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Parent and Clinician Communication During Paediatric Burn Wound Care: A Qualitative Study

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ABSTRACT

Purpose: To thematically describe parent-clinician communication during a child's first burn dressing change following emergency department presentation.

Design and methods: An observational study of parent-clinician communication during the first burn dressing change at a tertiary children's hospital. Verbal communication between those present at the dressing change for 87 families, was audio recorded. The recordings were transcribed verbatim and transcripts were analysed within NVivo11 qualitative data analysis software using qualitative content analysis.

Findings: Three themes, underpinned by parent-clinician rapport-building, were identified. Firstly, knowledge sharing was demonstrated: Clinicians frequently informed the parent about the state of the child's wound, what the procedure will involve, and need for future treatment. Comparatively, parents informed the clinician about their child's temperament and coping since the accident. Secondly, child procedural distress management was discussed: Clinicians and parents had expectations about the likelihood of procedural distress, which was also related to communication about how to prevent and interpret procedural distress (i.e., pain/fear). Finally, parents communicated to clinicians about their own distress, worry and uncertainty, from the accident and wound care. Parents also communicated guilt and blame in relation to injury responsibility.

Conclusions: This study provides a description of parent-clinician communication during paediatric burn wound care.

Practical implications: The results can assist healthcare professionals to be prepared for a range of conversations with parents during potentially distressing paediatric medical procedures.

Introduction

Effective healthcare communication between patient and clinician is an important aspect of clinical procedures (Levetown, 2008). Communication needs to be clear, direct, and at the patient's and family's level of understanding (Fisher & Broome, 2011; Hart, Kelleher, Drotar, & Scholle, 2007; Wanzer, Booth-Butterfield, & Gruber, 2004). Effective communication can build rapport and reduce distress and discomfort (Hart, Drotar, Gori, & Lewin, 2006; Levetown, 2008; Wanzer et al., 2004). Effective communication is associated with patient satisfaction, treatment adherence and improved patient health (Charlton, Dearing, Berry, & Johnson, 2008; Hart et al., 2007; Nobile & Drotar, 2003; Wanzer et al., 2004). Comparatively, poor healthcare communication can be negative and distressing for patients (Nagpal, Vats, Lamb, Ashrafian, Sevdalis, Vincent, & Moorthy, 2010) and is a common reason for complaint (Reader, Gillespie, & Roberts, 2014). Adult patient-clinician communication has been researched extensively (Stewart, 1995; Stokes, Jacob, Gifford, Squires, & Vandyk, 2017), but less attention has been given to parent-clinician communication during paediatric healthcare (Giambra, Haas, Britto, & Lipstein, 2018; Hallström, Runeson, & Elander, 2002; Watson, Kieckhefer, & Olshansky, 2006; Wissow et al., 1998). Parents not only advocate for their child during clinical procedures (Giambra et al., 2018; Sng et al., 2017), but are often distressed

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themselves due to their child's illness or injury (Foster, Young, Mitchell, Van, & Curtis, 2017). While the child's experience during paediatric burn wound care has been well documented (Egberts, Geenen, de Jong, Hofland, & Van Loey, 2018; McGarry et al., 2014), this paper focuses on the parent's experience. Understanding what is communicated between parents and clinicians may affect how parents support their child and also their own coping.

Parent-child-clinician communication is task-related and relational in nature (Callery & Milnes, 2012; Foster et al., 2017; Giambra et al., 2018; Levetown, 2008). Task-related communication involves the parent and clinician asking questions and providing information, while relational communication involves the clinician building a therapeutic relationship with the family, including reflecting feelings, showing compassion, and providing comfort and care. A meta-synthesis found children were unlikely to interact directly with nurses, relying on parents to communicate their needs (Sng et al., 2017). Qualitative studies highlight how inclusive and caring communication and behaviour promotes positive relationships and improves accuracy of communicated information (Fisher & Broome, 2011). Further, clinician trust strongly predicts parental adherence to care (Baenziger et al., 2020), showing manner is important for all parties.

