Abstract

In recent years, there has been a proliferation of sophisticated, user-friendly and accessible instruments of video data collection (e.g., mobile/cell phones and tablets) which facilitate video-based research and analysis. This paper reports on the opportunities and challenges of undertaking video analysis by reporting on the qualitative video analysis of a subset of 30 purposively selected videos from *#notanurse_but*, a parent-driven video campaign initiated by WellChild, a UK charity. This paper provides insight into one way of conducting video analysis, appreciating that a variety of approaches exist and that methodological reflections on analytical work with video recordings are limited. The authors critically consider researcher subjectivity; the everydayness of video data; making assumptions; and the incomplete picture provided by video data. Despite notable limitations to the approach of video analysis as a standalone method, the authors conclude that video analysis is capable of eliciting data that may not otherwise be obtained.

Keywords: Parent-driven campaign, parent-videos, qualitative analysis, video analysis, videos

The Absent-Present Researcher and Data Analysis of Pre-recorded Parent-Driven Campaign Videos

This paper reports on the opportunities and challenges of undertaking analysis of videos generated as part of a parent-driven campaign. It does so by reporting on the qualitative video analysis of a subset of 30 purposively selected home videos from *#notanurse_but,* a video campaign initiated by WellChild, a UK charity. This campaign stems from parents of children with complex health care needs self-identifying that they are 'not a nurse but' they must undertake nursing type roles to care for their child. **The research question underpinning the study from which this paper has been developed was: what are the motivations *for* and the affect *of* the #notanurse_but campaign videos? We refer the reader to Anon et al. 2018 for full information about the original study and findings.** The aim of this paper is to provide insight into one way of conducting video analysis in health research, appreciating that a multitude of approaches to video analysis exist (Knoblauch et al. 2006).

Research methods which have been used to explore the experiences of parents caring for children with complex care needs include observations (Woodgate, Edwards, Ripat, Borton and Rempel, 2015), interviews (Whiting, 2013), and surveys (Miller, Nugent, and Russel, 2015). With the production of audio-visual data (gathered using video camcorders, digital cameras and camera-enabled mobile phones), and their quick adoption by researchers, a new methodology of 'video analysis' is emerging (Knoblauch, 2012). Originating from sociology (see Gottdiener, 1970), visual research methods are now firmly entrenched in health research (Knoblauch, Baer, Laurier, Petschke, and Schnettler, 2008), and are a powerful tool for qualitative research (Knoblauch and Schnettler, 2012). Though video is now used widely in research within the social sciences and beyond, including children's geographies, as we discuss below, there have been few attempts to discuss the methodology of working with this medium as an instrument of data analysis.

The use of videos in research

In the last few decades, children's geographers (e.g. Blazek and Hraňová, 2012; Kindon, 2003; 2016), and geographers more broadly (e.g. Garrett, 2010; Laurier, Strebel and Brown, 2008; Laurier, 2016; Simpson, 2011), have begun to engage with the use of video in research. This body of scholarship predominantly focusses on the production of videos as part of research. For instance, Kindon (2003, p. 142) advocates participatory approaches to video production in "destabilising hierarchical power relations". Further, Blazek and Hraňová (2012) find that the collaborative process of video production can have transformative benefits for co-producers. Other geographical research has focussed on video as a means of dissemination (van Blerk and Ansell, 2007) rather than data collection or analysis. This research focussed on the power and potential of video as a means to bring children's voices into decision-making concerning policy and practice (van Blerk and Ansell, 2007). However, few geographers have considered the use of pre-recorded video as data. A notable exception is Laurier (2016) who makes a plea for human geographers to use the collection of videos available on YouTube and other video content sites, for instance Tumblr and Google Video. Laurier (2016) believes that, when we turn our attention towards video, we gain access to temporal, embodied, bodily, material and mobile aspects of spatial practices (see also Garrett, 2010). Despite the commitment of geographers to using video as part of their methodological toolkits, there is a notable deficit of research using pre-recorded video, and thereby an associated lack of published work documenting methodological reflections on analytical work with video recordings.

Videos have also been used widely in health research involving children, from video analysis of communication in paediatric consultations (Cahill and Papageorgiou, 2007) to caregiver-child feeding and teaching observations using videos (Barnard, 1990). One popular

trend, within and beyond the health literature, is the analysis of home videos (amateur videos often filmed in the home). Home videos can offer researchers insight into behaviours and interactions, and the environment in which 'real life' takes place (Baranek et al., 2005: 22). However, Gibson (2005) highlights how videos that participants are asked to produce as part of a research project can lead to the co-production of video accounts between participants and researcher, as the participants construct and situate their videos within the researcher's remit. Rich et al. (2000) argue that video diaries provide a more direct understanding of participants' experiences than that afforded by data more directly controlled by the researcher. Although using pre-recorded videos can eliminate constructed and situated videos, Baranek et al. (2005) highlight issues related to the lack of control over the conditions in which subjects are video-recorded. This means that there may be ethical issues regarding consent (i.e. is consent already granted if the videos are in the public domain), and the videos may contain content which is outside of the researcher's focus.

