Nursing Dissertation Proposal Example

Abstract

Research Question: What are nurses' perceptions and experiences of providing psychological care to burn victims?

Background: Burn injuries are a common traumatic experience which can set an enormous amount of stress and strain on an individual's psychological state. Due to the improvements in emergency services and burn treatment in the past century more and more burn survivors are required to make psychosocial adjustments to cope with their new body image (Lawrence et al. 2006, Klein et al. 2007, Ullrich et al. 2009).

There are known support groups to aid this adjustment post hospitalization however literature demonstrates the lack of research into the psychological care provided by nurses during the patient's recovery period in hospital. Thus the research question "What are nurses' perceptions and experience of providing psychological care for burn victims?" was developed.

Aim of this study: This study aims to explore nurses' perceptions and experiences of providing psychological care in order to identify areas of psychological care which can be improved or developed to enhance quality of practice.

Methods: The research method chosen and best suited to this study is descriptive qualitative research. The proposed method for data collection is open-ended semi-structured interviews which will be audio taped to maintain accurate accounts of information given.

Sample: The researcher intends to use 6-8 registered nurses who fit the outlined criteria chosen through purposive sampling. It is proposed that that the clinical nurse manager (CNM) of the chosen burns unit will distribute letters of invitation and consent forms to registered staff nurses in the unit.

Data Analysis: The researcher proposes to make use of Colaizzi's (1978) data analysis approach following the transcription of audio recorded information.

Findings: It is hoped that the outcome of this study raises awareness of the need for psychological care in the recovery period of burn injuries and with the knowledge gained from nurses' experiences and perceptions improve standard and quality of psychological care in burn units.

Chapter 1

1.1 Identifying the Research Issue of Interest:

From the literature accessed it is evident that the psychological needs of burn victims is a vital part of their recovery following their injury, however there is little research carried out regarding the extent or format of care necessary. For example Bernstein (1976) is one of many researchers who investigated the idea of burn victims who had suffered large total body surface area (TBSA) injuries, in visible locations of the body and concluded that these victims are thought to have decreased self-esteem and value of their role in society. Bernstein discusses significance of attractiveness in society, and concludes that burn survivors have to come to terms with their new body image and re-establish personal worth following their injury. Although Bernstein recognises the psychological needs of burn patients in terms of what they must overcome such as new body image, how we can support these challenges and patients is not discussed. Studies in the US and Canada (Holaday & Yarbrough 1996) and in Europe (Van Loey et al. 2001) reveal that patients are not often psychologically assessed and/or provided with psychological care in burn units. One clear finding from studies previously carried out is that a minority of burn victims report significant psychological issues due to their injuries as it is not usually assessed or discussed while hospitalised (Fauerbach et al. 1999, Tebble et al. 2004, Fauerbach et al. 2005, Hulbert-Williams et al. 2008). Thus, the researcher identified and selected this issue as it is not only an area of personal interest, but also as it is an area identified in the literature review which has only been given attention in recent decades and has not yet been looked at in depth. This issue is often overlooked when trying to care for the acute burn victim however it can prove to be a more serious psychological issue further along the line if not cared for effectively throughout the recovery phase (Ullrich et al. 2009). The majority of literature in relation to burn injuries

focuses on the acute physical care of the injury (Williams 2009 & Rowley-Conwy 2010). However from the literature review, which was carried out corresponding to the psychological effects of burn injuries, it was found that, following assessment, many burn victims suffer psychological harm post recovery in burn units. As a result the researcher wishes to identify the current psychological care being provided by registered nurses and gain an insight into their opinions and experiences of the subject. Therefore by carrying out research looking at the role the nurse plays in caring for burn victims psychological state during the recovery phase, we may begin making the necessary adjustments to the care already in place; which may be in need of reassessment and remodelling in order to provide the best holistic care and in turn psychological care possible for burn victims. Hospitals, staff, nurses and most importantly burn victims may all benefit from further research and training in this area of care.

