure is described as a sense of happiness, delight or satisfaction (Oxford Dictionary, 2015). Respondent E explained caring for her grandmother was a negative experience. ***I was emotionally exhausted by the end of the shift.*** On the contrary Respondent A reported being pleased to be involved during the delivery of her best friend's baby. ***I was glad to be present and my friend was relaxed and loved sharing the experience with me later.*** The positive emotional experience was evident during the episode of care and will be a long-term recollection for both the respondent and the patient.

Respondent F expressed similar circumstances assisting her sister in-law with the delivery of her first baby. ***My sister-in-law had said throughout the pregnancy that she hoped I would be there to care for her and I was! The opportunity to care for my sister-in-law during her labour was purely a matter of chance that I was rostered on, but it was also a privilege.*** Both A and F were present for the arrival of a new baby, something that society sees as a celebration. F confesses being in attendance did cause her some fatigue. ***I think my levels of personal stress were a little higher than usual, as I think I put a lot of pressure on myself to perform normally.*** The emotional effects of caring for a significant other may offer pleasure however can manifest itself in a degree of exhaustion.

Pleasure can encompass feelings other than joy. Respondent D was able to feel gratification even though her care episode included a much sadder event, caring for her grandmother prior to her passing away. ***It was hard to see your loved one suffering but we thought before she passed away we have given her the best care we could offer. She was at peace and comfortable.*** Caring for her grandmother allowed her an opportunity she could only have by being the nurse providing palliative care at the end of her life with love and affection. Although not a celebration like birth, D was able to find pleasure in the delivery of quality care and will have these fond memories to ease her pain.

By contrast respondents, in these stories have demonstrated that their experiences have also culminated in exhaustion. Even though Respondent D expressed a level of satisfaction while nursing her grandmother she admitted feeling a high level of responsibility. ***My parents relied on me all the time as no one in the family is in the medical field. It was hard sometimes.*** Combining the emotional involvement and the responsibility she felt towards her grandmother D expressed her fatigue when she said, ***Since my significant other is my grandmother the care is more intense.***

Respondent E was also caring for her grandmother but was not rewarded with any level of pleasure. She reported, ***she kept asking why I hadn't checked on her, and that she was lonely. I had to tell her over and over that I had five other patients who needed showers and medication, and to be rolled, gotten out of bed. She didn't get it. She thought I should have been with her for my whole shift. I wanted to show her what a great nurse I was, but she was very demanding.*** The personal expectation of E's grandmother built up during the course of the shift resulting in E declaring ***I was emotionally exhausted by the end of the shift.*** These testimonials show the emotional involvement of caring for a significant other can be a pleasure or a drain on the nurse.

4.6.7.Stress

Stress was the most reported effect on respondents caring for a significant other in the role of employments. The Oxford Dictionary describes stress as 'A state of mental or emotional strain or tension resulting from adverse or demanding circumstances' (2015). The respondents' in this study experienced impact on their stress levels as a result of the personal relationship between themselves (the nurse/midwife) and their patient who was also their significant other. Respondents expressed both positive and negative effects on

their stress levels during the episodes of care. Nurses who reported a mostly positive experience still identified negative stressors during the care episode. Many of these impacts can be related back to the different concepts mentioned in Table 1.

Reductions in stress levels were reported for both personal and professional circumstances. Respondent F reported decreased professional stress associated with decision-making. ***In many ways caring for someone you know well in labour makes my job easier.*** While Respondent B reported caring for her young child in her role of employment reduced her stress as a mother by not having to leave her sick child to attend her job. In this instance she carried out her employment and cared for her child simultaneously. ***My personal stress level was lower because I was able to spend time with her and keep an eye on how she was going while I was at work.*** Many family members of sick individuals are required to continue to earn a living and this is often in conflict with their desire to spend time with their sick loved one. Her obligation to her daughter as a mother increased her professional stress during her shift as expressed by her comment. ***My stress level at work increased due to being worried about her while I had to attend to my other patients.*** This confession of obligation as a mother, in this case caring for a paediatric patient (her daughter) and to guilt towards her other patients, has made the significant other relationship an additional stressor for this nurse.

Professional stress was mentioned by several of the respondents in relation to what their colleagues would think about them caring for a significant other in the role of employment. Respondent A said ***I felt guilty being so involved with my patient emotionally while my colleagues went about their usual business.*** A demonstrated increase in stress due to guilt at spending time and energy on the most important person in their patient load, their loved one, and secondly the pressure related to peers judging their actions. Two of the respondents mention both of these issues simultaneously in their feedback. Respondent E expressed increased stress levels ***I felt bad for my other patients and was getting quite short by the end of my shift. I was worried my colleagues would think i was neglecting my other patients.*** Respondent H's account corresponded when she confessed ***I think my levels of personal stress were a little higher than usual, as I think I put a lot of pressure on myself to perform normally... making sure I wasn't seen to be treating a family member any differently to other women.*** Scrutinizing actions and behaviours to remain within what the nurse/midwife considered 'normal behaviour' was a

distraction in itself. Concern about how their colleagues would perceive them when caring for a significant other suggests that they believed the care they were providing was different or could be different to that offered to an unknown patient.