Writing on a retrospective video analysis of sensory-motor and social behaviours of children at 9-12 months, Baranek (1999) tells how videos may be a narrow representation of a child's behaviour; parents may preselect pleasant scenarios to film, and avoid video recording children during mundane and predictable events or occurrences. This level of manipulating the situation for the sake of what is appearing in the video is what Knoblauch et al. (2006: 12) refer to as 'recipient design'. Although similar arguments have been presented regarding interviewing (Von Benzon, 2015) and ethnography (Fine, 1993; Moeran, 2007), Knoblauch et al. (2016: 11) contend that the presence of video technology exerts an influence on the situation being recorded, known as 'reactivity'. In this view, data captured through video is not necessarily 'the story', rather it is 'the story they want to tell' (Yates, 2010: 283).

Video recordings have been heralded as 'more detailed, more complete and more accurate' (Knoblauch, Schnettler, and Raab, 2016: 10), and of a more compelling, narrative

character (Noyes, 2004) than notes from observational data. The amount of detail that can be captured in video recordings, both visual and oral, makes them a powerful resource compared to fieldnotes (Derry et al., 2010; Simpson, 2011). Whilst the recording of an event is understood by some to have limited impact on the data, being a replica of the event, others have argued that, notwithstanding the absence of the researcher, videos still provide examples of 'doing identity work' (Gibson, 2005: 36). This reflects how participants position themselves to be perceived by a certain audience, and therefore the content can be influenced, albeit differently than if the researcher was present. Further, it must be noted that there are opportunities for idiosyncratic interpretation of the 'facts' presented by video, as well as empirical concerns for the assessment of truth. This relates to Mackay's (1995) argument that the appearance of objectivity in videos is just that: an appearance. This appreciates that 'natural data' found in video recordings does not resemble the data found by natural scientists. Since video analysts agree in the interpretative character of their data, there should be no misunderstanding of natural data in this sense (Knoblauch et al. 2006).

Discussing visual methods, Yates (2010: 283) proposes two main purposes to using videos: to find out more about the things/events in the world that are the experiences of participants (the social setting or daily processes), which the author terms '*windows to the world*', and to find out more about the subjectivity of the person, (who are they, and what matters to them?), which the author terms '*windows to identity*'. Analysis of video data in this project was concerned with both the windows to the world (e.g. administering medicine and getting children reading for school) and the windows to identity (e.g. mother and nurse).

In this paper we reflect on our analysis of home videos recorded by parents as part of the *#notanurse_but* campaign. The aim of this paper is to reflexively detail one way of conducting video analysis. It is not our aim within this paper to describe the content of the videos, rather we address methodological considerations. It is important to emphasise that we

are using parent-driven videos that were pre-recorded (recorded as part of the campaign). Working with 'repurposed video' (video that was collected without consideration of research goals, Derry et al., 2010: 8), enabled the presence of the 'absent' researcher (the researcher who was not there during the filming) (Gibson, 2005: 34). Arguably, this 'fly on the wall' approach is comparable to non-participant observation (Caldwell and Atwal, 2005), allowing us to gain a more family-centred subjective perspective than if we had requested the families to produce the videos and provided direction.

Firstly, this paper provides an overview of the *#notanurse_but* campaign. From this, the paper turns to discuss video analysis in the research project. It then provides a critical reflection of the video analysis, with particular attention to: researcher subjectivity; the everydayness of video data; assumptions made by the researchers; and the incompleteness of video data. The paper concludes by summarising the challenges and opportunities for video data.

Overview of the *#notanurse_but* Campaign

WellChild is a national UK charity providing support to children with complex health care needs and their families. *#notanurse_but* is a parent-driven campaign that stems from parents of children with complex health care needs self-identifying that they are 'not a nurse but' they must undertake nursing type roles to care for their child. The campaign was launched with the aim of influencing commissioners of services, professionals and policy makers to improve support of and services for carers (Jones-Berry, 2015).