1.2 Literature Review:

There have been many studies carried out related to burn injuries, most of which focus on the physical implications of burns, however this literature review will concentrate on some of the psychological and social implications and nurses' perspectives regarding these issues. The literature collected and analysed in this review were accessed from online databases including CINAHL, PsycINFO, PsycARTICLES, Academic Search Premier, PubMed and Ovid. Only English language papers with full texts available were reviewed. All studies accessed were international studies as there were no Irish studies found in relation to this topic. There were over 40 articles accessed however not all were completely relevant and as a result not included in this review. No set timeframe was decided upon yet the most valuable studies came under the parameter of 1990-2010. A variety of research studies were accessed most of which were found to use qualitative research methods in their studies. No printed texts were used in this literature review as texts available were more suitable to care of physical burn injury.

From the literature several key topics were identified and discussed however, due to word constraints only the most relevant topics will be chosen to be discussed in detail while others may only be mentioned in this section. These chosen themes include psychological implications, interventions and the nursing role.

With the increased survival rate of burn patients comes psychological complications. Burn injuries include both losses and gains in relation to: functioning, identity, roles, lifestyles and relationships (Williams et al. 2003 & Moi et al. 2008); which poses major stress on patients. Burns force victims to try to come to terms with new bodily appearances, how others react to this new appearance, and coping with physical limitations. These new life stressors create many psychosocial complications for patients (Patterson et al. 1993). There are three stages of physiological recovery and patients psychological needs vary at each stage (Wiechman & Patterson 2004).

1.2.1 Psychological Implications:

Burn victims are at high risk of developing various psychological issues which can vary from person to person. These issues include anxiety, grief, sleep disturbances, post-traumatic stress disorder (PTSD), depression and stress. Three central psychological disturbances were recognised as the most commonly witnessed including depression, anxiety and PTSD. As stated by Lawrence et al. (2006) depression is the most common disorder on follow-up among burn victims.

Moi et al. (2008) undertook a qualitative, longitudinal, phenomenological research study to gain an understanding of the lived experience of a burn victim. This was done through 20 open, in-depth interviews during 2005-2006, on average 14 months post injury. The study was carried out in Norway where 14 participants, most of which were men, were selected to participate in the study. The participants discussed both physical and psychological disturbances as part of their experience with burn injury. The psychological effects identified by the participants, such as isolation, social withdrawal and feelings of stigmatisation, are predisposing factors of depression. Anxiety is another very common issue following, injury of any kind and hospitalisation. Hulbert-Williams et al. (2008) implies that sufferers of larger burns experience greater levels of anxiety when compared to those who have smaller burns. In contrast Tebble et al. (2004) argues that burn injuries no matter what size can have psychological implications for the patient.

A qualitative, experimental study was carried out by Hulbert-Williams et al. (2008), investigating anxiety levels related to burn injuries in the United Kingdom (UK). In total 60 participants were recruited for the study 30 of which had no injury, used as a control group. Results showed greater levels of anxiety in those with

burn injuries and even higher in those who were injured in the previous three years. This study concluded that burn victims require more than just physical medical treatment in overcoming the trauma of suffering a burn and require a role in therapeutic technologies to relieve general anxiety and other psychological implications experienced by burn victims.

Tebble et al. (2004) lead a prospective, longitudinal qualitative research study in order to examine the psychological impact of facial injuries and influence of scarring characteristics on self-consciousness and anxiety levels. Self-report questionnaires were given to those presenting to the accident and emergency (A&E) unit in a UK based hospital. A collective 63 people participated in the study with a criteria limited to those with a visible wound larger than 1.5cm in length. The Derriford Appearance Scale (DAS-59) (Carr et al. 2000) using only two subheadings for this study and the State trait Anxiety Inventory (STAI) (Spielberger 1970) were put into practice for this study. Factors identified as impacting on self-consciousness were then studied using the state anxiety results; this found that anxiety and social self-consciousness did not decrease six months after the injury. Living arrangements displayed mixed results, thus reflecting an indication of support to be made available based on individual needs. This study concludes with mention to further training to relevant staff and additional research into cognitive behavioural and social skills workshops for affected patients.