Five observational studies have investigated parent-clinician healthcare communication (Callery & Milnes, 2012; Giambra et al., 2018; Hallström et al., 2002; Svendsen, Moen, Pedersen, & Bjørk, 2016; Wissow et al., 1998). Hallström et al. reported several parental needs during paediatric hospitalisation: The parent (and child) feeling secure, open clinician communication, perceived control and parental competency. Wissow et al. found parents were more engaged and reported higher satisfaction when clinicians provided counselling and information (replicated in a parent-reported survey, Hart et al., 2007). Callery & Milnes and Giambra et al. reported parent-clinician variation in agreeableness about medical care and communication during clinic visits: Clinicians focused on explaining medical information, while parents showed more active listening or understanding. Only Svendsen et al. (2016) studied communication *during* a paediatric clinical procedure (peripheral vein cannulation), finding parents reacted to paediatric procedural distress by working with or opposing the clinician, depending on perceived procedural success. Parental expectations regarding their role in paediatric clinical procedures may relate to the clinician's communication before and during the procedure. Further research is required to understand usual parent-clinician communication during challenging and painful procedures that may precipitate child (and parent) distress.

One example is burn wound care. A paediatric burn and associated wound care is distressing and potentially traumatising for children and their parents (Bakker, Maertens, Van Son, & Van Loey, 2013; De Young, Hendrikz, Kenardy, Cobham, & Kimble, 2014; Egberts, Geenen, et al., 2018; Kornhaber, Childs, & Cleary, 2018; McGarry et al., 2015). This is compounded by developmental difficulties of understanding and managing distress (anxiety, fear, pain) in the most common age group of affected children: 1–4-years-old (Stockton, Harvey, & Kimble, 2015). Parents commonly report high guilt, posttraumatic stress symptoms (PTSS), depression, and anxiety during the first month after the injury (De Young et al., 2014; Egberts, van de Schoot, Geenen, & Van Loey, 2018). Parents express signs of distress during the acute wound care phase of burn recovery (Egberts, de Jong, Hofland, Geenen, & Van Loey, 2018), and some parents report burn wound care as the most traumatic part of the injury (De Young et al., 2014; De Young, Kenardy, Cobham, & Kimble, 2012). Burn wound care can be distressing because it provides reminders of the injury, and painful because physiological changes increase pain sensitivity and reduce effectiveness of pharmacological pain relief (Brown, De Young, Kimble, & Kenardy, 2019a; Connor-Ballard, 2009; Cooper & Pavlin, 1990; Sharar et al., 2008). Procedural distress and PTSS are also positively related to pain (Brown, Kenardy, & Dow, 2014; von Baeyer & Spagrud, 2007). Despite the emotional nature of these procedures, most parents prefer to be present and report a sense of control if present (Egberts, de Jong, et al., 2018). Burns clinicians report understanding parents need to be in a safe, secure and trusting environment to process feelings of guilt and reinforce their parental identity (Lernevall, Moi, Gjengedal, & Dreyer, 2019). Although parents' experiences of paediatric burns wound care have been explored through interviews (Egberts, Geenen, et al., 2018; Morley, Holman, & Murray, 2017), observations of parent-clinician communication has not.

Parents and clinicians report procedural communication and relationship building is important (Callery & Milnes, 2012; Fisher & Broome, 2011). Parents prefer to be informed about what to expect from burn wound care, how burns heal and how to support their child (Egberts, de Jong, et al., 2018; Morley et al., 2017; Power & Franck, 2008). Parents also desire clinicians to have strong communication and pain assessment skills, to recognise parental distress, and provide debriefing after wound care (Smith, Murray, McBride, & McBride-Henry, 2011). By understanding what is communicated during paediatric burn wound care, clinicians can better respond to the parents' needs, wishes, and experiences, to support psychological recovery. As the child's primary care giver, parents can also help their young, preverbal child to cope if they themselves are supported.

Purpose

While research has investigated the qualitative experience of communication during other paediatric clinical procedures (Fisher & Broome, 2011; Hallström et al., 2002; Svendsen et al., 2016; Wanzer et al., 2004; Watson et al., 2006), little is known about what is communicated between parents and clinicians during paediatric burn wound care. To address this, we aimed to thematically describe parent-clinician communication during the first burn dressing change following Emergency Department (ED) presentation, using an observational study. The findings can improve provision of family-centred and trauma-informed care for young patients and their parents.