Respondent's stress caused by the belief they were being judged by their peers were justified when Respondent A was approached by colleagues who questioned the appropriateness of caring for a significant other in the role of employment. ***My colleagues did ask me why I was caring for someone I knew, which did make me evaluate whether or not it was the right thing to do?*** This prompted her to consider, ***how it would have affected the situation and the friendship had there been any complications with the birth.*** This level of concern for the personal relationship increased her stress levels during this shift. Respondent F acknowledged feeling guilty for discussing her grandmother from a personal viewpoint. Her admission ***I found myself discussing my grandmother with my colleagues and this probably wasn't fair, as I was giving my personal opinion, not just about her care. This made me feel guilty, and when my mum rang to ask me how she was going that night I felt guilty talking about her care,*** illustrates the stress caused by juggling the personal and professional roles, especially when it comes to communication and confidentiality. All of these accounts highlight the intense judgement nurses and midwives feel from their peers and how the pressure to performing 'normally' actually amplified the stress experienced by the respondents.

Overall the respondents indicated that the impact of nursing a significant other in the role of employment was stressful. Whether the nurse and midwives experienced a positive or negative emotional effect, all reported varying degrees of pressure. This was from themselves, their peers or their patient and family. It involved basic reflection, concern for what could have gone wrong, guilt, exhaustion, distraction and role confusion. The most concerning impacts were those that the respondents failed to comprehend, even with reflection. This inability to identify risks has highlighted an area of concern relating to nurses and midwives caring for a significant other in their role of employment.

4.7 Conclusion

The chapter has presented the results of the survey distributed to investigate the experiences of nurses and midwives caring for their significant other in the role of employment. The results have been delivered in two sections, quantitative and qualitative results. The quantitative section provided results relating to demographic information describing the respondents and from the Likert scales in relation to the respondents perceptions of the impact of their experiences against concepts highlighted from the literature review. This data was accompanied by graphs to facilitate interpretation for the reader. The narratives provided by the respondents have been analysed as significant; concepts were highlighted and tentative explanations of the relationships between identified concepts. The final chapter in this thesis will consider and discuss the qualitative and quantitative data outlined here, their relationship to and impact upon the phenomenon of interest.

CHAPTER 5: DISCUSSION AND CONCLUSIONS

4.8 Introduction

This chapter will draw together the data and analysis from Chapter Four to demonstrate how the major concepts link together and their significance to the caring experiences of the respondents who contributed to this study. The chapter begins with discussion of the demographic data and its implications. This is followed by a discussion of how the major concepts link together and are related to the experience of caring for a significant other in the nurse's and midwives' role of employment. This will be concurrently contextualised through correlation with the quantitative findings and comparison with the contemporary literature. Presentation and discussion of the findings arising from this study will be followed by discussions of the recommendations for practice, education and research originating from this study. Finally, an overview and conclusion to the study will be presented.

4.9 Demographic data

This section of the chapter will discuss the findings in relation to the general demographics of the respondents who shared their experiences of nursing a significant other in the role of employment.

Nurses' and midwives' registration in Australia comprises 82% registered nurses and midwives and 18% enrolled nurses (HWA, 2011). This proportion was loosely reflected in the surveyed cohort: 87% of the cohort was registered nurses and midwives, 13% were enrolled nurses. This is an indication the cohort represents a reasonable representation of nurses at these hospitals and Australia wide.

Another consideration for the minor representation of enrolled nurses is the fact enrolled nurses are required to work under the direction of a registered nurse as a part of a health care team (NENA, 2015). This may be the reason that only 13% of the respondents were enrolled nurses. Making the decision to care for a significant other in the course of employment is unlikely to have fallen within the enrolled nurse's scope of practice due to the professional requirements of the team dynamic.

More than three quarters of the respondents in this study had completed a university degree or postgraduate studies while 86% of respondents had over 10 years nursing experience. Formal education and longer careers with exposure to patient care infers many years of knowledge and experience to draw upon when making professional decisions. This may have contributed to their willingness to participate in the survey. In contrast, respondents who had less than ten years' experience may not have had the opportunity to care for a significant other in the role of employment and are less represented in this study. It could also be a reflection on cultural changes between current and previous generations of nursing practice (Weston, 2006). Guidelines and policies relating to best practice and legal liabilities have seen an increase in consistent practices world wide. The Nursing and Midwifery Board developed boundary guidelines in 2010 which may have impacted the decision making process related to nurses and midwives caring for a significant other in the role of employment (NMBA 2010). This remains to be seen as the survey did not ask 'when' the care episode occurred. This is a potential limitation the researcher did not anticipate when developing the survey tool. It is an aspect of this phenomenon bearing consideration in the future.

More than half of the respondents in this study reported caring for a direct blood relative or spouse in the described episode of care. Another quarter involved caring for extended family members including in-laws. The remaining respondents reported caring for a close friend. Of the respondents who cared for a significant other, more than half of the admitted it was voluntarily. This suggests that nurses and midwives are proactive about providing care for their loved ones. Two respondents reported caring for their significant other due to staffing needs at their facility suggesting they had no choice in the matter. This study was conducted in metropolitan hospitals where one could assume other staff members would be available on any given shift to relieve a nurse or midwife faced with caring for a significant other. This would be a different matter in the rural area where relief is difficult. Two of the respondents said it was their significant other's request for them to provide care and the remaining respondents reported a combination of the above-mentioned reasons.

Nursing is a profession that is transferable nationally and internationally and many nurses and midwives work in different locations throughout their careers. Although nurses and midwives were recruited for this study from metropolitan hospitals, fourteen

percent of respondents reported experiencing the care episode in rural hospitals, where it may have been more difficult to avoid or considered normal. The representation of rural experiences in this study may reflect the smaller populations and increased likelihood that the nursing staff in rural areas will know of or be related to a higher percentage of the population. Alternatively, it may reflect the interesting fact that in Australia only 27% of nursing positions are in major city hospitals (abs.gov.au, Australian Bureau of Statistics. Australia Social Trends, April 2013).