The home videos, which can be considered diaries, have an essence of 'a day in the life of…', and are created by parents whose children receive support from WellChild. The idea for the videos originated from one mother who, in collaboration with WellChild, launched the campaign and called for other parents to create videos. Parents use the videos to share (and/or

raise awareness of) aspects of their lives with children with complex needs, for instance: administering medication, maintaining their child's airway, and undertaking a sleep study. The videos are uploaded and shared on platforms including the WellChild website, the WellChild Families Facebook page, a dedicated *#notanurse_but* Facebook campaign page, via YouTube, Twitter, and parents' personal Facebook pages.

The videos varied in terms of their length and content, and therefore we provide a brief overview for the reader's benefit here. The duration of the videos was between 8 seconds and 9 minutes 52 seconds (average 2 minutes). All but two videos were exclusively filmed inside the home. The rooms included appeared to be the living room/lounge, hall, kitchen, "medical room," child's bedroom, and parents' bedroom. There were some instances where it was unclear in which room the video was being filmed. In all but one set of videos the main narrator was the mother. A few videos did not have narrators but simply filmed what was happening. Some videos introduced us to the child with complex health care needs and provided a medical history/set of diagnoses; others did not do this. Often the person filming remained anonymous. The people included in the videos either in person or indirectly through photographs or being referred to included: the narrator (mother or father); their partner; the child with complex needs; their child's siblings; grandmother, carers (including school bus carers/ drivers); and other people (unclear of specific role) within a respite setting.

We would encourage interested readers to engage with some videos from the campaign as they read our paper. These videos can be accessed[1] on Facebook, Twitter and YouTube by searching for '#notanurse_but', as well as on the WellChild website.

[1] Please note, the videos can be accessed on these sites at the time of writing, although the authors have no control over the availability of the videos on these sites in the future.

Video collection and analysis of the *#notanurse_but* campaign

The dataset for this study consisted of 47 videos generated by parents for the *#notanurse_but* campaign. These videos were publicly available on social media, including YouTube, Facebook and Twitter. We purposively selected a subset of 30 videos to analyse. The inherent bias of this non-random technique arguably contributes to its efficiency (Tongco, 2007). This selection was undertaken to ensure representation of all parents who had posted videos, the range and content of video (for instance, in terms of more 'everyday' activities such as getting ready for school and those with a more 'medical' focus such as taking part in a sleep study, and the online platforms that the videos were posted on). **Where parents have produced multiple videos, only some videos were included by each parent (not all) to ensure we had a greater variety and scope of published videos. Our approach to analysing the videos was qualitative and inductive (Goldman, Erickson, Lemke, and Derry, 2007). We were guided by Barron and Engle's (2007) best analytical practices proposed for working with pre-existing video data, as detailed below.**

Videos provide rich records of everyday phenomena including tone of voice, facial expressions, body language, visual subjects and props. Video data are multi-sensual and sequentially ordered, including speech, gestures, artefacts, signs and symbols (see Knoblauch et al., 2006). Other aspects of videos that require attention relate to cuts, camera angle, and other editing techniques (Knoblauch et al. 2006). Owing to the complexity of video, it is easy to 'become lost in the detail' (Derry et al., 2010: 17). Recognising this, we developed a data extraction sheet which helped us to maintain focus, whilst also helping to ensure consistency between researchers.

We initially used this data extraction sheet to extract data from four videos. All four researchers were informally trained in using the data extraction sheet to record observational

data. The first version of this sheet presented some challenges, as it did not accommodate all the comments we wanted to make, and in certain categories it encouraged duplication. Following a group discussion about the strengths and weaknesses of the data extraction sheet, we collapsed some fields, clarified working terms/definitions to help define the focus of what data should be recorded, and added some new fields. For instance, one researcher suggested that we include a section on clinical language to capture the terminology used by subjects. The final data extraction sheet (see Figure 1) supports Barron and Engle's (2007) best analytical practices for working with pre-existing video data, allowing us to map (identify what is happening and who it is happening to), explore the 'sense of being there' (affect), macro-code (generate a timeline for key events in the video) and produce a narrative summary of key selected moments. Abiding by this data extraction sheet did not preclude 'additional discovery-oriented work' within the videos (Derry et al., 2010: 16), as we documented anything we considered important that did not fit within the predefined categories in the section 'Any other comments?'

