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Paediatric nurses' and parents' perceptions of busyness in paediatric acute care: an ethnography

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Thesis submitted in fulfilment of the requirements for the degree of

Master of Nursing (Research)

under the supervision of Professor Margaret Fry and Dr Suzanne Sheppard-Law

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CERTIFICATE OF ORIGINAL AUTHORSHIP

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I, Melinda Simpson-Collins declare that this thesis, is submitted in fulfilment of the requirements for the award of Master of Nursing (Research), in the Faculty of Health, School of Nursing and Midwifery at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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This thesis would not have been possible without the diverse number of people that supported me along the way. The ethnography is dedicated to my family, paediatric nurses and families that require hospitalised care. This study highlights the incredible work that these paediatric nurses do every day.

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ABSTRACT

Background: Busyness within modern health care has often been defined as time constraints and increased workload, leading to individualised perceptions of stress. To date, no published studies have sought to explore busyness as a construct within therapeutic relationships in a paediatric acute care setting or how cultural dimensions of paediatric nursing fosters perceptions of busyness within everyday care practices.

Aim: To explore a notion of busyness within the context of paediatric acute care and how this influences the therapeutic relationship between paediatric nurses and families.

Method: Ethnography was the research design selected for the study. Semi-structured interviews with 10 paediatric nurses and 10 parents, and 40 hours of non-participant observations were conducted. Brewer's (2000) framework for ethnographic analysis and interpretation was utilised and findings were presented as a realist tale.

Findings: Seven themes emerged, which detailed cultural dimensions of busyness that influenced paediatric acute care. Perceptions of busyness challenged teamwork and re-shaped therapeutic relationships between paediatric nurses and families. During perceived busyness task focused care became the dominant culture and hindered family centred care. Instead, challenges emerged that required role negotiation, balancing expectations and re-forming of collaborative partnerships. The emotional cost of busyness created a sense of personal conflict that surfaced within nurses and care activities. Similarly, parents were challenged during times of busyness, leading to feelings of frustration and powerlessness.

Conclusion: This ethnography has identified a culture of care that was influenced by busyness. Roles within therapeutic relationships, paediatric nurse and parental expectations and collaborative partnerships were re-shaped by busyness. The findings highlighted the importance of family centred care to paediatric nurses and gave social understandings and insights into the complexities of the paediatric nurse – parent partnerships, which assisted to define dimensions of the therapeutic relationship. Importantly, the ethnography has brought to the surface how paediatric nurses and parents negotiated and balanced their partnership to achieve a desired therapeutic relationship. This ethnography has addressed a significant research gap and provided new insights into nursing, paediatric nursing practice, education and research.

LIST OF ABBREVIATIONS

ACCYPN	Australian College of Children and Young People's Nurses
AIN	Assistant in Nursing
AWCH	Association for the Wellbeing of Children in Healthcare
CNC	Clinical Nurse Consultant
CNE	Clinical Nurse Educator
CYPN	Children and Young People's Nurse
EEN	Endorsed Enrolled Nurse
FTE	Full time equivalent
IVF	Intravenous fluids
NHS	National Health System
NTS	Nursing Teamwork Survey
NUM	Nursing Unit Manager
Obs	Observations
RN	Registered Nurse
TRN	Transitional Registered Nurse

CHAPTER 1: INTRODUCTION

INTRODUCTION

This chapter presents the significance of the study and research aims. The increasing complexity of paediatric health care, service delivery and the constant flow of patients through clinical areas can be perceived as busyness. Whilst paediatric nursing places the family at the centre of care, a sense of busyness may influence the way family's care needs are perceived and result in expectations being unmet. This ethnography was undertaken to generate an understanding of the construct of busyness and the complexities that are embedded within therapeutic relationships between paediatric nurses and families in a paediatric acute care setting.

SIGNIFICANCE OF THE STUDY

Paediatric nurses today require specialist knowledge and skills to work with families to optimise outcomes and the experience of care. The therapeutic relationship is fundamental to the quality and safety of nursing care. For paediatric nurses, a family centred care approach ensures that all family members are recognised as members of the care experience not just the sick infant, child or young person. For paediatric nurses, care delivery can only be optimised when a positive therapeutic relationship has been established through a family centred care approach. However, little is known of how busyness influences paediatric nursing and therapeutic relationships in acute hospital settings.

Further, as a Paediatric Clinical Nurse Consultant (CNC) I understood the language, nuances, and context of paediatric care. Often throughout my workday nurses would report that they were busy. However, how a perception, notion or construct of busyness influenced paediatric care practices, cultural norms and the therapeutic relationship was largely unclear.

Therefore, this ethnography sought to develop a deeper understanding of the construct of busyness and how busyness influenced paediatric nursing care, delivery of family centred care and implications for paediatric nursing practice.

THESIS STRUCTURE

This thesis comprises of nine chapters. Chapter one provided researcher context. Chapter two presents the background of Australian paediatric services, in particular New

South Wales and the historical and philosophical underpinnings of paediatric nursing. Chapter three presents an integrative review, which critiques available literature. Chapter four details ethnography as methodology, which comprises of the research process, data analysis and interpretation, ethnography as realist tales, and the ethnographer's role and identity. Chapter five presents the ethnography as methods, which involved non-participant observation and face to face interview techniques and secondary data sources. The methods chapter also details selecting key informants, recruitment and field relations, insider outsider perspectives, data management, data analysis and interpretation, ethnography as text and ethical considerations. Chapter 6 presents findings - the constantly changing landscape, which describes the paediatric unit and participant demographics, and the themes include: i) a shifting culture of care; ii) shared practices; iii) the culture of care; and iv) being a parent in hospital. Chapter 7 presents findings - the shaping of practice. The themes include: i) cultural dimensions of paediatric care; ii) shaping the therapeutic relationship; and iii) the emotional cost of busyness. Chapter eight presents the discussion and details an interpretation of the findings and relevant literature. Finally, chapter nine presents the implications and conclusion of this thesis, detailing the implications and considerations for paediatric nursing practice, education and training and future research.

RESEARCH QUESTION

How do paediatric nurses and parents construct a notion of busyness within therapeutic relationships in a paediatric acute care setting?

RESEARCH AIM

To explore a construct of busyness within the context of paediatric acute care and how this influences the therapeutic relationship between paediatric nurses and families.