Twelve respondents reported providing care for their significant other in a variety of acute care settings: emergency, post-operative care and obstetrics. Acute care requires close observation, dynamic analysis and decision-making and provision of care to a patient with serious but short-term health issues (WHO, 2012). The remaining two respondents provided care for patients receiving palliative and rehabilitation services. This type of care requires ongoing monitoring and health promotion but generally is non-urgent in nature (WHO, 2012). The care provided by respondents for their significant other varied from high to low acuity.

This demographic information suggests that nurses and midwives were agreeable to provide a variety of care for their significant other, and more experienced respondents and those working in rural areas were more likely to have been exposed to this phenomenon.

4.10 Caring for a significant other in the role of employment.

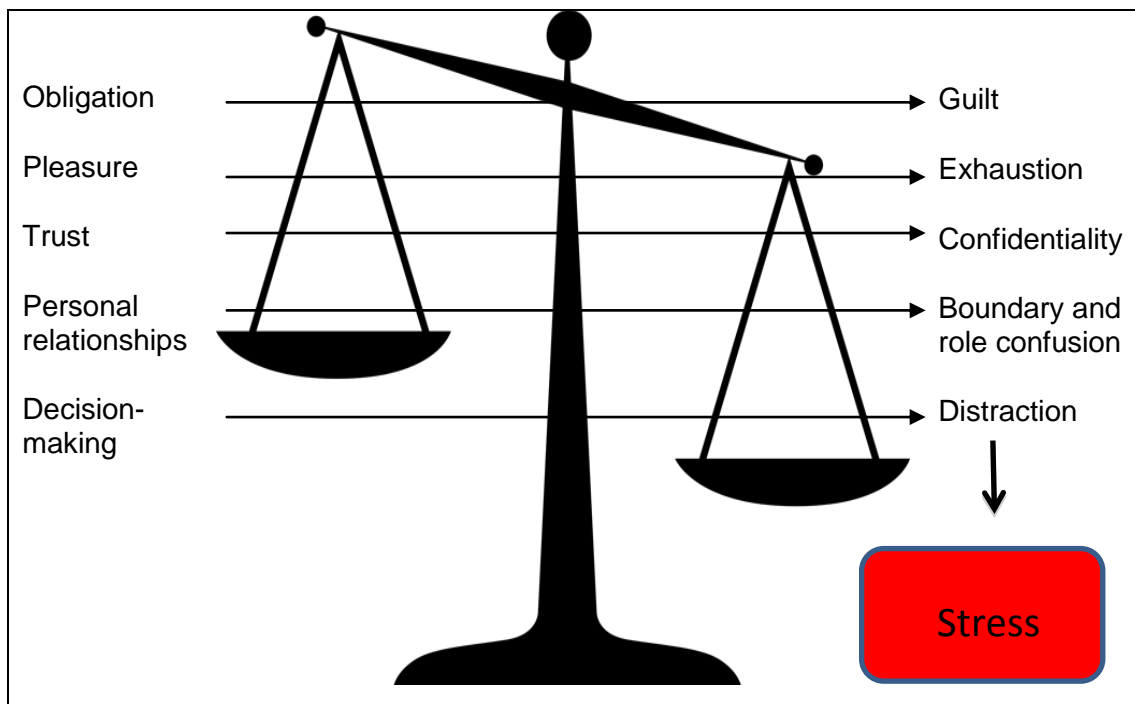
This study has been concerned with describing the experiences of nurses and midwives who care for a significant other in the role of employment and its impact. Nurses and midwives who responded to the survey illustrated that the existence of a close personal relationship between nurse/midwife and patient affects the optimal functioning of the professional, affecting the nurse/midwife both professionally and personally. Respondents' recollections showed that they personalise the importance of patient outcomes, are distracted from the usual daily plan and alter their 'normal' decision making processes. Personal effects included role confusion as a result of the concurrent professional/patient/significant other relationships, exhaustion and guilt. All of these

effects lead to alteration in stress levels experienced by the nurse/midwife specifically because they were caring for a significant other as opposed to a stranger.

Caring for a significant other had an effect on stress levels throughout the care episode that started with the decision to care for a significant other in the role of employment. More than half of the respondents reported making the choice to care for

Their significant other themselves. The accounts showed the initial reasons the respondents wanted to care for their significant other were to show they were a 'good nurse', to appease the patient or their family members' desire for them to care for their significant other or their need to take control over the care provided to their sick significant other. These initial reasons for commencement of care (reassurance of quality care and control over that care) were shown to be catalysts for increased levels of stress as the care episodes unfolded; these are illustrated in figure 16. There were reported increases in both professional and personal stress associated with all facets of the role including guilt, decision making, confidentiality, distribution of care and emotional involvement often leading to role confusion and exhaustion.

Figure 16: The impact of caring for a significant other in the role of employment



5.3.1. Obligation

Nurses and midwives reported feeling obliged to care for their significant other for both internal and external reasons. Internal pressures from the respondents themselves included wanting to prove their capabilities as a nurse/midwife to the significant other patient or their family members. Respondents reported needing to feel in control of the patient's best interests and outcomes by being the patient's nurse/midwife and providing care options and tasks to a level acceptable to themselves. This behaviour is supported by other studies where healthcare professionals felt pressure to provide health care for their family and friends. Reasons included their own desire to ensure the quality of the care, their availability, reduction in health care costs and an inability to refuse requests (Eastwood, 2009; Endacott, 2006; Evans, 2007; La Puma et al, 1991; Nik-Sherina, 2006).