Design and methods

Research team

The team included professors of burns research and clinical psychology, research fellows with nursing/PhD and clinical psychology Masters/PhD qualifications, a clinical nurse consultant, and researchers with undergraduate psychology training. Two authors have over 5 years of experience supervising and conducting qualitative research.

Setting

The Pegg Leditschke Children's Burns Centre is a state-wide service, annually managing over 1000 paediatric burns. Together with the Acute Pain Service, the Centre has a pain management protocol, as follows. Clinicians assess analgesic requirements based on patient risk factors (body location involved, mechanism of injury, age, previous procedural concerns), which may be amended after family consultation. Analgesics commonly include ibuprofen, paracetamol and oxycodone, and potentially intranasal fentanyl or midazolam. The Centre also utilises non-pharmacological pain relief techniques including clown doctors, music therapy, and distraction (bubbles, smart devices, etc.).

Participants

Participants were recruited as part of a prospective observational study on family interactions during paediatric burn wound care (Brown, De Young, Kimble, & Kenardy, 2018a, 2018b). Previous research focus sought to quantify the parent-child distress relationship, while the current paper qualitatively studied parent-clinician communication.

Ninety-four families were approached between September 2015 and July 2016. Two families declined involvement and five families' data were retrospectively excluded. Families were excluded if the child was not given analgesia prior to the procedure, had a comorbid brain injury or developmental delay, the family spoke insufficient English, or the injury was suspected to be intentional. The female researcher (E.A.B) approached each family in the hospital to explain the study purpose and tasks. The final sample consisted of 87 families of children aged 1–6-years-old presenting for the first dressing change. All families presented with at least one parent (22 instances both parents were present, 14 instances 1–2 parents plus grandparents, siblings, uncle, family friend, or au pair were present). In total, 74 mothers and 35 fathers were recruited.

The sample represented most burn presentations (Stockton et al., 2015). The mean child age was 2.95-years-old (*median* = 2.00, *SD* = 1.72). Most injuries were scalds (48%) or contact (48%), the percentage of total body surface area burned ranged from <1–12%, and burn depth ranged from superficial-partial to full thickness.

All parents provided written informed consent. All clinicians ($n = 37$; doctors, nurses, occupational therapists, physiotherapists, social workers) were previously informed of the study purpose and methods and consent was implied through their continued presence. The study was approved by the Children's Health Queensland Hospital and Health Service and The University of Queensland Human Research Ethics Committees. Queensland Children's Hospital provided institutional approval.

Data collection

The female researcher (E.A.B) was present for the dressing removal and debridement (removal of dead tissue and wound cleaning). The audio recording began three minutes before the dressing removal, until two minutes after debridement. Recordings ranged from 5.95–23.83 min.

Data analysis

Recordings were transcribed verbatim and transcripts analysed using qualitative content analysis (Elo & Kyngäs, 2008) in NVivo11 qualitative data analysis software. Field notes were not made. The goal of this inductive analysis was to describe the communication content as a conceptual framework. The first 15 transcripts were independently coded by two authors (E.A.B., M.E.). All meaningful fragments were assigned a code, reflecting the main content of the fragment. These codes were reviewed in detail until consensus on a derived provisional coding scheme. The two authors divided and independently coded the remaining transcripts, following the provisional coding scheme. To maintain intercoder consistency, new codes and questions were discussed as required. Subsequently, open codes were grouped and merged to identify overall themes and subthemes and create a hierarchical structure. Most codes were identified in the first 40 transcripts, with occasional new codes identified thereafter. Although thematic saturation was achieved (the final 11 transcripts revealed no new themes), sampling was not based on saturation, as the sample size was predetermined by the larger research project. Peer debriefing was used to establish agreement and enhance the trustworthiness and credibility of the findings: Three authors (B.G., K.S., J.K) provided feedback on the data interpretation and identified themes. Transcripts were not returned or discussed with participants.