RESEARCH OBJECTIVES

The objectives of this research study were to identify how:

1. Attitudes, beliefs, and values are socially constructed and influenced by a notion of busyness for paediatric nurses and parents
2. Paediatric nurses and parents perceived busyness within a paediatric inpatient unit and its influence on family centred care

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CHAPTER 2: BACKGROUND

INTRODUCTION

This background chapter provides an overview of current paediatric services within Australia and specifically New South Wales. The chapter details the evolution of paediatric nursing and includes a historical perspective and the development of family centred care.

The aim of this background chapter is to provide context for the thesis and following chapters. The background chapter assists to frame the research question by contextualising paediatric settings and models of care.

AUSTRALIAN PAEDIATRIC SERVICES

Australia has over 695 publicly funded hospitals providing about two thirds of all hospital beds (Australian Institute of Health and Welfare 2019) with the remaining beds situated within the private sector. Australian paediatric services are positioned across a vast geographical area and service a population of 4.7million (0 to 14 years) children and young people (Australian Institute of Health and Welfare 2020). Paediatric services provide emergency, inpatient, outpatient and community based care for infants, children and young people living in metropolitan, regional, rural and remote areas across six states (Queensland, New South Wales, Victoria, Tasmania, South Australia, Western Australia) and two territories (Northern Territory and Australian Capital Territory) (Australian Government 2019).

Responsibility for the provision of Australian health care services is shared across national, state and territory, and local governments. However, the administration and management of public hospitals is the responsibility of the state and territory governments (Commonwealth of Australia 2019). For the purposes of this background chapter, paediatric services within New South Wales (NSW) are detailed, as the thesis presents a study undertaken in that state.

NEW SOUTH WALES PAEDIATRIC SERVICES

The NSW public health system covers a large geographical area (801,150km^2) (Australian Government 2001) and provides care to more than 7.5million people which includes infants, children and young people (NSW Government 2020). The definition of a paediatric patient according to the NSW Ministry of Health included infants, children

and young people up to their 16th birthday (0-16 years of age) (NSW Ministry of Health 2017). Children living with a chronic lifelong condition or disability may transition to adult based services during adolescence (12-18 years) to enable a smooth and effective transition.

Currently, there are 176 NSW hospitals providing care to people, with 173 of those able to provide emergency care to both adults and paediatric patients. The three remaining state hospitals, categorised as Level 6 services, provide specialist paediatric care to children and young people. Paediatric health facilities provide a diverse range of services depending on their geographical location (metropolitan, regional, rural and remote) and role delineation.

The NSW Paediatric Service Capability Framework (2018) outlines the minimum standards for paediatric service scope, service requirements and workforce for Level 1 to Level 5 hospitals. The level of service applied to a facility or acute hospital is determined by local health districts, workforce capacity and the clinical networks responsible for clinical services at their facilities (NSW Ministry of Health 2018). Whilst 67% of paediatric cases are admitted into a Local Health District facility, 33% are transferred and/or require admission to a specialist children's hospital (NSW Ministry of Health 2017). To improve access to NSW specialist paediatric services, a network of level 6 hospitals (Sydney Children's Hospital Network [Children's Hospital Westmead and Sydney Children's Hospital-Randwick] and John Hunter Children's Hospital) was established to ensure optimal access to paediatric care irrespective of geographical location.

THE NEW SOUTH WALES CHILDREN'S HEALTH CARE NETWORKS

The NSW children's health care networks aim to ensure appropriate management and transfer of paediatric patients that are critically unwell or have chronic and/or complex care needs (NSW Ministry of Health 2017). Across NSW, the Children's Healthcare Networks cover all NSW Local Health Districts (n=15). The Children's Healthcare Networks was developed as a hub-and-spoke approach and connected all health districts with specialist paediatric services. Given the significant geographical distance of NSW, it was paramount to connect services so that individualised care could be provided to the paediatric population living across NSW (NSW Ministry of Health 2014, 2017).

Most infants, children and young people are assessed and managed close to home in hospitals outside of the specialist children's hospitals. Local Health Districts have

collaboratively formed networks across NSW with appropriate paediatric specialist teams within the NSW Children's Healthcare Networks, with the aim of meeting the needs of infants, children, young people and their families (NSW Ministry of Health 2017).

PAEDIATRIC NURSING: A HISTORICAL PERSPECTIVE

Paediatric nursing has changed since its origins in the mid-1800s. These changes reflected shifts in societal views towards children including: the needs and the rights of children and families, the development of specialist acute care paediatric nursing and more broadly the nursing profession (Glasper & Mitchell 2010). Importantly, paediatric nursing sought to ensure that nurses working with children, young people and families had the specialist knowledge and skills required to provide developmentally appropriate family centred care through the development of the ACCYPN standards of practice (Australian College of Children & Young People's Nurses 2016) and the NSW Paediatric Service Capability Framework (NSW Ministry of Health 2018).

The first hospital that opened specifically to care for children was in Paris in 1802, followed by: St Petersburg in 1834; Vienna in 1837; and London in 1852 (Jolley & Shields 2009; Lomax 1996). It was during the 1800s, that the emotional needs of the child were first prioritised. Nurses began to practice care that incorporated the psychological and developmental needs of the child (Woods 1987; Yapp 1915).

Florence Nightingale was instrumental in portraying the nursing of children as a motherly occupation, whereby affection for the child was shown by the nurses in an un-masked and overt way (Nightingale 1886). Historically, Nightingale was the first to note the importance of accurate observation of the child as part of the caring concept assisting to build a relationship between the paediatric nurse and child or young person. Nightingale referred to these qualities of the paediatric nurse, stating that it was a necessity to have a "*love for children*" when working in a paediatric ward (McDonald 2017, p. 117). This way of caring and working with children and their families showed respect for family relationships and initially defined the therapeutic relationship for paediatric nursing.

