



Clinical RESEARCH/AUDIT



The nurse's experience of dressing changes

Comparisons are often drawn between qualitative and quantitative research. This article describes how qualitative research can be used to understand nurses' experience of dressing changes without arguing that one approach is better than the other. In a hermeneutic phenomenological study, 18 nurses from across the continuum of care (acute, residential and community care settings) participated in taped interviews about what it is like to change a dressing. Using the interviews as a basis, the author provides an understanding of this experience for nurses and provides a context for the impact of phenomenological research.

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KEY WORDS

Chronic wound care
Nurses' experience
Hermeneutic phenomenology
Dressings

Healthcare education often focuses on empirical research based on quantitative data collection, development of diagnoses, intervention strategies and quantifiable outcome measures. The majority of articles published in healthcare journals reflect the laboratory report style of prediction, control and measurement that has dominated healthcare research and practice. It is this form of research that readers will be most familiar with.

However, over the past 30 years, there has been a move within healthcare to view questions regarding human behaviour from a frame of reference that reflects the inextricable link of mind and body rather than follow the Cartesian duality that divides mind and body as separate entities (Osborne, 1994). Qualitative methodology, such as grounded theory, ethnography and

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hermeneutic phenomenology have offered researchers alternative frameworks with which to present the findings of qualitative studies (Polkinghorne, 1983).

The essence of hermeneutic phenomenology is to provide a deeper understanding of the phenomenon in question (in this case, the experience of changing a dressing). It is based on the interpretation of participants' words and meanings using art and literature to assist in providing a rich tapestry of writing and images for the reader. For this reason, the writing format and style may not be as familiar to the clinician (van Manen, 1997).

The intent of this paper is to provide the reader with an understanding of the value of this type of qualitative research. As healthcare providers who are concerned with maximising the health of our patients, hermeneutic phenomenology offers an opportunity to delve into the meaning by interpreting the experience for both caregiver and patient. This exploration may lead us to an increased self-awareness, which in turn opens us to the potential we have to achieve a greater understanding of what moves and motivates us when caring for patients with wounds.

A historical perspective of wound care

Wound care has traditionally been classed as basic patient care, along with other activities such as toileting and feeding. The task itself runs the risk of becoming identified as more

important than its actual effect when it is embedded in a documented, institutional structure. For example, the importance of adherence to the morning care schedule may diminish the focus on skin assessment or mobility issues during bathing. According to Doering (1992), if a nurse's main concern is the task itself, the focus of attention may narrow to the details of how the task is performed without consideration of how this task is relevant to the overall care of the patient. The fundamentals of patient care which are routinised, repetitive, and task-oriented appear to offer little opportunity for the caregiver to pay attention to the moment or be assured that the task at hand is truly in the best interest of the patient (Sherwin, 1998).

Origins

Language and the use of words are integral aspects of hermeneutic phenomenology, which is about interpreting meaning of experience. Meaning, as a multidimensional experience, includes the context of the origin of words because words provide a link between experience and expression. For example, locating the origin of the word 'wound' in the root of 'suffering' helps us understand that the underlying meaning reflects its origin as something that is about suffering. Although we may not actively think of the derivation of words as we communicate with one another, their original impact and significance underscores their meaning. Hermeneutic phenomenology is an approach that jostles

the subconscious to remember what connects us to our roots.

The origin of the word wound comes from Old German (*wunde*), but its earlier root comes from the goth, *winnan*, meaning to suffer (Hunter and Morris, 1899). A modern definition is: 'any break in the tissue, skin or organ that is present through force (violence), accident or surgical incision' or 'any injury or slight to the feelings or reputation' (Oxford Dictionary, 1995). However, the physical wound with which nurses are most familiar is that which is caused by trauma to underlying tissue, creating non-viable tissue resulting in a pressure ulcer. Interestingly, trauma comes from the Greek 'wound', the root of which is *tere*, meaning 'to rub, turn' (Etymonline, 2005). Rubbing of the skin is one of the causative factors of pressure sores.