The American Psychiatric Association (1994) characterise PTSD by three symptoms; re-experiencing (upsetting thoughts of the traumatic event), avoidance (suppression of trauma related stimuli), hyper arousal (i.e. unable to sleep or anxiety).

A cohort longitudinal research study which explored the investigated the impact PTSD following a severe burn injury was carried out by Fauerbach et al. (1999). This study was completed in the United States (US) making use of 86 participants. Many tools were utilised in order to assess the levels of distress experienced some, of which include the Davidson Trauma Scale (DTS), the Beck Depression Inventory (BDI; Beck et al. 1961) and the Satisfaction with Appearance Scale (SWAP; Lawrence et al. 1998). This study recognises that those identified as suffering from PTSD experience a pessimistic outlook; high levels of depression symptoms and greater level of body image dissatisfaction (BID).

Findings suggest that personal traits and characteristics may be a vital variable that contributes to level of post burn adjustments. Nightmares and intrusive thoughts related to the traumatic incident in the first four weeks of hospitalisation can be indicative of acute stress disorder and lead to PTSD (American Psychiatric Association 2005). All members of the multidisciplinary team (MDT) in burns units recognise that the patient's psychological state affects their physical recovery thus acknowledge its importance (Klein; 2009). It is part of the nurse's role in burns units to psychologically assess, intervene and support burn victims. It is vital that nurses make use of the Zung depression scale (Zung 1965) in order to avoid over prescribing anti-depressants when a burn patient may only be acting rationally to the situation as opposed to being depressed. Klein (2009) states by identifying the patients' previous coping strategies for stressful situations may give an insight into how the patient will cope with their new injury. Assessing, identifying and treating psychological issues following traumatic burn injuries is an integral nursing role which contributes to the physical recovery of the patient. According to Fauerbach et al. (2005) psychological needs and issues delayed the rate of recovery of both physical and psychosocial health and function.

1.2.2 *Interventions:*

From the available literature it is evident that there are both psychological and social implications post burn injuries, however there is a clear need for further research into the psychological care available, the effectiveness of this care and explore and expand additional care interventions.

Blakeney et al. (2005) produced a qualitative study which examines the efficiency of a short-term and intensive social skills training program as an intervention to improve psychosocial adjustment. The researcher chose a prospective randomised experiment which included one intervention group and a control group both consisting of 32 participants who suffered from a burn injury two years prior to the study and were identified as having a form of psychosocial difficulties (elevated behavioural issues or diminished competence). This study was aimed at adolescents aged between 12 and 17 with a mean age of 14. 175 adolescents were contacted by mail and follow-up phone calls, both parents and teens were sent written explanations of the study along with consent and assent forms, of these 103 responded, and were then assessed using the Child

Behaviour Checklist (CBCL) which was completed by a parent or guardian and from this the final 64 participants were selected. The intervention was carried out in a residential work shop format over several days. A curriculum was followed which made use of didactic material, audiovisual aides and experiential exercise (e.g. role playing), goals and assignments for practicing specific skills during life-activities were also set throughout the workshops. In contrast the control group only received usual treatment and follow-up appointments regarding surgeries and only received psychological/psychiatric attention upon request. One year following the intervention it was found that those who received the intervention work shops became less withdrawn and had fewer somatic complaints, whereas there was no significant change in the control groups. Although this study was carried out using adolescents it can be applied to adults as the curriculum followed by the intervention group was developed by Changing Faces a non profit organisation in the UK who reported success in using the curriculum with adults.