The 1920s, in the United Kingdom (UK), brought about significant changes in society which influenced hospitals and institutional systems. Societal changes shifted health care institutional systems to focus on productivity instead of children and family needs (Jolley 2007). During this time, social beliefs about the needs of the children and the nature of childhood became dominated by behaviourism (Watson 1928). Up to the middle the 20th century, children in the UK were admitted to hospital without their parents. Furthermore, hospital's stated that parents were not allowed to visit their child and this

meant that children would often endure a lengthy admission alone (Jolley 2007; Robertson 1970). At this time, models of paediatric hospital-based care reflected a paternalistic approach, whereby parents were passive and/or excluded in health care decision-making for their child. Family visits, when permitted (30 minutes duration) and parents were discouraged from touching their child as it was thought that this might interfere with care and treatment (Waterhouse 1962). At this time, parents were expected to co-operate with scientific, unemotional and professionalised driven care (Jolley 2007).

The early approach to paediatric care and the separation between parents and children has been reported to have caused long term psychological trauma (Bowlby & Robertson 1953; Jolley 2007). Adding to the separation trauma, were contrasting perspectives, at the time, of how affection and care should be shown between nurses and children. As a result of this approach paediatric nurses were often perceived as cold and uncaring (Jolley 2007). During World War II (1939-1945) society's focus on behaviourism and professional control shifted. The implementation of a family centred care approach began to emerge within the hospital setting (Jolley & Shields 2009) driven from the work of John Bowlby and James Robertson.

The pioneering work of John Bowlby and James Robertson, both from the UK, greatly influenced how children were cared for in hospitals and institutions in the later part of the 20th century (Alsop-Shields & Mohay 2001). Bowlby and Robertson's are credited as the pioneers of family centred care (Shields et al. 2012). Firstly, through detailed research on the effects of separation between a mother and child and later by adapting their research to the separation effects of children due to hospital admission (Alsop-Shields & Mohay 2001). John Bowlby's theories and the practical work of James Robertson gained momentum not only in the UK but across the United States of America (USA), Europe and Australia. Social change was in part due to the impact of World War II experiences, whereby society was ready to listen and make changes within their culture, in particular concerning the mass evacuation of children (Jolley & Shields 2009). In addition, Robertson was instrumental in turning Bowlby's theories into practice travelling across the globe to Australia, USA and Europe to speak with children's hospitals and schools to explain the effects of separation trauma on parents and children (Alsop-Shields & Mohay 2001).

In Australia, the Association for the Wellbeing of Children in Healthcare (AWCH) was first established in 1973 (a voluntary organisation) consisting of both professional and non-professional people with an interest in advocating the non-medical needs of children, young people and families in health care (Association for the wellbeing of children in

healthcare 2020). Over the past four decades the AWCH has influenced operational and care practices for families accessing hospital services for their child and young person.

To further improve paediatric nursing care in the 20th century, the Australian College of Children and Young People's Nurses (ACCYPN) developed standards of practice (Australian College of Children & Young People's Nurses 2016) in conjunction with the Nursing and Midwifery Board of Australia's National Competency Standards for the Registered Nurse (Nursing and Midwifery Board of Australia 2013). Today, the ACCYPN standards are used as the basis for the credentialing of the Children and Young People's Nurse. Specialist nurses and generalist nurses working with children, young people and their families use these standards as part of their practice and professional development. These standards of practice outline the minimum standards that apply across various practice settings and diverse patient populations and include both the beginning and experienced specialist Children and Young People's Nurse.

Paediatric nursing has changed dramatically since the 1800s, now embracing the child and family as a unit and seeking to optimise the therapeutic relationship through a family centred approach. Paediatric nurses require specialist knowledge, skills and communication capabilities to work with families. The fundamental shift in how health care organisations viewed families was a key driver in establishing the specialty of paediatric nursing.

PHILOSOPHY OF PAEDIATRIC CARE: FAMILY CENTRED CARE

Family centred care is a philosophical approach to caring for sick children and their families. Towards the end of the 19th century family centred care was well recognised and accepted within paediatric acute care settings and today has been widely adopted in developed and non-developed countries (Shields 2001; Shields et al. 2012). John Bowlby and James Robertson are credited as the pioneers of family centred care (Shields et al. 2012). Family centred care focuses care around the whole family, whereby all family members are recognised as recipients not just the sick infant, child or young people (Jolley & Shields 2009). Health professionals who practice family centred care consider the impact of an admission on all family members (Shields et al. 2012).

A family centred care model anticipates parents or carers active involvement with their child or young person during the hospital stay. Parent's or carers can stay with their child or young person to alleviate distress and psychological trauma to the child, young person and their family (Jolley 2007). Further, having a parent or carer stay in hospital enhances the therapeutic relationship between paediatric nurses and family. The presence of a

parent or carer provides the optimal environment to build partnerships of care and form well-connected relationships (Shields & Nixon 2004). These therapeutic partnerships seek an equal partnership between families and the paediatric nurse, which enables the sharing of information, care negotiations and shared responsibilities (Coyne & Cowley 2007). A family centred care model seeks the family's perspectives and their input forms part of the clinical decision-making and defines the therapeutic relationship (Neff et al. 2003).

Family centred care fosters a partnership approach often involving the whole family in health care decision-making about a child or young person's care (Kuo et al. 2012; Shields 2015). However, there is limited evidence of a single definition of family centred care and furthermore the evidence suggests that it is not effectively implemented (Al-Motlaq et al. 2019; Coyne & Cowley 2007; Shields et al. 2012). Shields (2015) defines family centred care as family inclusion in the decision making and the provision of a child's care. The health care professional's role within a family centred care model is to consult and provide communication that encompasses open and honest dialogue with the family enabling the parent/s to lead the care (Hutchfield 1999; Irlam & Bruce 2002). A family centred care approach places the family at the centre of care, which promotes less distress and trauma for infants, children, young people and their family.

Although family centred care is widely recognised in today's paediatric acute care settings, the previous Cochrane review on family centred care for children aged 0-12 years was in 2012 (Shields et al. 2012). The concept of what is known as family centred care continues to evolve. Partnerships in care, parental participation in care and negotiation of care are key concepts within the literature (Arabiat et al. 2018; O'Connor, Brenner & Coyne 2019). Current literature shows that there is a shift away from the concept of family centred care to partnerships in care and child-centred care in paediatric acute care settings (Arabiat et al. 2018; O'Connor, Brenner & Coyne 2019; Shields 2015; Uniacke, Browne & Shields 2018). Partnerships in care and the construct of busyness is analysed in detail in the discussion chapter. Thereby, adding to the gap within the literature related to the construct of busyness and the influence on partnerships in care within therapeutic relationships in paediatric acute care settings.