Wound care was one of the earliest roles for nurses — particularly when caring for casualties of war (Majno, 1991; Maher, 1999). In fact, the word dressing has its origin in the military terminology of alignment of columns of troops, from the Old French, 'dresser', meaning 'put right, put straight', from the Latin, *directus*, meaning 'direct, straight' (Hunter and Morris, 1899).

The majority of the research literature that relates to wound care focuses on assessment of the wound and treatment options. While this literature offers indispensable information and practical tools for providing good evidence-based care, research literature on the topic of the nurse's experience of dealing with wounds is scarce. In general, the focus of experiential research has been on the patient and their family's response to a health issue or life experience (such as diagnosis of cancer, birth or living with a chronic illness). Nurses themselves have been reluctant to explore the meaning of 'mundane' aspects of care (Lawler, 1991) despite the importance given to these often repetitive and 'basic' tasks (Lomborg and Kirkevold, 2005; Doran et al, 2006).

Missing in the literature on the topic is discussion of nurses' attitudes and thoughts at dressing changes, which are little understood or explored. Nurses' actions impact profoundly on wound

healing and the patient's quality of life. Thus it is important to understand the nurse's experience of dressing changes.

Phenomenology is an approach that allows the exploration of individuals' relationships with the world, to understand the meaning of phenomena as completely as possible. It is the study of the world as it is experienced investigated through descriptions of these experiences, as removed from everyday life (van Manen, 1997).

The quest for a methodological approach

Nursing encompasses the bio-psychosocial and spiritual complexities of human beings who live in a multidimensional world.

These complexities can have intense meaning and can have an impact on the person at micro, meso and macro levels. The intricacy of these overlapping layers can be either teased apart and separated to address distinct issues, or examined as a whole to take into account the essential relatedness of each component. Each of these approaches can be used to come to a more profound understanding of the experience of chronic wound care. Hermeneutic phenomenology enables the researcher to both tease apart and bring together the elements of wound care leading to an understanding of the meaning of the experience of providing wound care.

In this study, interviews were carried out with a purposive sample of 18 nurses from the three care settings: acute, residential and community care, with 6 from each area. Letters of invitation were sent out to wound care colleagues with a request to post the invitation to their colleagues who might be suitable. Those selected had to be nurses with at least a year of experience providing wound care as part of their regular nursing care (i.e. not wound care experts), were not nurses with whom the author had worked previously, and were willing to participate in taped interviews with open-ended questions. Six nurses from each sector were interviewed in a site removed from their clinical work. The interviews lasted for one to two hours, and transcriptions were used as the basis of the interpretive work of the study. The initial question asked of each nurse

was 'Tell me what it is like to change a dressing'. From this point, the interviews developed following the participant's direction, and each nurse was able to freely discuss this one question. Direction was only provided to avoid obvious tangential discussions/topics.

It was interesting to see whether there were differences in how the nurses from the three different settings talked about their experiences of dressing changes. The relationship with physicians, time constraints and the workplace (staff mix and environment) all could have a potential impact on the nurse's experience of changing dressings.

The structure of nursing is rooted in the past and is traditionally military in design. Hierarchical relationships, regimented schedules and rules of conduct still form the framework for much of the nursing environment. Wound care has been an area where the doctor-nurse relationship has had a traditionally paternalistic pattern. However, the past decade has seen a substantial shift in how the relationship is expressed, as well as the ways in which nurses implement their roles.

As van Manen (1997) asserts, the world encompasses space, time and relationships and any attempt to separate each of these aspects can threaten the true meaning of the experience. The language of nursing culture and literature describes the impact of workload, shift work, injuries or models of professional practice or abstract concepts such as empowerment. This precludes the richness and depth of meaning as nurses move through the working day. There is little within the literature that refers directly to the experiences of the nurses' day-to-day life.