External influences that lead respondents in this study to decide to care for their significant others in their role of employment included feeling pressured by the patient or their family members. This pressure came in the way of encouragement to join in as in the two stories involving the delivery of newborns by respondents A and F. Both of these respondents were actively encouraged to be involved in the care during the pregnancy by expressions of hope and desire from the patient/ their significant other. Being involved in the joyous arrival of a newborn was a delightful proposition. On reflection, though both respondents were able to identify increased levels of stress and concern due to the personal relationships and sense of obligation. This response was confirmed by a study of mental health practitioners who reported greater stress when the care involved their partner and/or child (Endacott et al, 2006).

In contrast to the recruitment to a pleasant experience are the examples of varying degrees of coercion where respondents felt bullied into caring for their significant other. Three respondents reported their significant other requested they provide care for them during their hospital admission. Respondents D and E both suffered due to their inability to refuse to care for their significant others when encouraged to do so by the patient or their family members. They both expressed feeling stressed by the personal relationships and pressures. Outcomes from the coercion were reported in the form of poor judgement and altered decision-making abilities. Respondents who felt obliged to care for their significant other against their wishes reported feeling frustrated and easily

lost their patience. All of these emotional responses lead to guilt and exhaustion. Similar reactions to the demands of significant others were reported by physicians who agreed to provide care for their relatives and close friends even though they were uncomfortable doing so (Eastwood, 2009; La Puma et al, 1991; Nik-Sherina et al, 2006).

Within the medical profession, providing care for a significant other seems commonplace, with 97% of 465 physicians surveyed reporting having provided care for a family member (La Puma et al, 1991). There are similarities of experiences here for physicians and nurses: both finding it hard to refuse care requests from significant others. It is important to note though that nurses are not independent, autonomous practitioners in the way physicians are. Nurses, employed by an organisation, may have several levels of supervision overseeing their management of health care. Their work and decision making is guided, to varying degrees, by policies and protocols.

5.3.2. Role Confusion

Personal relationships between the nurse and the patient were associated with role confusion. The nurses in this study showed limited ability to maintain the professional role of nurse when confronted with an ailing significant other. Some respondents discussed incidents that showed awareness of role confusion, whilst others were oblivious to its effects on their professional role. Two of the respondents who cared for their grandmothers found it difficult to disengage from the role of granddaughter and were overwhelmed by the personal effects on their professional role. The respondent's level of devotion and need to please lead to feelings of obligation, frustration, stress, exhaustion and guilt (Baca, 2011; Baron, 2008; Crunden, 2010; Eastwood, 2009; Endacott, 2006; Feeg, 2006; Gottlieb, 1996; La Puma, 1991; Mailhot, 2002; McClune-Trust, 2010; Mills & Aubeeluck, 2006; Nik-Sherina et al, 2006; Pugh, 2007).

There were nurses whose role confusion caused a preoccupation with caring for their significant other. An article by Mailhot (2002) suggests that treating a family member changes the dynamic in the relationship from empathy for the patient to sympathy for the patient. She explains that the switch to emotional involvement brings with it an inability to be objective or assess the situation as one would when caring for a stranger. This corresponded to Respondent B's need to stay with her daughter and her perceived guilt

when having to attending to her other patients. This desire to be mother impacted her professional availability to her other patients. Respondent E on the other hand felt guilty for not spending enough time with her other patients because she was preoccupied with appeasing her grandmother. In both of these instances the nurse was inherently defaulting to the personal role and knowingly providing more time and care to the patient that they had an established important relationship with. The desire to perform as a 'good' friend or family member instinctively placed an increased level of attention on that patient ahead of all others. Role confusion altered the normal professional accountability of the nurse and these nurses expressed an increase in their professional and personal stress as a result.

There were indications the type of personal relationship between the nurse and patient has different effects on the ability to perform the professional role. Respondent B, a mother caring for her daughter on shift, was able to maintain the controlled, decision-making demeanour, which is synonymous with the role of a mother. The granddaughters however showed a level of disempowerment in their inability to take control of the situation and perform the role of the nurse as they normally would for a stranger. They appear to behave as granddaughters and accept direction from the senior family member, over their normal professional behaviour. Further research in this area is recommended to establish if this is significant and consistent throughout the experiences of nurses caring for a significant other in the role of employment across Australia and internationally.

In all of the instances where nurses reported events and behaviours that indicated role confusion the nurse was unable to separate the professional role from the personal role. The two roles were intertwined and one had an impact on the other. This was corroborated by the literature where doctors and nurses found difficulty in separating the personal and professional roles when caring for a family member or close friend (Baron, 2008; Holder & Schenthal, 2007; Mailhot, 2002; Peternej-Taylor & Yonge, 2003). Crunden's reflections on his wife's stay in the intensive care unit supports the finding that nurses are unable to separate their personal and professional roles (2010). He reported needing to be involved with her care and decision-making, insisting on viewing all test result even though he was only there in the capacity of a family member.

5.3.3. Distraction

The existence of a personal relationship when nurses care for a significant other in the role of employment demonstrated different facets of distraction. Respondents expressed distractions due to the emotional repercussions of the concurrent roles of significant other and nurse. Whether the care took place by choice or by coercion, the nurse felt a responsibility to provide care above and beyond what would normally be expected. This pressure manifested itself in a distraction from the professional role. Distraction, in turn, resulted in guilt, frustration, over involvement and ultimately, stress. All of these emotional responses drew attention away from the clinical facets of the role, and established a difference between caring for a significant other and a stranger.