SUMMARY

This chapter outlined the delivery of paediatric services throughout Australia and specifically NSW. Paediatric services, across NSW, provide diverse models of care to meet the health care needs of this specialised population. Also presented in the chapter was the shift from institutional systems and a paternalistic approach to paediatric health

care to embrace family centred care. This shift, driven in part by social change, led to new philosophical underpinnings from which the importance of family and the therapeutic relationship emerged. From these philosophical underpinnings emerged a new model of care, widely adopted, and referred to today as family centred care. Importantly, paediatric nursing requires not just specialised medical knowledge and skills but communication capabilities to establish, enable and foster family partnerships in health care settings.

The following chapter presents an integrative review. The chapter details a synthesises of available evidence of busyness in health care and how the construct has been shaped in western society, modern health care and nursing.

CHAPTER 3: INTEGRATIVE REVIEW

INTRODUCTION

This chapter critically reviews the literature related to a construct of busyness within western society, modern health care and paediatric nursing. The aim of this integrative review was to critically appraise and synthesise the available evidence that explored the construct of busyness within health care settings. Given the limited evidence available within paediatric literature, adult health care research was also explored. Nonetheless, the review focused on the perspectives of the paediatric nurse, child or young person and their parent.

The review also explored key concepts related to busyness such as: time, time pressure, and workload, and their influence on therapeutic relationships. The chapter first presents the process undertaken for this integrative review. The following section synthesised literature that related to the construct of time within western society. The final section explored dimensions of busyness within modern health care.

INTEGRATIVE LITERATURE REVIEW METHOD

An integrative literature review was selected as the best approach to understand current evidence and a construct of busyness. Integrative reviews promote the inclusion of a diverse range of research methods and have been widely used to contribute to evidenced based practice and nursing more broadly (Kirkevold 1997; Whittemore & Knafl 2005). This type of review supports the examination of different methodological perspectives such as quantitative and qualitative research. The critical examination of different frameworks and perspectives from a diverse range of research paradigms enabled new understandings of specific phenomenon to emerge (Hopia, Latvala & Liimatainen 2016; Torraco 2016).

Whittemore and Knafl's (2005) framework was chosen to support the integrative review and to strengthen the systematic approach for critical analysis. The following section was guided by the five stages of the framework: i) problem identification; ii) literature search; iii) data evaluation; iv) data analysis; and v) presentation.

DATA BASE SOURCES

A range of data bases were selected to maximise exposure to available literature. The data bases searched included: Excerpta Medica Database (EMBASE) including Medline,

Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, ScienceDirect, PSYCInfo, Google Scholar and Cochrane.

INTEGRATIVE LITERATURE SEARCH STRATEGIES

The integrative review search strategy included a range of search terms for the different databases and no time limit was imposed. The search strategy terms and inclusion and exclusion criteria for relevant primary sources is presented in Table 1.

TABLE 1: INTEGRATIVE REVIEW INCLUSION AND EXCLUSION CRITERIA

Criteria	Justification
Explored and/or examined constructs of busyness.	No methodologies were excluded. The review focused on experiences and perspectives of health professionals and families. Therefore, constructs of busyness required exploration of both quantitative and qualitative studies. Literature reviews were also included if topic related.
Examined nursing and family experiences.	Perspectives of busyness from nursing and family experiences was the primary aim. Experiences and perspectives included both adult and paediatric nurses due to the limited evidence available relating to paediatric nursing.
Published in English-language.	Papers published in languages other than English were excluded, as the researcher was unable to accurately translate research findings.

Source: (Butler, Hall & Copnell 2016)

For this review, the search terms included different concepts to capture available literature. Search terms included: **concept one**: busy* OR busyness; **concept two:**

busy* AND nurse* OR p?ediatric nurs*; **concept three:** busy* AND therapeutic relationship; **concept four**: time OR time pressure AND nurse. Hand searching of reference lists was undertaken and relevant literature located. The Prisma flow diagram (Figure 1) details the integrative review search process.