Providing nurses with the opportunity to reflect upon a specific component of their practice (in this case, changing a dressing) in an environment that was removed from their usual workplace, gave them the space to recollect what was important to them about this experience. The luxury of sitting down in a quiet environment, where attention was focused on their descriptions of something they



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Figure 1. This Happened

The intern and I begin our rounds.
 In room two, the intern watches me;
 he doesn't like this patient anyway—
 she's messy, a see-through plastic tube
 pulls bile from her stomach
 to a bottle near her head.
 A small balloon inside her throat keeps pressure
 on vessels wrecked by years of gin.
 The patient's wide awake,
 But she can't talk.
 I see her eyes open, her skin
 pale at the moment these veins
 blow, like a tire blows.
 Blood backs up her nose.
 She tries to sit;
 her wrists are tied.
 I take her hand and say, OK, OK.
 The intern leaves.
 Next the patient's gut lets go.
 Stool and blood clot between her legs,
 Hot and soft, not like sex,
 More like giving birth. OK, I say.
 We let our fingers intertwine.
 By 8:15 the woman calms.
 Clots thicken in her throat;
 she holds her breath.
 At nine, blood coins
 close her eyes. I breathe deep,
 stroke the patient's arm.
 The intern,
 who went downstairs to sleep,
 will ask me later.
 But what happened here
 can't be said again
 and be the same.

usually did as routine, enabled them to describe in detail how they go about their work, and what is important to them. For example, Pam, a community nurse, recollected her first visit to a patient at home: '...I'll call when I'm on my way, just to remind them that I'm coming, because I always make sure they know exactly what's happening. Then when I arrive at the door, I'll say "Hi, I'm Pam, and I'm going to do this dressing"...'.

'In the community we don't have the luxury of sterilised dressing trays, so we have a routine with boiling instruments in a pot... so I have a lot to say to that patient on the first visit. Not only am I coming as a new person, a stranger, I have to build up some kind of rapport with them, I have to explain the routine and if I can I'll even say [to them]: "Can you think of some pot with a lid for future visits?". I usually bring in forceps and the packing and whatever else we need to do the dressing... I explain that, I always take my time and say it in layman's terms.'

Pam described how her interaction with the patient at the first visit is imbued with the sense of the clinical phronesis, or the wisdom of practice. This approach to the patient's needs as described by Schultz and Carnavale (1996) comes from a perspective that is wholly attuned to the patient. It is a practice that is open, attentive and accepting. While this approach would seem to clash with the realities of the clinical world of time, space and relational transactions, it appears to relax the barriers as the nurse relates to the here and now of being present with the patient.

Time, for nurses providing wound care, is linked to the desire to provide holistic care and the recognition that the wound has more complexity than what can be seen on the surface. The nurses in this study were aware of the need to address the amount of work they have to do in order to take the time required for dressing changes. The constraints of 'clock time' — linear time — can hinder the nurses to do the best they could under the limits imposed by multiple demands. The nurses described that as they developed more experience with wound care (attending courses, spending time with mentors, etc), they became more aware of the complexity of the wound and the management issues around treatment decisions. As their knowledge of treatment options increased, the time required to spend on wound management also increased. Thus the increased knowledge about wound care created time constraints of its own.

It is not true to the nature of human beings to maintain boundaries and isolation (Vanier, 1998). There is a risk of 'messiness' that nurses providing wound care seem unconcerned about, but it is the experience of intimate contact with another body that makes it difficult to objectify the experience.

Margaret, a nurse in acute care said: '...for the patient [the wound is] a huge issue. It might be the one thing that's causing stress in their life at this point in time. It's difficult to keep who we are and reflect it on them and make them try to be more like who we are, or try to see things from our perspective. And,

as nurses, we need to learn how to see things from their perspective.'

In the community, the nurse is faced with the patient's sense of entitlement within the home domain, where the ability to support the patient's perspective must be balanced by the purpose of the nurse's visit. For example, Pam who works in community care said: '...they put a patient hat on when they're in hospital, whereas when they're at home they have much more control. It is their home and you do have to respect that, regardless of whether you would like to live the way they live or not...'