A retrospective qualitative study was lead by Muangman et al. (2005), to investigate the importance of both physical and psychosocial variables that predict survival in patients with large burn injuries, looking at social support in particular. For the purpose of this literature review only the psychosocial factors will be discussed. Patients were selected based on the percentage of total body surface area (TBSA) affected by the burn only those with ≥ 60% TBSA burns were selected to participate. Patients with social support were those who had family and friends present during there time in the intensive care unit (ICU). 36 patients were selected following a careful assessment of medical notes, and then categorised into two groups, survivors and non-survivors. It was found that there was a greater social support in the survivor category, 81% of the survivor group had some form of social support compared to that of the non-survivor group where only 35% had social support. It is evident that those without any social support from family or friends are at higher risk of complications, thus the nursing staff and multidisciplinary team should be aware of those with little support and in turn provide the necessary positive support required and find ways to decrease anxiety and stress levels the patient may be experiencing.

Fauerbach et al. (2002a) completed a study where two coping strategies were compared (venting emotions and mental disengagement) when coping with body disfigurement following a burn injury. Findings of this study were

hypothesized and ultimately found that the use of one coping method were less likely to portray symptoms of depression where as a use of both strategies were more likely to display symptoms of depression. Following this study Fauerbach et al. (2002b) continued this work with a further study into the relationship of ambivalent coping to depression symptoms and adjustment. The study used a prospective longitudinal design to investigate the effect of acute post burn coping strategies on depression and health related quality of life (HRQOL). This study was conducted using 76 adult burn patients admitted to a regional burn unit in the United States. Recruitment was carried out over two and a half years where of 715 burn patients only 286 met the criteria and agreed to participate. The exclusion criteria included early transfer or discharge against medical advice, those who died before discharge and a mini mental state exam (MMSE) score of less than 23/30. The inclusion criteria were purposefully broad and included two specifications; the patient must be 18 years or older and meet the criteria of severe burn injuries (American Burn Association 1984). Data was gathered within the first 72 hours of admission three tools were used in order to facilitate the collection of data these include the COPE scale (Carver et al. 1989), the Beck Depression Inventory (BDI) (Beck et al. 1961) and the SF-36 (Ware et al. 1993). The BDI was again administered one week post discharge, and then the BDI and SF-36 readministered two months later. Results suggest that those who used both emotion venting and mental disengagement had both larger TBSA and TBSA-FT (full thickness) than those who used one or none of these coping methods. The use of both coping methods was however associated with greater symptoms of depression (see Appendix I) and symptoms decreased or stabilised with frequent use of either mental disengagement or venting emotions. This study portrays limitations including self–reports, which is subject to variances and bias, future studies my benefit from third party informants and/or work evaluations. Also this study was carried out up to 2 months post discharge; it remains unknown whether the effects remain consistent beyond this point.

It is evident from these studies that psychological interventions or coping strategies enhance patient recovery following burn injuries. Suppression has proven to be neutral or even beneficial, particularly in coping with pain in which distraction, imagery and other suppression techniques have proven effective (McCaul & Mallot 1984, as cited by Fauerbach et al. 2002b, p.394). It may profit

burn patients if we systematically examine their preferences and goals for suppressing or processing coping as well as their efficiency and frequency to do so. It is vital that individual difference in cognitive behaviour and motivation are taken into account when considering coping strategies which may be most beneficial for the patient at hand.

1.2.3 Nursing Role:

Burn care requires close multidisciplinary team (MDT) alliance for optimal patient outcome, at the centre of any MDT there is the nurse, coordinator of patient care. Not only does burn care require a large amount of knowledge regarding physical effects of burns but also demands rehabilitative and psychosocial skills (Greenfield 2010). Rehabilitation for burn victims begin from the day of admission for a number of years following discharge, with aim of restoring full function or as near as possible to the patients pre-burn state. In addition to this rehabilitation, care for the patients' psychological and social well-being should also be managed. This can be achieved through continued nursing input with both patient and family and ensure continuous communication with both is maintained (Williams 2009).