Respondent E acknowledged being overwhelmed by the pressures associated with caring for her grandmother. Her time was monopolised by the requirements placed on her as a granddaughter, which impacted the efficiency and confidence of the nurse. This nurse also reported feeling guilt towards her other patients who were receiving less of her time as she tried to placate her relative. Many of the nurses worried about their other patients feeling neglected or not receiving the care that would have been provided should the nurse not be caring for a significant other. Nurses were aware that this was a risk in their declarations of concern. Nonetheless, they appeared to continue to provide their significant other with the majority of their attention. This clearly suggests this is an inappropriate arrangement, and suggests that decisions about who should be caring for patients closely connected to an individual nurse be guided by persons or protocols independent of that relationship.

Many of the nurses' reflections included their concerns about their colleague's judgement and opinions of them caring for a significant other in their role of employment. This supports the concerns by Respondent E that these nurses believed that to some degree this was a noticeable aspect of their performance during the specific care episode and supports the feelings of guilt. Respondent A had her concerns validated when her colleagues did question whether she should be caring for her close friend. This made her wonder if she would have been able to deal with any emergency situation in an appropriate way.

Distraction as a concept was not represented in the peripheral literature, even though the nurses in this study either reported feeling distracted or gave examples that pointed to distracted behaviours. Distraction as a direct consequence of caring for a significant other has not been represented in the literature, however there are many studies linking hospital errors directly to other forms of distraction (Pape, 2005; Vecchione 2003; Beyea, 2014). This is a concern that should be investigated further due to the established risks between distraction and clinical errors.

5.3.4. Decision-making

Impact on the decision making process of the nurses was self-reported in the survey sliding scales. Seventy one percent of nurses surveyed reported their clinical decision making ability was unchanged when caring for a significant other, and the remainder reporting improvement. Ethical decision-making self-assessments were similar with only two nurses reporting a negative effect and the remainder reporting unchanged or improved results. There seems to be little self-awareness of actual changes to the decision-making processes when nurses care for a significant other in the role of employment.

The incidence of distraction discussed in the previous paragraphs identifies potentials in alterations to the usual decision making processes of the nurses in this study. Many examples of alterations in normal performance of the nurse have been discussed in this thesis. The first decision made by the nurses was to accept their significant other as a patient, even though some of the nurses admitted to being opposed to doing so. Respondent E reported consequences of being coerced into caring for her grandmother lead to a decrease in her decision making ability, as evident in her reflective statement ***Looking back, I suppose it is something I could have handled better***. She did not include this consideration when completing the questions relating to alterations in decision making in section two of the survey, raising questions about nurses' awareness of the implications of caring for a significant other in the role of employment. This was not specific to Respondent E.

Many of the nurses admitted their desire to spend time and effort attending to their significant other over their other patients. This is an alteration to their normal

distribution of care between their patients and an alteration to normal decision-making. It does not necessarily mean that required care was not provided for their other patients or that on any given shift there may not have been a patient who received more attention than another. The difference with caring for significant other in the role of employment is the possibility of becoming over involved due to the established personal relationship, as was reported by a study of physicians who provided care for their family members (La Puma et al, 1991). Although not conclusive this may be a transferable risk in the nursing profession.

Ten respondents reported their decision-making ability to be the same or enhanced when caring for a significant other as opposed to stranger (see Figure 8, chapter 4). Respondents A, C and F all acknowledged improved decision making abilities due to the personal knowledge about their patient. Having an understanding of their usual coping strategies, pain tolerance and beliefs were reported to have assisted them to evaluate their patient's needs faster than they would be able to for a stranger. Nurses reported quicker decision-making ability due to the already established level of trust between themselves and their significant other, which allowed the nurse to ***get to the issue quicker***. Respondent C conversely did use the trust and knowledge of her father to make decisions for him, instead of with him. This could have breached his rights to be informed and make care decisions for himself as outlined in the Australian Charter of Healthcare Rights (2008). There is an ambiguous area here that may see the nurse making decisions that meet their own needs rather than that of the patients. "Boundary violations by the provider occur when the healthcare professional displaces or confuses his or her own needs with the patient's needs" (Boland-Prom & Anderson, 2005). Having a close personal relationship with the patient could intensify this risk. Respondent C showed little insight into the potential boundary violation in her account. This highlights a concern for nurses caring for a significant other in the role of employment. Are nurses capable of putting their own desires for the outcome of their loved one aside while they explore the positive and negative impacts of all treatment options with the patient?

Contrary to the assumption that all nurses would go above and beyond normal requirements to provide improved care to a loved one, Respondent G illustrated how personal knowledge of a patient could hinder their ability to provide appropriate assessment and treatments. Respondent G acknowledged that she thought her husband

might have been over exaggerating his symptoms because she believed he had a low pain threshold. Luckily for G's husband she allowed her colleagues to take responsibility for his primary care as he did require a cardiac interventional procedure. This is an example of a nurse being complacent in the decision making process of a patient she has a personal knowledge of. The personal relationship may interfere with unbiased assessment and evaluation of the patient's symptoms and results risking delays to timely decision-making. This potential risk is supported by the reflections of an ICU nurse who admitted to ignoring the knowledge of how seriously ill his wife was in ICU to avoid dealing with the reality of her condition and the possible outcome (Crunden, 2010).