Researchers can allow personal beliefs and individual biases to intrude upon what should be an objective process of interpretation (Stafford and Stafford, 1993). The danger of bias exists without sufficient checks on interpretation. To increase the reliability and validity of the analysis, each video was reviewed by at least two researchers (see also Cahill and Papageorgiou, 2007; Caldwell and Atwal, 2005). If there were any areas of discrepancy, the video was shared with other members of the research team as a means to guard against inherent bias and to become reflexively more aware of any assumptions. The discussions over discrepancies were also useful in surfacing salient dimensions for analysis, and to highlight potential issues to investigate further (Jordan and Henderson, 1995). We analysed the videos separately and came back together to discuss our independent analysis. This reduced the likelihood of the selective subjectivity of the observer (Caldwell and Atwal, 2005). There was

a high degree of consistency between the researchers' observations, although as we detail below there were also discrepancies.

Although video analysis can be time consuming (Derry et al., 2010), it can be undertaken in manageable portions, as the researcher can rewind and fast-forward parts of the video to revisit or re-code observations (Caldwell and Atwal, 2005). Erickson (2006) recommends repeated viewing to reach agreement on major events, transitions and themes. Other researchers suggest that replaying the video provides opportunity to correct possible misconceptions (Joseph, Griffin, and Sullivan, 2000) and to reflect on the minutiae of apparently mundane everyday activities (Simpson, 2011).

We deemed each video to be a unit of analysis and analysable events (Gibson, 2005), with the start and end points being defined by the start and end of the video. The entirety of each video was viewed but we did not transcribe the entirety of each video (this is more characteristic of conversation analysis, see Laurier, Strebal and Brown, 2008), instead we transcribed key aspects of the dialogue, pertinent to answering the research question, including medical terminology and other significant phrases relating to the activity being undertaken/shown, or the key message being presented. We chose to analyse the videos manually to maintain closeness to the data.

Ethics

The study was approved by the Faculty of Health and Social Care Research Ethics Committee at Edge Hill University (FOH125). The Ethics Committee did not view the videos although they could have accessed them. As the videos were publicly available online, consent to view and analyse them was not required. We gained specific assurance from WellChild, including from their Head of Family Services (responsible for liaison with families about the

campaign), that parents were aware that the study had been commissioned and that videos would be selected for analysis.

There are many ethical challenges and possibilities that video creates in relation to participants' power, dignity and participation (Anderson and Proto, 2016). Further, the ethics surrounding video with and for young children is a complex field (White, 2017), raising issues of consent and confidentiality (Robson, 2011). The videos were entirely parent-driven and the parents were responsible for ensuring their child's agreement (where the child had capacity) to be part of the video. The guidance notes provided by WellChild to support parents making videos asks parents to gain children's permission and explain the purpose of the videos. This permission is checked by WellChild when the videos are submitted for hosting on the WellChild website. However, WellChild cannot provide the same level of checking for campaign-linked videos which parents post to their personal Facebook pages or YouTube accounts.

If we saw something of concern in the videos we would have initially discussed this within the research team to determine the nature of the concern and our course of action. If the team agreed that there was a concern over video content then the project lead would have made contact with the Head of Family Services and the Director of Programmes at WellChild to discuss and attempt to resolve the issue. For example, evidence of a poor clinical technique could have been resolved by ensuring appropriate skills input and potentially WellChild removing/editing the video. In addition, if the concern had been one relating to child protection we would have immediately instigated the University safeguarding policy, informed WellChild, and taken appropriate stepped action.

All due care was taken in terms of research governance in relation to the storage and management of the completed data extraction sheets.

Findings

In what follows, 'Researcher 1' and 'Researcher 2' refer to the first and second researcher to view each video. Each member of the author team performed the role of 'Researcher 1' and 'Researcher 2' across the analysis of the data set. Throughout the discussion, we deliberately use the word mum (as opposed to mother) as this is the role that they positioned themselves in, and using the word mother would change the dynamic. The parents' names and the names of their children are presented as their names are attached to the campaign videos within the public domain.

Researcher Subjectivity

The research team consisted of four researchers: three children's nursing academics (each with experience of researching with and/or caring clinically for children with complex health care needs) and one social scientist (providing an external, non-health/nursing perspective), and two of the team are parents. This combination of disciplines and perspectives ensured that different viewpoints underpinned the analysis of each video (see Barron and Engle, 2007). We must acknowledge that, as an audience, we were likely to be atypical of the intended audience (although the campaign is not completely explicit on who the intended audience is). Interpretation of video data, as with any analysis, must take into account the subjective perspective of the researcher (Knoblauch and Schnettler, 2012), and so we watched some of the videos as a group when discrepancies occurred to allow us to explore similar or different perspectives and phenomena (Engle, Conant and Greeno, 2007). Where there were discrepancies, we viewed the videos until consensus was reached, consensus being defined as equivalent interpretations and observer agreement over the phenomena (Stafford and Stafford, 1993). This process can be considered as consultative validity (Syke, 1990).