A prospective, longitudinal quantitative research study was carried out by Wikehult et al. (2008) which assessed negative emotional experiences during burn care in aim of improving the development of optimal nursing for these patients. The study was carried out in a large Swedish hospital responsible for caring for those with severe burn injuries. The admission criteria was based on the recommendations American Burn Associations (ABA) including; total body surface area (TBSA) burned and TBSA with full thickness burn (TBSA-FT). A total of 42 patients participated in the study, all of which were above the age of 18 at time of injury. This study examined psychiatric morbidity along with physical, psychological and social well-being. Over all this study found low ratings of negative emotional experiences which are an encouraging discovery for burn care nursing. Patients with severe burns are often greatly dependent on nurses and nursing interventions in the burns unit. Nurses should be aware of the negative experiences encountered by their patients, particularly the feeling of powerless which was found to be the most commonly rated experience. Patients reported feeling most powerless when unable to make decisions regarding daily care, this

should be acknowledged by nursing staff and patient empowerment should always be encouraged. It is also the nurses' duty in burn care to assess and observe both verbal and non-verbal signals of emotional distress and reduce these feelings to avoid PTSD in the future. These findings coincide with those found by Moi et al. (2008).

Nurses have a pivotal role in burn care particularly through the rehabilitation phase where most social and psychological issues come to light. It is crucial that all nurses be aware of this, it is a vulnerable time for burn victims where they rely on healthcare staff for emotional support and encouragement. As nurses are present with the majority of the day and spend much of their time with the patients, they are relied upon to observe and assess any new issues such as depression or PTSD which may be oncoming. Nurses assess, plan, implement and evaluate physical and psychosocial needs on a daily basis in order to provide an optimal level of holistic care (Baker et al. 2007).

1.2.4 Conclusion:

The aim of this literature review is to acknowledge the psychosocial implications of burn injuries on the victim's lives which are often overlooked by nursing staff and other health care professionals. This review identifies the key psychological implications post burn injuries, discusses possible interventions previously studied and used by healthcare professionals and patients (Wiechman & Patterson 2004), and also takes a look at the nursing role in relation to psychological needs which proves to be a vital role for burn victims (Baker et al. 2007 & Williams 2009). Although the nursing role is identified as an important part of the patients care, no literature has been found in relation to psychological care for burn patients from a nurse's perspective, thus the researcher has chosen to carry out this study from a nursing point of view rather than a patient.

1.3 Research Question:

What are Nurses perceptions and experiences of providing psychological care for burn victims?

From review of the available literature it is evident that more emphasis should be related to the patients' psychological state while hospitalised following a burn injury. It is one of nurses' roles to provide optimal care for all patients in a holistic

manner. Thus the researcher proposes a study to investigate nurses' perceptions and experiences of providing psychological care to burn patients.

1.4 Aims and Objectives:

This study aims to explore nurses' perceptions and experiences of delivering psychological care to burn victims in order to gain an understanding of the care currently in place. This study also intends to highlight areas within this field which may be in need of assessment, improvement and/or complete development, and in turn improve standards and quality of patients' psychological care.

Chapter 2

2.1 Methodology:

2.1.1 Introduction:

There is an absence of both Irish and international research into the area of psychological care provided by nurses for burn victims, and to address this issue the author proposes to carry out this study. Within this chapter the researcher will outline and discuss the most appropriate methods of design, sample selection, data collection and analysis. There will also be a description of the ethical considerations necessary to complete the proposed study.