Findings

Three overarching themes were identified and integrated in a model to describe parent-clinician communication during paediatric burn wound care. The themes include sharing knowledge, child procedural distress management, and parental emotional disclosures (see Fig. 1). The model reflects the themes are interrelated: Communication in one may affect another (e.g., clinician sharing knowledge about the wound may evoke parental distress; clinician providing procedural information may assist procedural distress prevention). Parent-clinician rapport-building is presented in the centre to underlie all themes.

Parent-clinician rapport-building was commonly observed: Clinicians greeted the child and parents, introduced themselves and explained their role. Sometimes clinicians asked the child's name, sometimes parents asked the clinician's name. One clinician remembered the child from ED. Clinicians almost never asked about the parent's well-being, except one asked a pregnant mother about her health. Rapport-building was observed through parents and clinicians sharing jokes and talking about nonprocedural topics (i.e., cake recipes). Some clinicians demonstrated reflective listening and empathy towards the parent's experience:

> *Clinician: What time did you get out of emergency on Friday?*
> *Parent: Umm… don't know what time it was. We didn't get home until almost 8.*
> *Clinician: Long day.Parent: Yeah.* [Transcript 12].

Parents commonly expressed gratitude, thanking and praising the clinician's procedural ability.

Sharing knowledge

Clinicians and parents shared knowledge according to four subthemes: Wounds, procedure, child, and further treatment.

Wounds

Clinicians provided information about the wound. Injury severity was frequently discussed. Clinicians commented on the look of the wounds, expectations regarding time to heal and itch, the possibility or likelihood of a skin graft, risk of scarring, and offered parents to view the wound. Parents asked questions about these topics and commented on the state of the wounds, noticing improvement and expressing concerns or relief. Clinicians made objective (e.g., burn depth) and subjective comments (e.g., whether the injury looked good or bad). Clinicians regularly expressed outcome uncertainty: "*So we'll put some dressings on it, and we will see you guys again next week and I don't suspect we need a skin graft, but we can't say for sure*" [Transcript 21]. Clinicians also explained the wound healing process, demonstrating where the wound showed reepithelialisation. The treatment itself was discussed: Efficacy of and experiences with the dressing, and previous first aid or ED care. How and when the burn occurred was also discussed. Mostly, the clinician was positioned as the wound knowledge expert. Occasionally parents took a more active role, sharing information and opinions about the wound, previous medical care, or alerting the clinician to wound care needed. Parents occasionally asked about alternative treatments, including using a natural oil (jojoba) instead of moisturiser after reepithelialisation. Clinicians also confirmed wound locations with parents.

Procedure

Clinicians generally took an expert role, while parents asked questions and sought clarification. Clinicians often prepared the child and parents for what to expect, by explaining the procedure steps: *"We're going to take the dressing off, the doctors will have a good look at it and we'll work out a plan to see how… how it's looking and I'll put the dressing back on and then [you can] go home."* [Transcript 16]. Clinicians also explained the procedure would help with healing and recovery. Occasionally clinicians demonstrated the procedure on the parent first. Either by repeating the clinician or taking initiative, parents gave preparatory instructions (e.g., to position the child so the clinician could access the wounded area easily), procedural information (e.g., about washing the wound), and explanations about the necessity of procedure (e.g., for healing) to the child. Sometimes parents asked the clinician whether