The ability of the observer consistently to observe and interpret phenomena, or to agree with other observers about their phenomena, is key to better levels of reliability in observations, and through this, a better understanding of the phenomena being studied (Stafford and Stafford, 1993). Knoblauch and Schnettler (2012) emphasise the importance of heterogeneity in the research team regarding their training, knowledge and expertise, to enhance the breadth and depth of analytical work. Our approaches to analysing the videos varied. For instance, the first author muted the sound on the second viewing of each video to enable her to pay attention to the props without being distracted by the audio. Other researchers listened to what was being said without looking at the video to call attention to language and medical terminology. The potential variances in approaches to data analysis of the videos was not problematic, and sits in line with non-standardised qualitative/interpretive social research (see Knoblauch et al. 2006).

One section of the data extraction sheet required the researchers to reflect on the affect of the video on them as viewers. Affect as we refer to it herein refers to an 'embodied experience' (Hemmings, 2005: 549) and sense of 'being there', placing the individual in a circuit of feeling and response (see Tomkins, 1963). Our responses highlighted the subjective nature of this task, and as researchers we sometimes drew on our past experiences. For instance, in video 19, mum Jill describes what has gone wrong with the ventilator (all the circuits are full of water). Researcher 1 describes how the video 'sets off all my internal warning bells…having worked with ventilators a lot I get that sense of impending doom that Jill describes in the post about the consequences' (Researcher 1, 24 November 2016). Researcher 2, having no experience of working with ventilators, tells how the video affected her because she could 'sense some panic in Jill's voice' (Researcher 2, 30 November 2016). Despite having different levels of experience with the situation documented, Researcher 1 and 2 had similar interpretations of the affect of the video. This is interesting when considering that there will

likely be great heterogeneity in the viewership of the campaign videos regarding experience with performing clinical tasks.

However, the affect of the videos was not always consistent across the research team. For instance, Researchers 1 and 2 had different perspectives on the affect/overall impact of the video 38, where a child is being administered pain relief, as can be seen below:

> This is a really gentle video – it's just filming what happens with dad just providing an explanation (Researcher 1, 24 November 2016).
>
> I found this video quite upsetting. I think that it is the crying noise that Fraser makes as though he is in pain when his medicines are being given to him. It's quite a disturbing cry for some reason that I can't explain (Researcher 2, 24 November 2016).

Cane and McKenzie (2001) also acknowledge disagreement in the interpretation of video data in their study. The example given above emphasises the importance of researcher reflexivity in video research (see also Carroll, 2009). Although we appreciate the importance of consistency in many aspects of data analysis, we deemed it unreasonable to expect agreement on something as subjective as affect.

Interpretations were also made by the researchers in response to the prompt on the data extraction sheet 'what is happening'. Regarding video 44, Researcher 1 comments 'Holly is in the foreground, in her chair – seems to be asleep' (14 November 2016). Researcher 2 disagreed with this, commenting 'Holly appears to be awake to me' (17 November 2016). These different observations, documented by researchers watching the same video, highlight the issues with subjective nature of video analysis. The examples documented above highlight the importance of having more than one researcher undertaking video analysis.

The Everydayness of Video Data

The campaign videos can be seen as 'natural' data (Knoblauch and Schnettler, 2012), as the recordings were made in situations affected as little as possible by the researchers (see Knoblauch et al., 2006; Silverman, 2005). Instead, parents were videoing to respond to the *#notanurse_but* campaign. We were struck by the parents' presentations (either intentionally or unintentionally) of 'everydayness' (Horton and Kraftl, 2006: 71) of their lives and the care duties for their child, which to us as viewers were both ordinary (getting ready to go to school) and extraordinary (managing a child with deteriorating oxygen saturations). The ordinariness such as school uniform hanging on a door (video 3), vacuuming and washing up (video 4), was seen in contrast to (although in tandem with) administering medication in the 'right dosages', doing feeds, and doing suction. Researcher 1 (video 13) captured this accurately when she describes 'a mix of the mundane and the out-of-the-ordinary' (18 November 2016) in the snapshot provided into Faith's (mum) life. Likewise, Researcher 1 (video 1) states that 'clinical care is calmly done – efficient. Just happens. No real sense of drama etc.' (30 November 2016).