5.3.5. Personal Relationship

The one factor that is constant throughout the findings of this study is the existence of a personal relationship. Fifty-seven percent of nurses in this study reported that caring for their significant other had a positive impact on their personal relationship. The existence of a close personal relationship between the patient and the nurse is the point of difference to nurses caring for all other patients. The personal relationship existed and had values attached to it before the care episode commenced. More than half of the nurses admitting to choosing to care for their significant other to ensure they received quality care. The nurses' responses were scattered with examples of interactions that affected the personal relationship during the care episode.

The stories involving positive impacts included two nurses, A and F, who were able to share the birth of loved and welcomed babies, creating memories that would be reminisced about in the future. They provided emotional support and understanding while delivering care tailored to the individual. This is a privilege not available to family and friends who were not nurses working at that particular facility on that particular day. Respondent D described the privilege of caring for her grandmother as she passed away. Although sad, this experience afforded her the relief of knowing her grandmother was comfortable and pain free when she passed away. These examples, although not without stresses, were experiences that nurses were grateful to have had. These nurses found pleasure in the aspects of delivering care to their significant other.

Not all of the respondents found enjoyment in their experiences. Respondent E not only suffered while carrying out her role, but the events of the care episode affected her personal relationship during and after the care episode. The relationship of granddaughter and grandmother suffered when it was temporarily converted to patient and nurse. Respondent E was frustrated and curt with her grandmother whilst she was in hospital. This breakdown in the personal role extended for months after the care episode and had a damaging effect on their relationship. Respondent E felt obliged to carry out the care for her significant other and this may have made her more susceptible to a negative outcome. Results that support this finding have been documented about nurses who care for sick relatives at home, with them feeling frustrated and exhausted (Mills and Aubeeluck, 2006).

Respondent A alluded to her concerns about the consequences of caring for a significant other if there was a poor outcome or crisis event. Nurses are informed about how to deal with emergencies and undergo simulated training and case study review for their professional development. With the effects on caring for a significant other has on role confusion and decision making discussed it does raise a question as to whether or not nurses can remove themselves from the personal role in such an event and make timely care interventions to avert a crisis. Individual's responses to crisis events are varied with some carrying out acts of superhuman strength to save a child, whilst another individual may go into a catatonic state to block out the crisis as it occurs. The ramification of a medical crisis occurring while a nurse is caring for a significant other is not represented in any of the respondent's accounts or the literature. It was mentioned in the nurses' reflections and does raise a concern about what would occur and what long-term personal effects may impact the nurse, the patient, their family and the interrelationships between them all. There is the possibility of blame and guilt that may never allow the relationships the opportunity to return to normal., I would suggest this should be a major consideration of employers in relation to not only duty of care to the patient from a care perspective, but to the nurse as an employee who may suffer personally from the impact of caring for a significant other in the role of employment.

One consideration that did not present itself in the study but should be mentioned is the basis for the personal relationship. As a profession we should not assume that all nurses have loving positive relationships with their significant others just

because we are employed in a caring role. Relationships break down for numerous reasons and nurses are just as likely as the general population to have strained relationships. It would not be impossible for decision making to involve a level of control or payback whether it is conscious or subconscious. As illustrated by the respondents' accounts of the need to please, there may be a subconscious need to punish or harm. Although not involving significant other patients, over 2000 nurses worldwide have been convicted of harming or killing their patients (Montaldo, 2015; Ramsland, 2012). Many of these nurses were seeking power, control, attention and financial gain, concepts that should be taken into consideration when considering the personal relationship between nurse and patient significant others.

We have seen examples in this study and in the related literature that indicated over involvement of the healthcare worker (Crunden, 2010; Feeg, 2006; Gottlieb, 1996; Mailhot, 2002; Mills & Aubeeluck, 2006) which lead to distraction and altered decision making processes. There is also evidence that physicians limit their emotional involvement with family member-patients to avoid uncomfortable emotional situations if there are negative results or outcomes (La Puma et al, 1991). Although this was not reported in this study more research into the effect on decision-making processes when nurses care for a significant other in the role of employment is warranted.

5.3.6.Stress

All of the concepts identified in this study had an impact on nurses' stress levels when caring for a significant other in the role of employment. Thirty-six percent of nurses in this study reported an increase in professional stress, and forty-three percent reported their professional stress did not alter. Altogether when analysing the respondent's accounts stress increases were identified in eighty-three percent of the stories. This mismatch of self-reporting and accounts experienced suggests that nurses are unaware of the real implications for them when they care for a significant other in the role of employment. This also questions whether they are capable of accurately evaluating the risks associated with caring for a significant other when deciding if it appropriate to do so.

Reasons that were identified in the nurses' accounts that encouraged the nurse to commence the episode of care were the desire to impress, established trust, reassurance

for the patient and a need to help. These resulted from obligation, pleasure of being involved, trust, personal relationship responsibilities, and the sense of knowing what's best for the patient in the form of decision making. All of the reasons the nurses thought supported the decision to care for their own significant other in their role of employment eventuated into guilt, role confusion, breaches in confidentiality, distraction and exhaustion. These were all a direct result of caring for a significant other compared to caring for a stranger.

Nurses' accounts included examples of decreased stress levels associated with trust and pleasure linked to caring for a significant other. An interesting observation is the existence of situations within these care episodes where the nurses' accounts reported both increases and decreases in stress. These findings supporting the idea that caring for a significant other manifest itself via a combination of the concepts in Figure 16 as stressful. Even concepts that commenced as positive or desired options, lead to stressful impacts on the nurse either professionally or personally. Increased stress or increased concern was reported by all of the respondents in this study across the concepts. It is clear that caring for a significant other either voluntarily or through necessity increases the stress placed on the nurses either professionally, personally or more often a combination of the two.