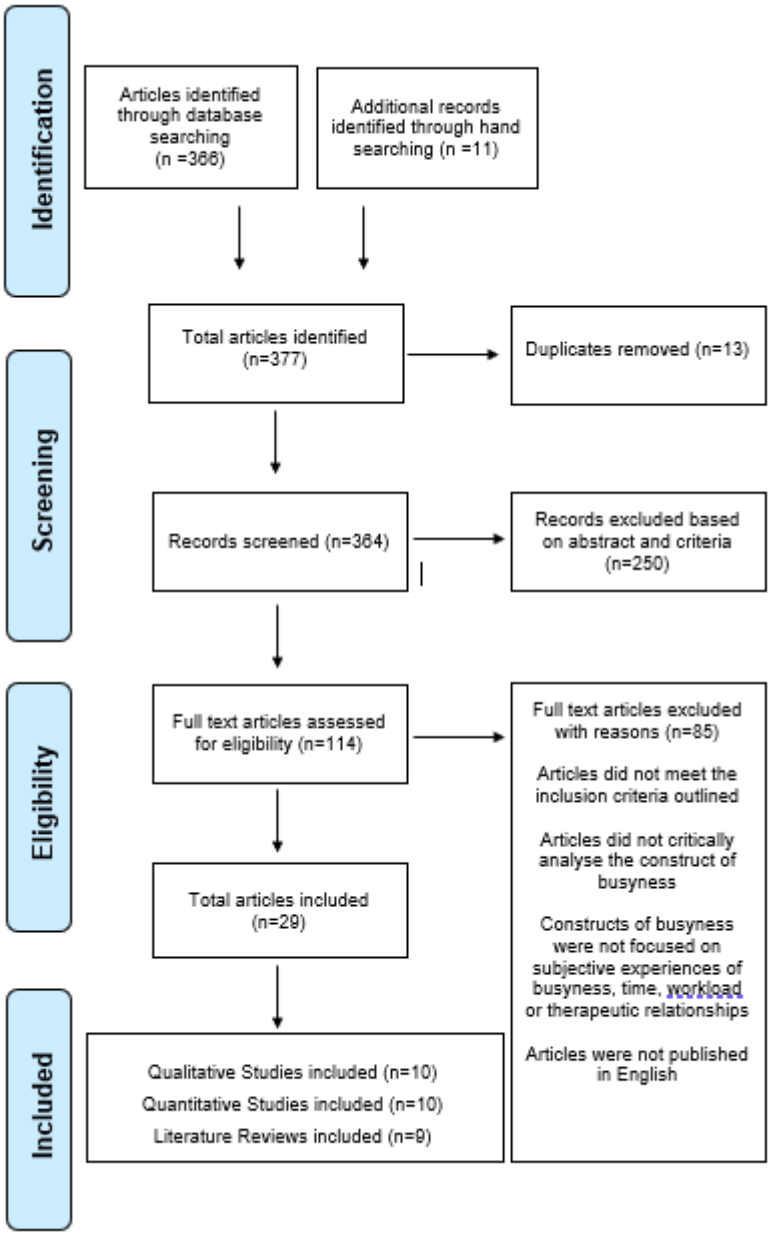

FIGURE 1. PRISMA FLOW DIAGRAM OF INTEGRATIVE REVIEW

DATA QUALITY EVALUATION

Kirkevold's (1997) framework supported the evaluation and screening of quality evidence from diverse sampling frames. The elements of this framework included: authenticity, methodological soundness, quality informational value and representativeness of available information. To further strengthen the rigor in the critique of qualitative research, the Evaluation Tool for Qualitative Studies (ETQS) was also used (Hannes, Lockwood & Pearson 2010). All research studies were initially screened based on title and abstract. All literature identified as meeting inclusion criteria had a full text review and were categorised for relevance to the research question.

DATA ANALYSIS

The data analysis processes undertaken for this integrative review incorporated the following methods: data reduction, data display, data comparison, conclusion drawing and verification (Miles & Huberman 1994). The process began with studies and literature being classified according to the country, sample and design. A word document was used to manage the process and make comparisons possible. This process enabled the identification of common patterns and themes.

The data analysis tool used was derived from the theoretical work undertaken by Miles and Huberman (1994); Patton (2002) and Sandelowski (1995) and reported by Whittemore and Knafl (2005). The tool incorporated six key components and was used to strengthen critical analysis and rigor. The steps for analysis included: i) noting patterns and themes; ii) seeing plausibility; iii) clustering; iv) counting; v) making contrasts and comparisons; vi) discerning common and unusual patterns; vii) subsuming particulars into general; viii) noting relations between variability; ix) finding intervening factors; and x) building a logical chain of evidence. Undertaking these analytical steps provided a method to move from basic description to critical synthesis of the literature (Miles & Huberman 1994).

INTEGRATIVE LITERATURE REVIEW FINDINGS

This integrative review identified 29 articles that related to a construct of busyness within western society, modern health care and paediatric nursing. The identified literature came from the following countries: United States of America (n=12), United Kingdom (n=4), Norway (n=3), Australia (n= 2), Canada (n=2), Belgium (n=1), Denmark (n=1). In addition, four studies were undertaken in Asian countries: Japan (n=1), South Korea (n=1) and Taiwan (n=2). The literature presented from these countries was conducted in

a variety of clinical settings; paediatric, neonatal, adult (including palliative, community, medical and surgical acute care) and universities.

Within the literature a construct of busyness was explored from a dimension of time and included how a lack of time, time pressure, and workload influenced care practices and the therapeutic relationship in adult, paediatric and neonatal care settings. Twenty primary research studies were identified; ten qualitative and ten quantitative. Three of these studies explored or examined experiences of busyness within health care and of those, two involved a paediatric health care setting. Topic related evidence included nine literature review studies. One article explored busyness from an economic cost perspective.

Qualitative research studies related to the construct of busyness are detailed in Appendix 1. These qualitative studies used methodologies which included: ethnography, grounded theory and phenomenology. Appendix 2 details the quantitative research studies that related to the construct of busyness. The majority of quantitative studies used survey methods to examine concepts related to busyness.

The integrative review findings led to the emergence of two key themes, which are presented in the following sections: a notion of time within western society and dimensions of busyness in modern health care.

A NOTION OF TIME WITHIN WESTERN SOCIETY

Concepts of time and busyness have been explored in the nursing literature (Jones 2010), western-based neuroscience (Hsee, Yang & Wang 2010), psychology (Festini et al. 2019; Festini, McDonough & Park 2016) and sociology (Orlikowski & Yates 2002). These diverse disciplines bring knowledge and understanding to the everyday subjective experiences of time as busyness. The concept of time within these psychosocial constructs were explored through human context in terms of measurement, experience and interpretation.

Exploration of the concept of nursing time was first undertaken by Jones (2010). Jones undertook a literature review, in relation to the concept of nursing time, and raised implications for theory development, clinical practice, administrative practice and research. The concept of nursing time within the literature review findings contributed to the construct of busyness within the nursing profession and moreover nursing practice. To fully understand nursing time, Jones (2010) importantly conceptualised three main constructs of time: physical, psychological and sociological, which will be further explored in more detail.

Physical time is consistent and refers to public time or clock time that is counted and numbered. It is objective and external to individuals. Psychological time is referred to as phenomenological time, which is subjective and mind dependent deriving from the interaction between the mind and environment. Psychological time is personal and individual, and this varied between individuals depending on internal and external contexts. In contrast, sociological time drives society, whereby expected behaviour is mutually agreed upon through sequential timing enabling sociological acts on all levels to (co)exist and operate (Katovich 1987; Maines 1987). This leads to coordinated and cooperative acts being achieved by multiple individuals at the one time (Orlikowski & Yates 2002). All three psychosocial components of time within western society interact with each other and influence behaviours on an individual and societal level. The way psychosocial components of time influence health care organisation operations, care practices and activities are largely unknown.

SUBJECTIVE EXPERIENCES OF BUSYNESS AND IDLENESS

Recent literature, from the field of psychology examined actual consumption of time and its relationship with individual experiences of busyness and idleness. From the literature, human perceptions of time are known to be generally affected by task engagement and this includes how individuals spend time and consume time (Hsee, Yang & Wang 2010; Yang & Hsee 2019). Further, an individual's activity patterns and unscheduled time within different cultures can influence experiences of busyness and cognition (Festini, McDonough & Park 2016).