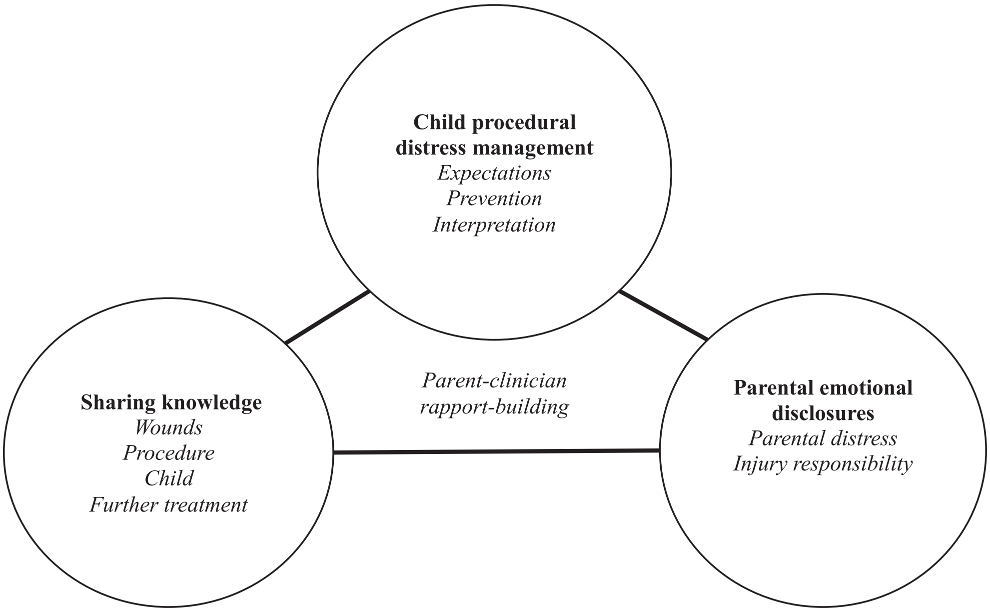

Fig. 1. Integrative model of the communication between parents and clinicians during young child burn wound care.

the procedure will hurt, or about analgesic side effects. Parents commonly reflected whether the procedure went better or worse than expected.

Child

Parents provided most of the child information, for example, the child's general temperament, *"In general, he doesn't like a lot of things on his hands, he gets a bit iffy about it"* [Transcript 3]. Clinicians also guessed child behaviour and temperament, *"Are you a quiet little kid?"* [Transcript 72].

Parents and clinicians occasionally discussed how the injury had impacted their child's behaviour. Parents asked if the child's coping with injury was normal, while clinicians inquired about the child's behaviour:

> *Clinician: …has he been up and walking?*
> *Parent: yeah.*
> *Clinician: Great. It's not stopping him in any way?*
> *Parent: no* [Transcript 44].

Some parents also shared how they tried to accommodate their behaviour to the child's needs, *"…we were very low key over the last couple of days, we've had some TV time"* [Transcript 3]. Clinicians generally reassured the parent they had made the right decision.

Further treatment

Clinicians provided most of the information about further treatment (procedures and home care). Clinicians sometimes explained when a skin graft might be needed. Parents also expressed uncertainty regarding the possibility of a skin graft. Parents and clinicians regularly discussed the next appointment time, with parents often asking whether they would need to come back for further treatment. Sometimes clinicians considered how far away the family lived when scheduling another appointment. Parents and clinicians also discussed caring for the child's wounds at home:

> *Clinician: So, the thing with a burn, you want them to be moving around as much as possible – it helps to stretch that skin that's new that's trying to um, heal over the top… and another big thing is lots and lots of moisturiser if there's any areas that are left over –*
> *Parent: What sort of moisturiser? Oh, you mean like the unbroken skin?*
> *Clinician: Yes. So, on any healed skin, um, lots of moisturiser – that just helps it from drying out like his lips – because it gets really dry, they want to scratch it, and that delays healing…* [Transcript 72].

Child procedural distress management

Parents and clinicians discussed child procedural pain/distress management through the lens of expectations, prevention, and interpretation.

Expectations

Parents and clinicians stated whether they expected the procedure to be painful. A clinician explained, *"Now we're going to do this nice and quickly, might be a little bit sore but I'll try and be as quick as possible, ok? So we're just [going] to try and get some of this skin off the blisters [because] it means it will heal quicker"* [Transcript 56]. Clinicians also expressed expectations of child distress to prepare the parents: *"[There are] a lot of blisters down there that we need to take off. So [colleague] is going to have to hold her nice and firm, but she will cry, so be ready"* [Transcript 83]. Some parents expressed negative expectations about the child's reactions, based on previous medical experiences: *"She's saying, 'I know [the clinician] will give me pain', you will give her pain..."* [Transcript 80]. During the procedure, parents expressed concerns about the child's coping. Afterwards, parents sometimes communicated they had not expected the child would be distressed.