Knoblauch and Schnettler (2012: 335) argue that video offers a 'microscope' into naturally occurring data. In contrast to this, we found instances where families shaped their actions and interactions due to the presence of the camera and their desire to transfer the *#notanurse_but* campaign message. In this sense, the video was not capturing 'natural' data (Knoblauch and Schnettler, 2012), rather data were being produced especially for the video. For instance, in video 7, mum, Leanne, interviewed her daughters Erica and Kyla about their sister Sophie who has complex health care needs. The video appeared staged with set questions that highlight the siblings' knowledge of Sophie's condition. Further, reflecting on video 1, a video about Christmas day, Researcher 1 notes how there is 'more of a scripted feel to parts of this video', with slides used to separate the different 'scenes'. The researcher reflects how she felt 'separate from the video' due to the different filming styles used (selfie, still shot, panning shot) and the extent to which the video had been edited (17 November 2016). Researcher 1 of

video 12, entitled ‘respite’, likewise reflects that, because the video seemed staged, it did not evoke a strong emotional response. Our observation relates to how videos are ‘performances of the everyday’ (Pink, 2003: 55). We found that the most impactful videos were those that were less manufactured, more organic, and more ‘fly on the wall’. For instance, analysing video 3, a video in which mum Leanne gives viewers a tour of her daughter Sophie’s medical room in their home, Researcher 1 notes how there is ‘very simple filming nothing technical or ‘showy’ about it. Very matter of fact – much like the tone of the video’ (1 November 2016).

Following Knoblauch et al. (2006), the ways in which data is crafted or constructed through video may be distinguished in two dimensions. First, various technical procedures, and second, the way videos address the situation captured (i.e. through replicating or attempting to make something seen which is not happening without their influence). Although it can be argued that such reactions render the obtained results unrepresentative of the natural situation (Neale and Liebert, 1980), we argue that instead of getting rid of ‘reactivity’, we should instead turn our attentions to the ways in which subjects react to the presence of a video camera – seeing this as a medium to express ‘difficult knowledge’ (Johnson and Kendrick, 2016: 667).

Related to the ‘everydayness’ (Horton and Kraftl, 2006: 71), we noted drawbacks to these pre-recorded videos, including poor visual and audio quality (see also Belardi et al., 2017). Researcher 1 (video 18) commented ‘the film quality is poor and slightly pixilated and blurred’ (25 October 2016). Researcher 1 (video 20) also commented that the video was ‘quite poor quality’ (7 November 2016), while Researcher 1 (video 36) comments on the ‘slightly wobbly filming’ (14 November 2016). Researcher 1 (video 47) comments that ‘the filming is initially a bit grainy and the camera zooms in pretty quickly’ (25 November 2016). Parents were often filming in difficult technical circumstances, for instance low light in the child’s bedroom, and their attention was on the content and message rather than the filmic quality. As

such, the poor quality of some of the recordings portray everydayness more than a professionally edited film.

Sometimes the poor film quality led to 'guess work' by the researcher about what props featured in the video. For instance, Researcher 1 (video 26) reflects 'There is a lot of paperwork on the walls, could be instructions/charts but wasn't clear due to film quality', and 'I think I can see a box of latex gloves/tissues' (30 November 2016). There were also instances where the volume of audio led us to miss potentially important data. For instance, regarding video 38, Researcher 1 records: 'mum says something very quietly I can't catch' (24 November 2016). Interestingly, the quiet volume of speech also led to our interpretation of parents as 'gentle and kind' (Video 36, 14 November 2016). Other instances of guess work throughout the analysis were not due to film quality, but due to a lack of knowledge, for instance about the parent, the child, and the house, as we now go on to detail.

Making Assumptions

In completing the data extraction sheet all researchers were requested to comment on where the filming was happening. In certain instances, this was clear – either because the narrator had described that they were in a particular place, or because there were signs to depict this – for instance, there was a sign stating 'medical room' on the door of a room in Leanne's house (video 3). When such information was not made available, we often made educated guesses, or assumptions. For instance, upon watching video 24, in response to the data extraction sheet prompt 'where is it happening', Researcher 1 tells 'not sure but it looks like Noah is lying on a bed. I can see what looks like a duvet cover and possibly some wooden cot sides' (24 November 2016). The comment from Researcher 1 is characterised with uncertainty: 'not sure but it looks like', 'what looks like', 'possibly'. Researcher 1 of video 28 also reflects that the location 'looks like a lounge' (1 December 2016), and regarding video 29, Researcher

1 comments that she 'presumes' the video is filmed in a lounge, because 'there's a comfy chair and next to Christmas tree' (17 November 2016).