The hospital environment does not always allow a relationship to develop. In fact, hospitals do little to support relationship development between nurse and patient, as patient assignment is usually determined by proximity rather than continuity of care. While this may be the nursing experience in acute care, it comes with a caveat. Iris, a nurse who works in acute care, said: 'I find that for the 12-hour shifts it's much more difficult for that consistency, because you're only there two days and then you're off for two days. When I worked [eight-hour shifts] I'd be there for 3-4 days or I might have one day off and then I was back in again, so you were able to be more consistent in the care that you gave.'

Despite the challenges of time, space and relationships, the nurse remains vigilant and attuned to the unspoken and intimate needs of the patient. Nurses find themselves in the dark hours of the night and early morning as the solitary messenger who can carry the fear and pain of the unknown experience and accompany the patient or the patient's family as they struggle through. Many times, it is the nurse who bears witness to the horror of the fungating wound or who is there as the patient draws his last breath.

The real quality of these 'present moments' is difficult to capture. The poem 'This Happened' by Cortney Davis (Davis and Schaefer, 1995) (Figure 1) describes one such experience from a nurse's point of view showing how nurses begin to search for the words to



Urgo Silver



share the richness and the importance of the relationship between themselves and their patients.

The experience of using an interpretive phenomenological approach to study the topic of changing a dressing has been a challenge. As van Manen asserts, there are no definite answers or solutions when using this approach. The point is that no conceptual formulation or single statement can possibly capture the full mystery of this experience' (1997), the approach of descriptive studies, questionnaires and rating scales lack the opportunity to express the wholeness of meaning within patient care. Rather, it is a way of unlocking hidden perspectives, and providing the opportunity for expressions of thoughts and feelings that nurses are not accustomed to speaking aloud. The nurses in this study were often surprised at their own words and response to the simple question, 'What is it like to change a dressing?'

Gabrielle, a nurse who works in acute care said: 'I didn't realise I had this much to say... I've never really had the opportunity to talk about what I think about nursing and what I do as a nurse... I guess I didn't realise how strongly I felt, or maybe I did, I just didn't have the words to say it, or thought anyone would be interested in hearing it.'

While researchers attempt to understand what nursing practice and the nursing environment mean to nurses, the approach of descriptive studies, questionnaires with open-ended questions and rating scales seem to miss the whole meaning. Nurses, reading about themselves in the nursing literature, may come to expect a paler version of themselves. When given the opportunity to speak unfettered, they may be surprised by their own words.

I too was not expecting the powerful sense of connection the nurses felt for the work they do and the patients they look after. My clinical observations of nurses changing dressings along with the overall thrust of nursing literature about wound care led me to conclude that nurses found wound care to be a time consuming and distasteful task.

Hermeneutic phenomenology involves the divesting of assumptions and biases as the researcher prepares to become open and non-judgmental. 'One begins to become less assuming, often abandoning assumptions about another or another's experience, and adopts a stance of "unknowing"' (Munhall, 2001). As the researcher in this study, I felt that I had divested myself of these assumptions as the conversational interviews took place. I became aware that the nurses in this study were not responding to the wound or to the patient in the ways described in much of the literature where the focus is on the practicalities of prevention, assessment, and treatment of chronic wounds. In fact, these nurses were keenly aware of the impact of the wound on the patient's life. While this may have been in relation to the selection or self-selection of the participants of the study, but the responses were so uniform among these nurses from different settings and with a variety of years of experience and backgrounds. It thus seems to be less a feature of their self-selection than expressing something that in fact has meaning for nurses — that they do feel for the patient's experience.