Actual versus perceived consumption of time was examined with a focus on busyness and idleness in an experimental study, undertaken in the USA by Hsee, Yang and Wang (2010). This study involved 98 college students (no age group reported) with the aim of testing two hypotheses; i) choice between busyness and idleness and ii) experiences in relation to busyness and idleness. Participants completed two separate confidential surveys about their school. The analysis focused on comparing two dependent variables, which were choice (location) and experience (feelings from the 15-minute duration). Results showed that 32% of participants chose the far away (busy) option. Busy participants reported greater happiness than idle participants and participants that experienced the far away location reported feeling happier. To rule out misprediction, the researchers tested another group of participants (n=52) by asking them to predict whether dropping a survey in a faraway location or nearby location in a 15-minute period would generate greater happiness. Most (64%) participants predicted the faraway location as resulting in greater happiness.

The cohort of college students recruited from Universities in the USA by Hsee, Yang and Wang (2010), limited the generalisability of these findings. In addition, the experimental design provided only a snapshot of the participant's experience as reported on the day of the experiment. Studying these participant's experiences over a longer period of time may have produced different results. Furthermore, behaviours reported from this study were used to determine busyness and idleness and these were characterised as either constructive or destructive. However, the researchers noted the challenges in defining what constituted constructive and destructive busyness. The study inferred that destructive busyness is easier to define than constructive busyness as there are laws and cultural rules or ethics associated with what is deemed as destructive, for example crime. Nonetheless, Hsee, Yang and Wang (2010) believed that futile busyness defined as serving no purpose other than to prevent idleness, was better for wellbeing than idleness and destructive busyness.

Despite the limitations of this study design, the results do present interesting psychological implications of those deemed busy and idle (Hsee, Yang & Wang 2010). However, given Hsee, Yang and Wang's (2010) study focused on moderate levels of busyness and idleness, how these outcomes influenced behaviour across all levels of perceived busyness was unclear. In addition, how individual capability impacted upon these concepts was not addressed by the study.

Activity patterns and environmental demands consume time and are noted to be associated with everyday busyness. In a study undertaken by Martin and Park (2003), country not specified (authors from Switzerland and USA), 121 community-dwelling individuals with rheumatoid arthritis aged 34 to 84 participated in a questionnaire that measured busyness. In this study, busyness was defined by environmental demands such as the density or pace of an individual's routine and impact on medication adherence. The authors Martin and Park (2003), sought to test the adapted Martin and Park Environmental Demands (MPED) Questionnaire. Demographic information was collected which included: employment, education, household size and medication taking errors. The questionnaire included seven questions related to the participant's experience of busyness in their everyday life. For example, how busy are you during the average day? How often do you have too many things to do each day to actually get them done? Each question required a response using a 5-point Likert scale, for example 1= not busy at all, 2= rarely busy, 3=somewhat busy, 4= very busy and 5= extremely busy. Higher scores indicated a greater perception of busyness. The results identified that there was a significant independent association between medication adherence errors and busyness (Martin & Park 2003) and highlighted the impact of busyness on

medication administration routines. The potential for busyness to lead to or influence adverse events within an acute care hospital is plausible, yet largely unknown. Busyness and its influence in health care settings requires qualitative research methods to increase the depth of understanding.

Whilst most of the literature found that individual perceptions of busyness were associated with positive outcomes, contrasting views emerged. Hsee, Yang and Wang (2010) and Martin and Park (2003) argued that the psychological need to be busy can have a negative influence in the form of compulsive activity. The authors suggested that compulsive activity may help to protect an individual from facing an existential void. Moreover, it was thought a continuous focus on outward tasks may lead to an avoidance of self-reflection and further remove the individual from their awareness of the present moment. Consequently, how perceptions of busyness inter-relate with perceptions of stress remained unclear across the literature.

However, in the literature certain physiological effects of stress and disease have been examined. Physiological effects have been proposed by McEwan (1998) and included stress-related responses that led to chronic disease in humans due to physiological inefficiency and dysfunction. In addition, genetic and developmental predispositions for illness and disease have been shown to affect the initiation and long-term effects of these physiological cascades. Hence, during times of stress, the balance of these stressors played a pivotal role in the preservation of health and maintenance of homeostasis (Pruessner & Ali 2015). To date, how human physiological systems and health predispositions inter-connect with psychosocial experiences related to busyness requires further investigation.

Busyness within western society is perceived through time. Subjective experiences of moderate busyness influenced human behaviours. Across the studies, this was demonstrated through an individual either engaging in more activity or reducing their activity depending on their perceived level of busyness. Yet it remains uncertain how busyness inter-related with stress and long-term health.

BUSYNESS AND COGNITION

The integrative review identified busyness and cognition as emerging research topic areas within the discipline of psychology. Importantly, recent research is exploring how busyness impacts on cognition and whether this interaction can have a flow on effect into work related activities and practices, and more broadly on long-term health.

Two recent studies, both from the USA, have studied the effect of busyness and its impact on cognition (Festini et al. 2019; Festini, McDonough & Park 2016). Festini,

McDonough and Park (2016) were first to use a large scale multi-modal assessment of cognition and brain structure, and health and function. The aim of the study was to assess whether busier people have better or worse cognition performance and whether this relationship with cognition varied with age. Healthy adults (n=330) aged between 50 to 89 years participated in a battery of neuropsychological tests to measure cognition.

Festini, McDonough and Park (2016) study required participants' to self-report on perceptions of busyness. To assess busyness, the Martin and Park Environmental Demands Questionnaire was used. The study found that perceptions of busyness decreased with age, women reported feeling busier than men, and highly educated participants reported higher perceptions of busyness. Further, busier participants demonstrated better processing speeds, episodic memory, working memory, and reasoning and crystallised knowledge. Interestingly, after controlling for age, participants that reported higher levels of busyness had better overall cognition findings, particularly for the assessment of episodic memory.

A later cross-sectional study by Festini, McDonough and Park (2019) sought to determine the characteristics associated with perceptions of busyness. The more recent study recruited 463 participants with no cognitive impairment (aged 20 to 89 years). The Dallas Lifespan Brain Study (DLBS) and the Martin and Park Environmental Demands Questionnaire was used to provide an average busyness score. Personality, health and lifestyle engagement measures were also collected. The results demonstrated that women reported feeling busier than men and perceived busyness declined with age until 60 years. In addition, despite age, other characteristics to emerge revealed that personality features such as agreeableness, neuroticism and lifestyle engagement including frequent participation in enjoyable activities led to higher busyness scores across the sample. Importantly, Festini, McDonough and Park's (2016) study suggested that feeling busy was associated with lower blood pressure (BP), lower body mass index (BMI) and more physical exercise. These results were consistent with the earlier work by Martin and Park (2003) and Festini, McDonough and Park (2016).