There was also disparity in opinion about where filming was taking place in video 47. Researcher 1 comments that she thinks the location is a hospital cubicle, 'as the bed looks like a hospital bed and there is a lot of equipment in the background' (25 November 2016). Researcher 2, however, said 'I think this is the child's bedroom at home and the room is just very medicalised' (25 November 2016). Such discrepancies that surfaced in the video analysis brought to the fore an interesting finding regarding the medicalisation of the home, and the difficulty in distinguishing between a hospital and home setting. This relates to how the presence of medical equipment, supplies, and staff can change the use, organisation and feeling of home (Yantzi and Rosenberg, 2008). Our subjectivity here relates to how an individual's experience of home includes its meaning and usability (Aplin, de Jonge, and Gustafsson, 2015).

We also made assumptions about equipment or props featuring in the videos. Researcher 1 (video 36) comments 'I think I can see a monitor – orange readout – but I can't make this out as it's not clear' (14 November 2016). When recording what clinical props are evident in video 11, Researcher 2 notes that there is a backup ventilator and one underneath the wheelchair, and drawing on experience of working with children requiring ventilation, adds 'This is probably BiPaP as I can't see a trachy' (30 November 2016). Importantly, these assumptions were made upon us solely viewing the videos (i.e. not meeting the parents and children, and not seeking clarification).

Assumptions were not only made around the visual properties of videos, but also the aural properties. For instance, analysing video 29, a video about Christmas time for the family, Researcher 2 added a comment: 'sounds of what seems like Christmas dinner in the background with quite a few people - clinking of cutlery and glasses' (17 November 2016). This assumption

would not have been made were it not for the presence of Christmas props, such as a Christmas tree and presents. Often, a combined lack of audio and visual information led us to make assumptions about the actors themselves. For instance, on many occasions the narrator of the video used the phrase 'we', however they did not identify who this 'we' is. We deduced that it was likely the partner or paid carers, but there was no evidence of this and 'we' could have been used to include the audience as well.

A contributing factor to the assumptions made by the researchers is that video data provides an incomplete picture of events, and interpretation of the events depends on the experience, exposure and expertise of the viewers. We explore the incomplete picture provided by video data below.

The Incomplete Picture

Importantly, although 'good research' can be undertaken with 'repurposed video', the absent-present researcher must consider how selection at previous stages affects video analysis (Derry et al., 2010: 8). Regarding the analysis of the *#notanurse_but* videos, this concerns: the decision of when to start and end filming by parents; the selection of which videos to submit by parents, and the selection of 'appropriate' videos by WellChild. Some but not all the videos were 'branded' as campaign videos with the opening of the video using a *#notanurse_but* 'title page' specific to the child and family; this helped to provide context and created a link to the campaign and helped the viewer make sense of the purpose of the video.

Despite insight provided by the videos recorded, we were mindful that there are certain aspects that the videos did not 'get at or capture' (Simpson, 2011: 344), namely the more affective aspects. This essence is captured by Researcher 2 (video 29, one of three videos recorded by this mother):

> Quite a short and factual video, with little sense of the mum's circumstances and who Ethan is – maybe when watched alongside the other videos this would be different (17 November 2016).

This idea of the benefit of viewing videos as part of a sequence is also picked up on by Researcher 1 (video 36) who says 'this very short clip is part of a series of other clips…it makes more sense if you watch the other clips' (14 November 2016).

For other videos, additional information was provided on social media accompanying the video (specifically Facebook and YouTube) in the title, caption, and comments. The inclusion of text provided additional context and helped ground our interpretive analysis. Reflecting on video 33, Researcher 1 comments:

> As soon as the video starts we see the action unfolding. There is no 'piece to camera' or introduction to the video. The viewer is therefore led to assume that this situation has already been ongoing for a certain length of time' (17 November 2016).

The text accompanying this video is useful as mum Lisa explains: 'Ok this is a little insight of a struggle with Spencer whilst trying to get him to the bathroom for pad change his carer is videoing for the purpose of showing to social worker'. This information provides a more complete picture of who is filming and the motivation for filming. In video 25, mum Jill is talking to the camera about the decision to start her son Noah on antibiotics. Jill adds the accompanying text: 'I forget on this video to tell you that part of my decision is based on secretions being thicker and greener too.' This highlights the usefulness of using accompanying text with the video, as opposed to having to re-record something due to missing out important information.

A further example of where additional information helped to provide a more complete picture was in video 19. The video involves mum Jill telling us about an incident with a wet

circuit and flooded ventilator. Jill shares her video on Facebook with an accompanying paragraph of text which intends to provide 'explanation for non medical people', but also sets the scene. In the accompanying text Jill provides an update, telling us that 'Spare vent set up now ready for Noahs sleep. Fingers crossed all goes well with this vent (no reason why not) tonight as I don't have a spare till tomorrow…' The comments on the Facebook page (by Jill and by people showing support) track the episode. Importantly, however, to be able to make sense of the accompanying text you would need to be able to understand shorthand medical terminology (e.g. vent = ventilator).