2.2 Design/Proposed method:

According to Parahoo (2006) the design selected for research should be the one most suited so as to achieve an answer to the proposed research question. For the purpose of the proposed research question the researcher has chosen to carry out a descriptive qualitative research design in the hopes to explore nurses' perceptions and experiences of the psychological care they provide to their burn patients. Qualitative research is a systematic, subjective approach to describe life experiences and give them meaning (Burns and Grove 2009). Qualitative studies allow researchers to explore behaviours, perspectives, feelings, and experiences in depth, quality and complexity of a situation through a holistic framework (Holloway and Wheeler 2002). In contrast quantitative research is a formal systematic approach which incorporates numerical data to obtain information about the world (Burns and Grove 2009), which would not be suitable to gain the information required for this study. There are four common approaches within qualitative research, phenomenology, grounded theory, ethnography, and historiography. As the researcher is a novice none of the above approaches were deemed suitable for this study thus a simple descriptive qualitative study was chosen. Descriptive design aims to describe the essential findings in a rigorous way that is free from distortion and bias (Brabury-Jones et al. 2010). Descriptive studies help discover new meaning, describe what currently exists, verify the rate of which something occurs, and categorise the information. Thus the researcher chose this design for the study as it facilitates the precise actions the researcher

aims to achieve such as identifying any issues with current practice or justifying current practice.

2.3 Population/Sample:

The researcher intends to acquire a purposive sample by recruiting nursing staff from a regional burns unit of a University-affiliated teaching hospital within Dublin. Cormack (2000) suggests that qualitative researchers use a small selective sample, because of the in-depth nature of the study and the analysis of data required. As the researcher intends to acquire a purposive sample there will be some exclusion and inclusion criteria requirements.

Include:

- Minimum of 6 participants and maximum of 8 (In order to gain detailed accounts of the responses and allowing for large amounts of information to be analysed, a small population size was chosen).
- Minimum of three years work experience in the burns unit (so as to obtain the opinions of those most experienced and exposed to this area of care).
- Registered Staff Nurses (this study aims to identify nursing perceptions and experiences of the challenges of providing psychological care, therefore participants must be registered staff nurses).

Exclude:

- Any other healthcare professional (e.g. doctors, students, health care assistants).
- Staff nurses with less than 3 years experience in the burns unit (To ensure the registered nurses have acquired enough experience to ensure they have come across challenges regarding psychological care).

Prior to gaining consent from participants, letters requesting permission to carry out the study will be sent to the necessary boards. Permission to carry out the study will be requested from the Trinity Faculty ethics committee (see Appendix II for letter of permission to ethics committee); if granted permission of access to participants will then be requested from the director of nursing and the units' clinical nurse managers (see Appendix III and IV for letter of permission to

the Director of Nursing and Clinical Nurse Managers). If all permission requests are granted, a letter of invitation will be distributed to all burns unit staff nurses, inviting them to participate in the study. Within this letter of invitation will be a short explanation which will comprise of the aims of the study, briefly what the participation will entail, the rights of the participants, discussion on confidentiality and phone numbers and email addresses of the researcher to allow participants to clarify any queries (see Appendix V for letter of invitation). With this letter of invitation will be a consent form, which must be read, signed and returned to the researcher by the participant in order to take part in the study (see Appendix VI for consent form). These letters will be distributed by the CNM in charge if permission is granted. The researcher will allow two weeks before selecting the final participants based on the set criteria, to ensure adequate time to consider the decision to participate, to allow for any questions or queries staff may have, and to allow an acceptable amount of time for all staff members to receive, read and come to a final decision regarding the invitation.

2.4 Data Collection:

As previously stated the researcher intends to carry out a qualitative study, in order to do so it will require one round of open ended, semi-structured, in-depth interviews. The researcher chose open-ended interviews as it allows participants to discuss their opinions, views and experiences fully in detail where as perhaps a set interview with closed ended questions may inhibit them to express their full opinions and feelings. With the use of semi-structured interviews the researcher will have prepared a topic guide or a certain amount of questions to be covered with each participant (Polit and Beck (2008). A face to face interview allows the researcher to observe any non-verbal communication but also allows both the interviewer and participant to seek any clarification necessary. The interviews will consist of six open ended questions, uniquely developed by the researcher for the sole purpose of this study (see Appendix VII for sample interview guide). The interviews are estimated to last 60 to 90 minutes however, these questions and times are merely a guide or structure to the interview sessions; it is the participant's responses which will lead the direction and length of the interview. The interviews will be audio-taped with permission from the participant to ascertain an accurate account of the interview which can be replayed for analytic purposes and anonymity will be assured during the course of the recording. Participants will

be reminded of their right to withdraw from the study or terminate the interview at any time before commencing the session. To ensure participants anonymity and privacy during the interviews, access to a private room within the hospital away form the clinical area will be negotiated with the Director of Nursing. The interviews will be carried out over a period of three days (two interviews a day), which allows the researcher to reflect and make adjustments as necessary.