Festini, McDonough and Park (2019) also identified that busyness did not show any detrimental health outcomes or relationship with work stress. Interestingly, despite health complications being more predominant in older populations, this study did not find that health variables interacted with age nor did this predict busyness. All participants were able to engage in activities and held responsibilities that contributed to a perception of busyness. However, the authors concluded that a more varied health sample should be examined.

Whilst studies (Festini et al. 2019; Festini, McDonough & Park 2016; Martin & Park 2003) reported an association between busyness and cognition, the benefits of staying active and busy throughout middle to late adulthood years were described. Future research is needed to examine different levels of perceived busyness, and how these different levels may influence individual health and stress levels.

The nursing, neuroscience, psychology and sociology disciplines identified topic relevant findings for this integrative review. Importantly, findings revealed dimensions on the consumption of time and how actual and perceived time was experienced by individuals within western society. These findings assisted to construct a notion of time that represented busyness and idleness and led to psychosocial and physiological implications that could generate behaviours and create cultural mindsets within communities.

DIMENSIONS OF BUSYNESS WITHIN MODERN HEALTH CARE

This section presents and synthesises current dimensions of busyness within modern health care literature. Current literature supports that busyness is experienced through everyday practices and therapeutic interactions. However, there was no standard definition of busyness within modern health care. Studies detailed in this review provide some insight into plausible definitions of busyness within the following contexts: experiences of busyness within daily work; barriers to research utilisation; and effective therapeutic relationships. Therefore, for the purposes of this thesis, the following definition of busyness is presented:

> *'Busyness is an individual perception of internalised pressure created by a situation where there is a shortage of time to accomplish valued work and often results in a reduced energy level' (Thompson et al. 2008, p. 542).*

Busyness often incorporated notions of time and workload as the key concepts related to perceptions of busyness. The concepts of time and workload were explored in a recent Norwegian qualitative study undertaken by Govasli and Solvoll (2020). This study explored nurses' experiences of busyness using phenomenological hermeneutical method. Four participants, with 10 to 40 years nursing experience, were recruited from medical, surgical, intensive care and nursing home environments. Hospital type and/or site/s were not specified, only that recruitment was undertaken from a small geographical area. Results from this study were developed by drawing on the in-depth interviews. Themes emerged from within the fictive narrative that showed an inter-connection

between external events and inner processes that continuously reinforced each other within experiences of busyness. The themes presented the different levels of busyness and nurses' perceptions of completing care requirements. Acceptable busyness was conceptualised by task completion within the nursing team, whereas intolerable busyness was viewed when unable to manage care plans and associated tasks. For participants, feelings of inner chaos and despair were generated from tasks that were perceived as important and remained undone. Although, the study only had four participants, the findings are important and require further investigation with a larger sample across different health care environments. Certainly, this study presented new and emerging concepts in relation to the construct of busyness.

Dimensions of busyness were reported to influence economic outcomes in a peer reviewed article that explored busyness within the dental industry in the USA (Vujicic 2015). The study suggested that dentists were not busy enough leading to a decrease in financial earnings (Vujicic 2015). Interestingly, this article explored busyness from an activity and funding viewpoint, implying that there had been a change in socioeconomic groups seeking dental care. Vujicic (2015) argued that the shift was due to a decline in working-age adults, a rise in paediatric and senior patients accessing Medicaid dental services and inflation rates related to dental expenditure. This decline in working-age adults accessing dental care was reported to be due to perceptions that related to cost and benefit. More specifically, dentists that accepted Medicaid were busier than their colleagues who did not. This provided an interesting perspective of busyness from an economic perspective, which could be used to develop new research questions in relation to positive aspects of being busy.

Busyness as a construct within modern health care is complex and multidimensional. Perceptions of busyness are influenced by time and workload and can be subjective and/or objective depending on the environment and context. The next section examines how busyness inter-relates with perceptions of time constraints and workload.

TIME AND WORKLOAD AS CONCEPTUAL FACTORS OF BUSYNESS

A lack of time and workload were identified, within the literature, as conceptual factors of busyness. Workload was a contextual factor of nursing time, requiring an increase in pace when task load and environmental complexities increased. Busyness is therefore proportional to the amount of work (workload) that needs to be done and the time available (Chan et al. 2018). The subjective experiences of time were previously discussed from a human experience and societal perspective, now those three main

concepts of time; physical, psychological and sociological will be explored further within the context of nursing.

Nursing time was conceptualised as a holistic framework by Jones (2010) in the USA. The framework incorporated underlying time attributes, antecedents and detailed consequences of each concept in terms of physical, psychological and sociological dimensions. According to Jones (2010), physical nursing time belongs to the social world outside of nurse-patient relationships and provides a platform for uniformity enabling standardisation and regulation of behaviour. Managers and administrators govern this form of time through nursing hours and nurse-patient ratios. The sociological form of nursing time was experienced through the sequential ordering of events within the daily routines of the practice setting. Psychological nursing time was also internalised and related to how the participant (nurse) experiences nursing. This encompasses the shared intersubjective experiences that form patterns of behaviour. Perceptions of nursing time were driven by these concepts, therefore feelings of not having enough time or a lack of time can have a detrimental effect on the individual themselves, nursing care practices and the organisation. These three concepts of time are inter-related and influenced perceptions of time.

A Canadian multi-centre ethnographic study undertaken by Thompson et al. (2008) explored the concept of a lack of time, busyness and nurse's research utilisation. This study included a sample of 235 nurses (both paediatric and adult) from seven units within four tertiary level hospitals located across two large cities. Data were analysed from 119 open-ended interviews, observations (n=213, field-notes) and 17 focus group interviews. The observation hours and focus group participants numbers were not specified. The findings led to development of a conceptual model with the following components: i) environmental; ii) interpersonal factors; iii) intrapersonal factors; and iv) culture and effects. The conceptual model comprised objective and subjective components. Importantly, a lack of control over time, interruptions and incomplete nursing care created feelings of frustration and powerlessness. This study raised the importance of activities that were allocated and the social meanings that were connected to these everyday nursing activities. Consequently, reading and reflecting on research was not perceived to be an acceptable form of busyness within these clinical settings. Thompson et al. (2008) argued that this resulted in a culture that undervalued research.