On some occasions, videos ended on a 'cliff hanger' and left us as viewers wanting to know 'what happened next?' In video 13, mum Faith tells how 'I've got to creep into her [daughter's] bedroom…without waking her up, wish me luck'. Researcher 2 tells how 'as the video ended immediately after this statement I found myself thinking "did she do it?" "did she manage to give medications without waking her daughter etc.?"' (21 November 2016). This desire to find out what happened next can reflect how the video was engaging, but also the relationship built up between the researchers and the families throughout the video analysis process, whereby we 'got to know them'.

In video 6, Leanne (mum) tells viewers that she has filmed 'quite a few procedures', but that the viewers will not have seen an emergency with Sophie, her daughter. Leanne then describes a situation where she had to clear Sophie's airway using suction, and that Sophie's sibling Kyla had observed this happening and had said 'Mummy, I don't want my sister to die'. This dramatic incident was not captured on film and Leanne's recounting of it stands in stark contrast to the everyday activities that she has filmed for viewing (e.g. getting ready for school). The videos available to view, then, provide an incomplete picture when viewed in isolation. They reflect what the parents wish to film, but also potentially what is convenient and appropriate to film.

The ‘incomplete picture’ also relates to what was captured in shot. For instance, analysing video 2, Researcher 1 notes that the ‘bit we see’ of the living room ‘looks calm’ (23 November 2016). This space could have been cleared for the sake of the video, or the rest of the room out of shot may depict chaos. A further example of this is when analysing video 38, Researcher 1 notes that the mum ‘bends down to do something (?? Switching off milk feed although we can’t see this for sure)’ (24 November 2016). As such, part of the story is lost by focussing on a small frame when filming.

Conclusions

With the popularity and affordability of home video production, as well as broadcasting on public sites such as YouTube, Tumblr and Google Video, video recording is a viable means of producing and collecting data (Baranek et al., 2005; Fitzgerald, 2012). Coupled with digital storage opportunities, video has enormous scope as a public data source, and as a means of data analysis (Knoblauch et al., 2008), thereby creating an enormous resource for researchers.

One advantage of video recordings as a data source is that they can be viewed multiple times in different ways, with different people, at different times in the history of a research project (Derry et al., 2010). **Though our analysis relates to a very particular setting, we believe that the reflections we offer from this study are applicable to researchers in other settings and encourage researchers to be reflexively more aware of their assumptions, tied up with their innate belief systems, when undertaking video analysis, and of course other types of data analysis. Whilst we join Laurier (2016) in advocating the use of pre-recorded videos as data for the light they can shed on spatial practices, perhaps outside of the typical reach of researchers, we problematise the idea of taking pre-recorded videos as unproblematic accounts of everyday life. Indeed, whilst the researcher is absent during the encounter, they are present during the analysis. Further, whilst the researcher is absent for the initial recording, the video camera (phone or other recording**

device) is present. Thus, this suggests a performance by those in shot or those recording to an audience.

Although the research project from which this paper emerged used a group of researchers to analyse the videos, there is scope (with necessary ethical permissions) to show the videos to other audiences later in the project's lifecycle. For instance, it could be possible to conduct video-elicitation interviews with parents and siblings who featured in the videos to provide their interpretation of what was going on, something which Derry et al. (2010) highlight as helpful.

Despite the inherent problems of video analysis due to the absent-present researcher as noted throughout this paper, related to: researcher subjectivity; making assumptions; and the incomplete picture provided by video data, we conclude that video analysis is useful as a standalone technique due to its everydayness, as it is capable of eliciting data that may not otherwise be obtained (Buchwald, Schantz-Laursen and Delmar, 2009). However, we highlighted that a potential problem in using recorded video as a form of data to be analysed is the ability to craft the production of the video by the person filming/editing. This is potentially problematic when considering video data as a representation of 'everyday life'. Other benefits and insights provided by the videos include capturing those moments such as in the middle of the night and on Christmas day, when we as researchers would not usually have access to data collection. Using video analysis as a standalone tool is particularly important for campaign videos which are also viewed in isolation by the public. **When reviewing other types of video data, such as home videos, we follow other geographers (Garrett, 2010; Simpson, 2011) in recommending that video analysis can be particularly useful as a supplement to more conventional methods (such as interviewing and observations) to provide a more complete picture of what is occurring.**

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