Prevention

Parents and clinicians attempted to prevent procedural pain and distress. Clinicians initiated most communication. Beforehand, clinicians commented how they would minimise child distress, for example, by completing the procedure quickly. Clinicians instructed parents on helpful procedural behaviour (positioning the parent close to the child, holding the child, allowing the child to play), and post-procedural behaviour (instructing the parent to cuddle with the child, allowing the child to eat/play). Parents sought clarification about these behaviours. Occasionally, parents informed the clinician the organised strategy to minimise child distress (e.g., television) would not work for their child. During the procedure, clinicians and parents made and repeated reassuring statements to ease child distress. Clinicians and parents also collaborated to distract the child with nonprocedural topics:

> *Parent: It was [the child's friend]'s birthday… two weeks ago, did you say Happy Birthday?*
> *Clinician: Did you blow out the candles on the cake? Did you go, (blowing sound) to all the candles?*
> *Parent: What did [friend] do to his cake? He got to bang his cake didn't he? A piñata cake.*
> *Clinician: Wow. And was there things all in the cake?*
> *Parent: Chocolate*
> *Clinician: Chocolates!* [Transcript 7].

Sometimes, clinicians asked parents to hold the child according to the hospital-wide nursing standard for procedural holding. When siblings were present, clinicians would decide whether to include (instruct the sibling to blow bubbles for the child) or exclude them (suggest the sibling leave).

The use and effectiveness of analgesia was discussed. Some parents asked if and what analgesia had been given, and if more was required. Clinicians explained and confirmed that analgesia had been given and sometimes paused the procedure to increase the dose. Once, when a child was highly distressed, their parent demonstrated advocacy,

> *Parent: He's going "stop…"*
> *Clinician: We're just going to stop a minute. We're going to have a bit of a pause for a minute… let's give you a bit more medicine…* [Transcript 35].

Occasionally, parents and clinicians failed to collaborate to prevent procedural distress. Some parents did not engage while clinicians attempted to minimise the child's discomfort, and occasionally parents actively (but perhaps inadvertently) frightened the child, *"It's just a little wash… to make sure there's no germs going into it, okay? Because you don't want your fingers to fall off…"* [Transcript 25].

Interpretation

Parents and clinicians interpreted the child's procedural behaviour, particularly the child's coping or reaction to analgesia. Parents also sought confirmation about the child's coping. The child's experience was frequently reflected, for example, when adhesive remover was used prior to dressing removal:

> *Clinician: Just a little spot on the belly…*
> *Child:Ah…*
> *Parent: Is it cold on your belly?*
> *Clinician: It's cold, isn't it!* [Transcript 12].

Parents and clinicians responded to the child's pain/distress in different ways. Parents and clinicians often acknowledged the child's pain and apologised to the child. Sometimes, parents and clinicians positioned the clinician as responsible for the pain. Some parents commented on the child's appearance, coping or distress behaviour, and expressed sympathy for the child. Other parents were not sympathetic: One commenting pain was "*part of the journey of life*". Sometimes, clinicians offered explanations for the child's distress, explaining the first dressing change was usually the most distressing or the exposed nerve endings were sensitive. Some clinicians made assumptions about the child's distress based on wound severity or what part of the procedure they considered painful. One clinician suggested the distress was related to the memory of the burn rather than the procedure: *"…because little kids they just remember how it's happened so he may get [upset]… more than it actually being sore [now]…"* [Transcript 48].

Parental emotional disclosures

Parents disclosed emotional content to clinicians regarding their child's injury and wound care, specifically about distress and injury responsibility.

Parental distress

Parents displayed multiple signs of distress during the procedure, commonly expressing emotions about the wound and procedure, including disgust, fear of what they were seeing (wound cleaning), concerns, and the emotional experience. Parents expressed concerns about potential changes to the child's appearance (permanent scarring) and the child's coping, and worry or uncertainty about the treatment and procedure. One parent commented *"Is there special stuff in there that obviously helps with the cooling? [Because] I thought he would be a lot more in pain…"* [Transcript 71]. Sometimes, parents disclosed distress during procedure: Some parents cried, refused to come closer to the child, or left the room. Other parents expressed exasperation at being unable to calm their distressed child. When two parents were present, occasionally one parent appeared more distressed but this was not always acknowledged by the other parent. One parent repeatedly discussed their own paediatric burn, remembering the dressing smell and comparing injury size. Some clinicians normalised the parent's experience or expressed empathy, asking about the parent's ability to cope with the dressing change and reassuring parents of the procedural value. Occasionally, clinicians advised parents on managing their emotions, suggesting they not watch or to focus elsewhere (e.g., play with the child), giving the parent the option to leave, preparing for the wound to look unsightly, or explaining that parental anxiety can increase child anxiety. Sometimes, clinicians reinforced a positive future expectation of the child's coping/healing.