2.5 Data Analysis:

"The purpose of data analysis is to organize, provide structure to, and elicit meaning from research data" (Polit and beck 2008). Data analysis will be ongoing in conjunction with data collection as Polit and Hunglar (1999) state as interviews are conducted, gathered data is synthesized, interpreted and communicated to give meaning to it. According to Burns and Grove (1999) qualitative data analysis occurs in three phases: description, analysis and interpretation.

The researcher will transcribe the interviews verbatim and analysis of the transcripts will be carried out by the researcher while utilising Colaizzi's (1978) seven step approach to descriptive data analysis (see Appendix VIII for Colaizzi's seven step process to data analysis). As the researcher intends to only have one round of interviews Colaizzi's seventh step will not apply, however the researcher will seek clarification of any issues at the time of interviewing. In order to achieve complete data saturation, thorough reading and re-reading is necessary to ensure all recurring information and variations are identified and only when no new information can be obtained is this achieved (Holloway and Wheeler 2002 and Polit and Beck 2008).

Volumes of data are gathered throughout the data collection process which requires the researcher to complete a reduction in data through categorising and identifying similar themes. This process allows the researcher to interpret findings more easily.

2.7 Pilot Study:

A pilot study is used to assist in the further development of a larger study it may be used in order to test study measures, estimation of interviews, testing validity of tools and estimation of outcome variables (Arain et al. 2010). Researchers benefit from carrying out a pilot study prior to the main study as it

allows for the identification of any weaknesses in the plans and allows time to rectify any necessary amendments before carrying out the remainder of the study.

In most cases it is recommended that a pilot study be carried out prior to the main research using 10% of the actual sample size, however as this study is a qualitative study with the aim of using 6 participants only one participant shall be used in the pilot study. This pilot study will be used to test the tools/frameworks trustworthiness, reliability, and also the interview location, audio recording sound, and time frames. This pilot study will be used as a method to discover any flaws in the current data collection plan, while also allowing enough time to rectify these before the main research takes place.

2.7 Robustness:

Rigor is associated with openness, scrupulous adherence to philosophical perspective, thoroughness in collecting data and consideration of all of the data (Burns and Grove 2009). Guba and Lincoln (1981) as stated by Morse et al. (2002), developed specific principles to examine trustworthiness and quality of research. These include credibility, dependability, confirmability, and transferability; as cited by LoBiondo-wood and Haber (2002).

Credibility evaluates quality and refers to truth in data (Polit and Beck 2008). By carrying out a pilot study this increases credibility this is also done by clarifying any issues at time of interviewing. Dependability refers to the stability of data over time (Polit and Beck 2008). Confirmability depends on others agreeing with the researcher's findings and interpretations (Parahoo 2006) to communicate trustworthiness of data. Transferability refers to the extent to which finding can be transferred to other settings (Polit and Beck 2008).

The researcher will incorporate these principles to enhance robustness of the study at hand.

2.8 Ethical Consideration:

All research studies present a number of ethical and moral dilemmas which must be identified and addressed prior to carrying out any research study in order to protect all participants from potential harm. This study will only commence once ethical approval has been achieved from the research ethics committee. The

following 4 ethical principles will be followed to ensure no harm will come to the participants.