5.4 Recommendations

This study has presented new information on the impacts associated with nurses caring for a significant other in the role of employment. The findings from this study highlight issues that have not been represented in the research and are deserving of further consideration.

5.4.1. For Practice

This study has shown that nurses do not always consider or are not aware of the possible personal and emotional impacts of caring for a significant other in the role of employment when making a decision about whether or not to care for their significant other. Are nurses the best people to make this decision the right decision? Should they be making it unaided?

Nurses in this study demonstrated how caring for a significant other impacts them personally and professionally. It was illustrated that nurses can be coerced into providing care for a significant other against their intuition, and that this has ramifications on their ability to cope with the increased stress associated with that care. Even nurses who were enthusiastic about caring for a significant other expressed increased stress and concern for changes to their usual provision of care and impact of their role. The over involvement and role confusion caused by the dual relationship was seen to manifest itself in distraction. Distraction had been proven to increase the risk of clinical errors and this should be taken into consideration when considering caring for a significant other in the role of employment.

The ability to conclude the care role and resume the personal roles is also shown to be at risk of being overlooked during the consideration for commencement of care of a significant other. The findings from this study should be taken into account by nurses placed in this position, as well as their managers, hospital leaders and the governing bodies of both enrolled and registered nurses and midwives. Health care facilities in Western Australia should develop policies to guide and support decision-making in this area.

5.4.2. For Education

Many of the guidelines relating to professional boundaries do not give specific examples or advice on issues relating directly to caring for a patient with whom a nurse previously had close personal ties. They refer to prevention of sexual, exploitative and inappropriate relationships that develop during the course of care. It would be useful for nurses using the professional boundary guidelines flow charts to include examples relating to family members and close friends. Examples of the type of care and the environment this situation could occur in and possible options to handle the situations would be highly beneficial to assist nurses using these tools.

5.4.3. For Future research

Future research into the impact on nurses caring for a significant other in the role of employment is needed to better understand what action, if any, may be needed. Areas for further investigation include:

- Effects on the quality of care relating to the concepts identified in this study.
- The full extent of effects on the emotional state of nurses who care for a significant other in the role of employment
- Are the current nursing guidelines and policies relating to dual roles, boundaries and code of conduct appropriate for situations where nurses care for a significant other in the role of employment?
- Are nurses the most appropriate persons to assess whether it is appropriate to care for a significant other in the role of employment?
- Do rural nurses have experience in caring for significant others that would assist with the development of policies, educational programs and tools for all nurses to consider when faced with the possibility of caring for a significant other in the role of employment?

5.5 Strengths and Limitations

A survey approach was used in this study to ensure the widest audience was targeted in the hopes of recruiting respondents with experiences in the chosen area of investigation.

A survey as the method of data collection can limit the depth of information available for consideration in this study. Survey results offer limited insight into personal response and reduce the ability for the researcher to encourage the respondent to share more in-depth information. It does not afford the researcher the ability to respond to visual cues offered by someone in an interview or group discussion. There is no capacity for the researcher to ask for clarification or to request an expansion on the information presented for emotional response. Interviews with the respondents would have provided additional content and allowed for common threads in the discussions to be expanded upon as each nurse shared their individual accounts. This was a missed opportunity, however with time constraints of this study and the unknown prevalence of the phenomenon the data collected was informative and sufficient to direct future studies.

The inclusion of the concepts and the rating scales on the survey tool was potentially another limitation in the quality of data collected. The concepts scales may have inadvertently prompted the respondents to include these concepts in their accounts,

rather than deliver their accounts based on their recollections and individual understandings. This consideration may have directed the respondent's accounts and ultimately affected the findings by pre-empting the inclusion of the concepts. Although the accounts were freely expressed as their individual stories, the inclusion of the concepts appears to have directed the nurse's recollections.

The survey was directed at respondents from hospitals in the same city run by the one company. There may be cultural or policy and procedural differences within this organisation that may not be replicated in other health care settings. This may have had an effect on the data collected and may not be a representation of the broader health care community. It is acknowledged that the respondents' accounts could have occurred in previous places of employment and thus the restrictions placed on the survey distribution may not have had a consequence on the results.

The survey did not ask for the date in which the care episode occurred. This information may have given an insight into whether this is a current issue and if the introduction of the Nurses Board boundary guidelines in 2010 affected the occurrence of this phenomenon since that date (NMBA 2010). This remains to be seen as the survey did not ask 'when' the care episode occurred. Future studies should take this into consideration as an area of interest.

5.6 Conclusion

This study has answered the research question: "How does the experience of nursing a significant other in the role of employment impact Australian nurses ?".+ midwives?

In the preceding chapters, nurses' experiences of caring for a significant other in their role of employment have been considered in an effort to understand the impact this phenomenon has on their professional and personal roles. The thesis that this study has argued to support is caring for a significant other in the role of employment has an impact on the ability for the nurse to carry out the role as they would when caring for a stranger. It highlights the outcomes for nurses who were unaware of the potential stressors associated with this specific care episode and the likely impact of these stressors. Nurses by nature want to please and heal, especially when the patient is their loved ones. The

decision to care for a significant other is not always made with informed overall considerations of the potential impacts on the professional and personal roles. Being involved with the care, and being in charge of the care are separate functions, ones that nurses may misinterpret without having previous experience to gauge upon.