Injury responsibility

Some parents disclosed thoughts and emotions regarding their perceived responsibility for the child's injury. Parents indicated whether they thought they, another supervising adult, or the child was responsible (e.g., the child touched the hot stove after being told not to). One parent blamed the injury mechanism (the sun for a sunburn) and promised future safety behaviour change (wearing hats and sunscreen). Generally, clinicians did not comment on perceived injury responsibility but occasionally provided injury avoidance education. Some clinicians expressed empathy for the parent's experience and attempted to remove responsibility from the parent.

Discussion

This study aimed to elicit the content of parent-clinician communication during paediatric burn wound care. Three communication themes, underpinned by parent-clinician rapport-building, were identified: Sharing knowledge, child procedural distress management, and parental emotional disclosures.

In sharing knowledge, clinicians spoke as wound, procedure and future treatment experts, whereas parents spoke as experts on their child. Parents wish to be informed about their child's hospital care (Foster et al., 2017; Hoppa & Porter, 2011; Lipstein, Dodds, & Britto, 2014; Power & Franck, 2008) and after a paediatric burn, parents desire information through all phases of treatment (Lernevall, Moi, Cleary, Kornhaber, & Dreyer, 2019; McGarry et al., 2015). The current findings agree parents want procedural, wound and healing information, which can contribute to a sense of control (Egberts, de Jong, et al., 2018; McGarry et al., 2015). Instead of only receiving information, parents also provided information about their child's preferences and personality, also seen in Heath, Williamson, Williams, and Harcourt (2018). Parents and clinicians show insight regarding older children (Callery & Milnes, 2012), however, the information parents share about young children can help clinicians better tailor care and procedural distress-prevention.

In child procedural distress management, parents and clinicians shared expectations about the child's reaction, collaborated with procedural distress prevention strategies, and interpreted the child's behaviour. In general, research supports parents and clinicians use *coping-promoting* behaviours towards the child (distraction, deep breathing; Blount et al., 1997; Cohen et al., 2015, Brown et al., 2018b; Sng et al.,

2017) to minimise procedural distress. Clinicians can successfully coach and model this to parents during procedures (Cohen, Bernard, McClelland, & MacLaren, 2005; Thompson, Ayers, Pervilhac, Mahoney, & Seddon, 2016). However, adequate analgesia for young children undergoing burn wound care is a continuing challenge. The recordings allude to possible restraint during wound care ("*hold her nice and firm*") and clinicians pausing the procedure to administer additional analgesia. There is exhaustive evidence against the use of restraint (Bray, Snodin, & Carter, 2015; Duff, Gaskell, Jacobs, & Houghton, 2012; Preisz & Preisz, 2019), but in practice the difficulty is using optimal pharmacological and non-pharmacological strategies with young children who are unable to communicate and differentiate between fear and pain (Brown et al., 2018a).

In parental emotional disclosures, parents spoke of their own distress and perceived injury responsibility. Paediatric burns have a clear negative psychological impact on parents, with acute self-reported distress (PTSS, guilt, blame) predicting later distress (Bakker et al., 2013; De Young et al., 2014; Foster et al., 2017). The current study found parents also *show* acute distress during wound care. Clinicians showed responses of normalising the parents' emotions, expressing empathy, and suggesting practical coping skills, although often no response was observed. Occasionally, the parent perceived a clinician's response (i.e., injury avoidance education) as blame. Feelings of blame can disempower parents from raising concerns in the hospital setting and undermine their feelings of reassurance (Callery & Milnes, 2012; Giambra et al., 2018; Lernevall, Moi, Cleary, et al., 2019).