2.8.1 Beneficence and Non-maleficence:

The proposed studies findings should benefit and cause no harm to the participants and society. The researcher aims to contribute to nursing practice and improve standards of care by carrying out this study. Psychological status of participants will be monitored as physical harm is unlikely. Privacy and confidentiality will be maintained at all times, all findings will be portrayed in a confidential manner no personal or identifiable information will be recorded or printed in the study. Audio taped interviews will be transcribed verbatim, thus no names will be recorded during the interviewing process. Once transcribed the data will be stored in password protected folders with restricted access and stored on an external hard drive which only the researcher will have access to. The Data Protection Act 1988 requires that data held on a computer must be accurate and up to date, it also allows the participants to view the information regarding themselves and to correct any errors if they so wish. It is very difficult to maintain anonymity when an organisation grant permission for such a study to be carried out, those in charge i.e. CNM's will often be aware of the staff members who are participating, thus all interviews will be coded and no names used so as participants responses are not identifiable.

2.8.2 Autonomy:

The researcher will respect the human right of free choice and will ensure informed consent is completed before carrying out any interviews. The researcher will ensure a regular review of what the participants have given consent to is carried out; this is referred to as a procedure of consent, which enables the researcher to renegotiate features of the consent form derived from the changing description of the inquiry (Munhall, 2001). All participants will be reassured that the option to withdraw from the research at any time without penalty or repercussions will be upheld. Kelly and Simpson (2001) recommend that researchers maintain close consultation and inclusion of all participants throughout the research process as there are some who may feel impervious to change.

2.8.3 Justice

All findings and results presented will be that of actual facts stated in the interviews. All participants' experiences and perceptions will be portrayed as they have done so in the interviews, no false information or accusations will be included in the final report.

Ethical issues may arise at any point during any study regardless of the scrupulous planning, therefore it is important that possible ethical issues are identified, prevented, and reviewed as best as possible prior to, during and after the study. Ethical principles provide direction to the possible issues not answers.

Chapter 3

3.1 Proposed Outcome:

The researcher intends to achieve with all the aims and objectives of this study. The researcher proposes to carry out this study with the hopes of raising awareness of the challenges associated with providing psychological care for burn victims. Through this awareness, current management may be assessed and challenged and in turn new practice developed to promote best practice in the clinical environment. From experienced qualified staff members encounters, other nurses may learn and add to their current nursing knowledge in this field. Each section of the proposed study will be documented, analysed and summarised for a final report which the researcher also proposes that findings be presented to all nursing staff of the burns unit in question and the director of nursing. With agreement and consent this study could be, in the future, followed up with an action research study to improve the psychological care being provided in burns units.

3.2 Limitations:

The researcher is a novice and this lack of experience will contribute to the limitations of the study. The small population sample size causes findings to only be relevant within the hospital it was taken from, and cannot be generalised outside of this study. In addition it is predicted that findings may benefit nurses and patient care in other burn units as a result of the knowledge gained. Qualitative research is not completely precise and complete objectivity and neutrality are impossible to achieve thus this may limit the accuracy of the studies findings (Holloway and Wheeler 2002).

3.3 Research Dissemination:

It is envisaged that the findings of this study will encourage new and improved nursing practice be developed and delivered in burn units nationwide. The researcher intends to present findings to colleagues at in service education days, with the hope that it will encourage all members of staff to reflect on the psychological care they provide to all patients. The researcher also proposes to submit the study for publication in various nursing journals.

3.4 Time Scale:

The Researcher aims to complete this study over a 15 month period. A table presented in the appendices outlines the estimates duration of each process (see appendix IX for time scale).

3.3 Resources:

The following expenses are an outline of expenses that will be required while undertaking this study:

Expenses	**Cost in Euros**
Travel cost (petrol)	100
Dictaphone/Batteries/Audiotapes	80
Phone and Internet Charges	150
Refreshments	50
Library Services	40
Stationary	70
Photocopying & Binding	100
Postage/stamps	20
Computer software/ printing/ink cartridges	300
Miscellaneous	200
Total	**1,110**