This thesis has discussed the findings associated with nurses' experiences of caring for a significant other in the role of employment. It is the expectation that nurses, hospital management and governing bodies will gain insight from this new body of knowledge and be able to direct further review of current practice and guidelines to support nurses and their managers when faced with this situation. For those nurses who are unable to avoid this specific patient interaction it is hoped that the findings from this study will open channels of communication, prompt review and, or development of guidelines and promote education to support nurses in maintaining positive outcomes professionally and personally. It is hoped that this study will prompt future research and raise awareness of the impact of caring for a significant other in the role of employment.

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APPENDIX 1: SURVEY



The Impact of nursing a significant other in your role of employment.

Participant Information and Informed Consent Form

This study aims to collect information about the experiences of nurses and midwives who have cared for a significant other in the role of employment. (A significant other is a person who is very important in your life. This person could be a spouse, partner, parent, child or friend).

This research project is being conducted as part of Masters in Nursing Research at Edith Cowan University. The information collected will be used to evaluate the positive and negative aspects nurses and midwives have associated with their own experience. Findings may then be useful for education development and policy development.

To participate you must be a nurse or midwife who has cared for a significant other in your role of employment.

Procedures

Participants will be asked to complete a short questionnaire consisting of demographic information, 15 multiple choice and one short answer question. The survey will take approximately 15 minutes to complete. Questions are designed to determine how nursing a significant other in the role of employment effects nurses / midwives.

Risks/Discomforts

Participation in this study may produce an emotional response when asked to reflect on experiences. Participants may access the Edith Cowan University counsellors at no expense to themselves should they experience emotional repercussion linked directly to sharing your experience for this study. This can be organised by contacting Deborah Sundin on PH 6304 3488 or the Counselling services directly on 93706706.

Participation

Participation in this research study is completely voluntary. Participants have the right to withdraw at anytime or refuse to participate entirely. If you desire to withdraw, please close your Internet browser to end the session, which will prevent your information from being collected.

Questions about the Research

If you have questions regarding this study, you may contact :-

| | |
|---------------------------------------|------------------------|
| Tania Arnold (Researcher) | tarnold@our.ecu.edu.au |
| Deborah Sundin (Principal Supervisor) | d.sundin@ecu.edu.au |
| Helen Godwin (Associate Supervisor) | h.godwin@ecu.edu.au |

Independent Contact Person

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
Joondalup WA 6027
Phone: (08) 63042170
Email: research.ethics@ecu.edu.au

Confidentiality

All data obtained from participants will be anonymous. Any names used by the participants in their short answer question will be changed to protect the confidentiality of both the participant and the people discussed.

Feedback

If you would like to be sent a copy of the research findings please include your email address in the box below. Email addresses will be stored securely and only used for the purpose of informing you of the final results and will then be destroyed.

I have read and understood the above information and desire of my own free will to participate in this study.

☐ Yes

☐ No

>>

Survey Questions

Please complete the information relating to your individual circumstances.

What designation are you?

- ☐ Enrolled Nurse
- ☐ Registered Nurse
- ☐ Midwife
- ☐ Nurse Practitioner

What is your highest nursing qualification?

- ☐ PhD/Professional Doctorate
- ☐ Master's Degree
- ☐ Bachelor Degree
- ☐ Post Graduate Certificate
- ☐ Diploma
- ☐ Hospital Based Training

How long have you been working as a nurse / midwife?

- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ 11 to 15 years
- ☐ 16 plus years

What relationship to you was the significant other that you cared for in your role of employment?

- ☐ Spouse/Partner
- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Child
- ☐ Grandparent
- ☐ Other

What type of hospital were you working in when you nursed your significant other?

- ☐ Metropolitan
- ☐ Rural
- ☐ Remote
- ☐ Other

Why did you nurse your significant other?

- ☐ My choice
- ☐ Significant others choice
- ☐ Clinical need
- ☐ Staffing need
- ☐ Other

What care was the significant other admitted for?

- ☐ Emergency care
- ☐ Elective surgery
- ☐ Chronic illness
- ☐ Acute care
- ☐ Obstetric care
- ☐ Palliative care
- ☐ Other

What impact did nursing a significant other have on your clinical decision making?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your ethical decision making?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your ability to maintain confidentiality?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your ability to maintain therapeutic boundaries?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your role as a nurse / midwife?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your role as a significant other?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your working stress levels?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

What impact did nursing a significant other have on your personal stress levels?

- ☐ Much Worse
- ☐ Worse
- ☐ About the Same
- ☐ Better
- ☐ Much Better

I invite you to record your experience of nursing a significant other in your role of employment.

Thank you for taking the time to share your experience and insight.

>>

APPENDIX 2: ADVERTISEMENT FLYER



Nursing Research

**Have you ever cared for a family member
on your shift?**

Was this a matter of choice or necessity?

**We would like to hear your story to gain an
understanding of your experience and any
challenges you may have had.**

**This is an invitation to all nurses who have cared
for a significant other in their role of
employment to complete a survey.**

You can access the brief survey online at:

https://ecuaa.qualtrics.com/SE/?SID=SV_77G2IUTnD2PYGy1

This nursing research survey has been approved by Edith Cowan University Ethics Committee and Joondalup Health Campus Human Ethics Committee.

If you would like further information you can contact the project leader

Tania Arnold via email: tarnold@our.ecu.edu.au or my supervisor

Dr Deborah Sundin: d.sundin@ecu.edu.au .