Nursing has often been described as a hands-on profession. The nurses in this study felt strongly that the 'laying on of hands', this intimate touch, connected them with the patient and the patient's experience. This aspect of nursing most powerfully defined who they are as nurses. The ability to touch and interact in this physical way manifested and exemplified the healing, caring aspects of the role of the nurse. Far from being repulsed, the act of changing a dressing gave these nurses a sense of accomplishment and control. Barbara, who works in long-term care said: 'I think the things with wounds is you can watch them at the worst stage and know that what you're doing each time you change it is helping them, watching it heal. And you feel a feeling of accomplishment. Wow, you know, what I did mattered and it was successful. I think as nurses, we like knowing that what we've done has been successful and helps somebody.'

'We can give medication 'til we're blue in the face sometimes and we're not sure

exactly what it's doing within. Ok, with blood pressure medication, there is some evidence, but the actual visualisation of something healing is an accomplishment. It's like a pat on the back that we give ourselves because all we've done is heal. That's how I feel'.

How the nurses worried, cared and supported their patients and their wounds reflected this deep, essential feeling for what it is nurses do as they provide wound care. It is what these nurses described as the great satisfaction of nursing and why they love being nurses. This is not to say that frustration over time constraints, inconsistency of care providers, and limitations of knowledge were not significant. Deb, who works in long-term care said: 'There's a lot more to it all. The awareness of them being them, that they are a person, it's not just come in, look at the foot and leave. They're a package deal and they need a lot more than what they get. It's too bad, like I said, the time factor; that's the only one thing I think is disappointing about nursing is there's just not enough time.' I think most nurses feel that they wish they could do more.

Implications for nursing and future research

It would be of value to use this knowledge as a means of revealing the unspoken experiences of deep caring that nurses may in fact keep hidden from view. Hermeneutic inquiry provides a powerful tool for researchers to aid in the interpretation of experience for both participant and the researcher. The results of studies such as this one can then be used to cultivate self-awareness and provide a supportive, positive approach to improving care.

Possible future research based on this study might include expanding the participant's experience to focus on male nurses, students and novice nurses since individuals within each of these groups may provide different perspectives on wound care which would offer insight into the lived experience of these different groups.

There are very few phenomenological studies of the experience of patients and their families within the context of wound care (living with chronic wounds) (Langemo et al,

2000; Beitz and Goldberg, 2005). The voices of patients and their families need to be heard. These studies could be used to create an environment that is open to change, for example, through focus group discussions which in turn could lead to effective implementation of nursing practice guidelines.

Qualitative research does not provide 'answers' or conclusions in the same way as quantitative research. It can rigorously challenge one's assumptions and biases. It is a robust methodology that forces engagement and implicates the reader in the process in a way that can be unsettling to one accustomed to the more predictable format of quantitative research. However, it is my belief that both of these approaches serve to assist in the quest for truth and understanding in the complex world of human health. **WUK**

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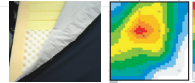
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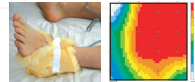
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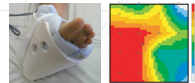
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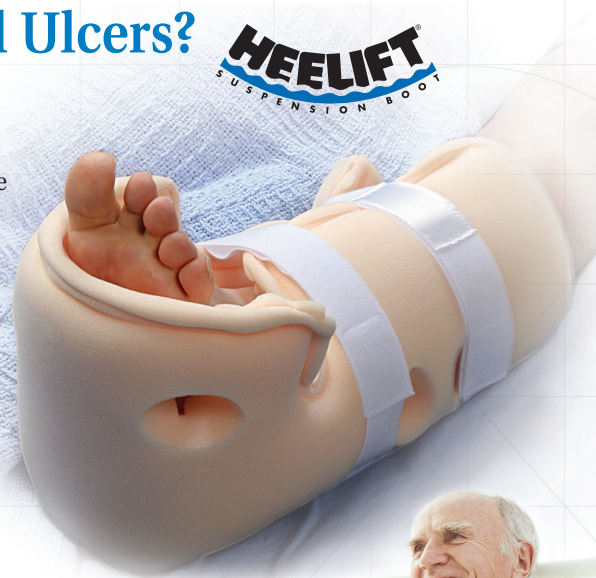


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