Rapport-building may have been clinician and parent strategies to inadvertently increase *parental coping*. Clinicians directed distraction and humour (diffusion) towards parents, possibly because the children were predominantly preverbal. While child coping strategies are commonly researched (e.g., Blount et al., 1997), parental coping strategies are not. The strategies for parents to promote *child coping* likely also assist with *parental coping* by contributing to a sense of purpose and control (Egberts, de Jong, et al., 2018). Developing this sense of connectedness may help the parent cope in addition to ensuring the parent is receptive to instructions about supporting their child.

There are avenues for future research. A sequential communication analysis of precursors and responses to parental distress disclosures could identify common patterns. Qualitative interviews or quantitative surveys could clarify parents' and clinicians' expectations and needs. This could inform educational resources for clinicians to prepare to provide parents with psychological support. Additionally, sibling role and experience was not investigated. Siblings' psychosocial needs are often forgotten (Kuo & Kent, 2017), and research could investigate the emotional benefit or toll of sibling involvement during wound care. Finally, although the findings focused on burns, they may generalise to other potentially painful procedures. Parental psychological distress and paediatric procedural distress are common in other hospitalised populations (Bernard & Cohen, 2006; Blount et al., 1997; Dahlquist & Pendley, 2005; De Young et al., 2014; Landolt, Vollrath, Ribi, Gnehm, & Sennhauser, 2003), and could present in parent-clinician interactions similarly.

Practice implications

The findings may assist clinician awareness and preparedness for parental conversations. Clinicians can finesse recovery trajectory and injury prevention communication to support rather than exacerbate parental concerns. While recovery uncertainty stems from unknown variance in healing rate (Brown, De Young, Kimble, & Kenardy, 2019b), clinicians can focus on minimising the adjacent uncertainty about the immediate treatment. Clinicians can inform the parent of the procedural steps for today, the protocols for pharmacological pain management and strategies for non-pharmacological pain management, and evidence that these protocols and strategies assist with expediting recovery, even if there is uncertainty about the prognosis or healing. Clinicians should also consider the timing of injury prevention education. Balancing assessment of the child's physical safety at home, it is preferential this conversation occurs at a subsequent (less emotionally heightened) appointment.

Parental distress management is increasingly recognised as important for paediatric physical and psychological recovery following a burn. Parental psychological distress impacts child coping and distress during burn wound care (Brown et al., 2019a) and reepithelialisation (Brown et al., 2019b). As the child and parent attempts to consolidate the burn experience, clinicians can use moments of disclosed distressto assist the parent with trauma consolidation. The trauma-informed care field describes optimal yet simple responses to parental distress including empathy, guidance on coping strategies, or promoting social or professional support (Alisic, Conroy, Magyar, Babl, & O'Donnell, 2014; Curtis, Foster, Mitchell, & Van, 2016; Hart et al., 2007; Kassam-Adams et al., 2015; Moss et al., 2019; Rodin et al., 2009).

Practical factors also influence parent-clinician communication. Clinicians are required to balance a duty of care with the needs of the patient, parents, colleagues, and tasks. Environmental enablers for optimal communication include adequate time, a quiet space, and engaged parents. Conversely, systemic barriers (time-limited, busy, noisy clinics), can be addressed to promote family-centred care. Note, clinicians can also encounter parental barriers: Parents who wish to leave quickly for work, school or travel reasons, avoid discussing psychosocial concerns, or have incongruent expectations.

Limitations

The study did not capture the full extent of parent-clinician communication. It is possible other themes/sub-themes exist because only a segment of the appointment was recorded. Further, additional meaning could have been gleaned from nonverbal communication with audiovisual recording. Additional themes/sub-themes could have also been present for families excluded according to the exclusion criteria. The findings should not be applied to families of older children as communication may differ. The researcher's presence potentially increased the risk of socially desirable communication, although the range of content suggests otherwise.

Conclusions

This study describes parent-clinician communication during paediatric burn wound care. Communication included sharing knowledge, child procedural distress management, and parental emotional disclosures. The findings provide directions for future research and clinician education to ultimately positively affect the child's, parent's and clinician's procedural experience. It remains "improved communication will enhance patient [and parent] outcomes and satisfaction" (Levetown, 2008).

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Declaration of Competing Interest

None.

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