Thompson et al. (2008) ethnography was able to bring to the surface an understanding of a lack of time and workload and their influence on research utilisation and perceived busyness. More importantly, the study led to a greater understanding of organisational and nursing culture within adult and paediatric nursing. However, given the

heterogeneous sample, it is unclear in the study whose perceptions are being voiced in terms of adult or paediatric nurses. The focus of the study was on research utilisation and not specifically the therapeutic relationship. Therefore, how busyness influences a nurse's belief system, values and practice and the therapeutic relationship in paediatric acute care remains unclear.

Similarly, a lack of time for research utilisation was reported in an Australian cross-sectional nursing survey (Hutchinson & Johnston 2004). The authors surveyed 761 Registered Nurses working in a tertiary hospital in Melbourne and 49% responded. This cohort reported that they had no time to read research (78.3%) and insufficient time on the job to implement new ideas (73.8%). In addition, participants (89.6%) argued that increased time for reviewing and implementing research was a moderate or strong facilitator. While there were consistent findings across studies (Hutchinson & Johnston 2004; Thompson et al. 2008) the low response rate, site limitations and potential for self-reporting bias needs to be considered. Nonetheless, Hutchinson and Johnston (2004) and Thompson et al. (2008) highlighted the importance of research utilisation and suggested that perceptions of a lack of time acted as a barrier to research utilisation.

A lack of time as a barrier to research utilisation was also identified in a Norwegian study that used a cross-sectional survey technique. The study involved nurses (n=407, 61.6%) across 20 units from a University Hospital (Dalheim et al. 2012). The survey, collected over one month, included 50 pre-structured questions (using a Likert scale) and four open-ended questions divided into five sections. Sections two to four specifically included 20 statements on possible barriers to evidenced-based practice. The results showed that insufficient time was a key barrier for: locating research, searching for organisation information (included guidelines and protocols) and implementing practice change. Interestingly, the lowest ranked barrier to evidenced-based practice was team culture.

The Dalheim et al. (2012) study was largely consistent with both the Thompson et al. (2008) and Hutchinson and Johnson (2004) studies in relation to insufficient time or lack of time to utilise research and implement research into practice. However, a contrasting finding related to team culture. Dalheim et al. (2010) identified team culture as a minor barrier to research utilisation, whereby Thompson et al. (2008) found team culture to be a significant factor in reducing research utilisation within the context of busyness. Yet, the different perceptions of team culture could be the result of study methods. Dalheim et al. (2012) included hospital units with managers that indicated their interest in the implementation of evidenced based practice and participation in the study. These studies

raised more research questions around time constraints and its relationship with team and organisational culture and the influence on evidenced based practice.

The notion of team culture in relation to time constraints and workload were concepts that emerged from the findings of a study undertaken by Benner et al. (2018) in a university-affiliated tertiary care children's hospital, in the USA. Benner et al. determined busyness through the measurement of time and workload in a sample of paediatric participants (n=253) up to age 21 years with a known inherited or acquired immunodeficiency at risk of neutropenia, that presented to the emergency department (ED) with complaints of fever or a temperature of 38^0celcius or higher. The pre post study sought to evaluate whether time to antibiotic administration was delayed due to busyness. Busyness was defined as concurrent hourly ED arrivals, which was representative of patient volume and workload. The intervention involved: the implementation of a clinical practice guideline; improvement in operational systems such as team communication; medical staff education and training of nursing staff to access central venous devices; multi-disciplinary support including pharmacists to increase availability of particular antibiotics prior to pathology results; widespread reminders; and the reporting of performance metrics to key stakeholders. Regression modelling found no difference in care practices related to busyness post intervention. Benner et al. (2018) argued that the ED team were able to deliver antibiotics without being directly affected by busyness.

Workload and time have been shown to positively influence team engagement, evidenced based practice and up skilling of staff, all of which inter-relate with team culture. Notions of team culture, perceptions of time constraints and workload defined as busyness need to be further investigated in a paediatric acute care setting.

Similarly, Seki & Yamazaki (2006) explored working conditions and the impact on medication administration in Japan. The researchers recruited nurses (n=90, response =97%) from four adult wards (nephrology, cardiovascular, neurosurgery and haematology) in one public hospital. A questionnaire was used to investigate nurses' perceptions of workload, busyness, shift work, work experience, fatigue and sleep deprivation. Workload was measured as the number of patients and intravenous (IV) medications per nurse. The study highlighted that cultural contexts influenced workload and busyness across the day shift, evening shift and night shift. Workload was reported as busier during the day shift as organisational processes governed the nurse's time and additional nursing tasks were required such as assisting medical officers with procedures, patient examinations and performing new treatments. These tasks were perceived to be in addition to patient care, which led to a higher frequency of near-miss

errors. In addition, higher frequencies of near-miss errors also occurred when nursing services were delayed due to busyness in combination with fewer experienced nurses to support knowledge gaps. Nurse to patient ratios were reported as being higher in the evening which changed the dynamics of the team and sudden changes or additional intravenous (IV) medication orders on evening or night shifts caused delays in administration due to less experienced nurses.

The study undertaken by Seki and Yamazaki (2006) showed that busyness in relation to time, workload and cultural meanings can have detrimental effects on the quality and safety of care. However, there are limitations with self-reported questionnaires, in that responder bias could occur from individual insight and knowledge of a near-miss error event. Furthermore, the different adult models of care may not be transferable into paediatric acute care. Nevertheless, this study did provide some important considerations that could be further investigated in a paediatric acute setting.

Contextual factors of busyness emerged in a focused ethnography undertaken in Canada by Chan et al. (2018). Participants were recruited from an adult acute medical ward in a University affiliated teaching hospital and data collection consisted of participant observation (600 hours over 98 visits) and interviews (n=35; 10 patients, 11 family members and 14 staff members). The study explored how palliative care patients with end-of-life care plans were cared for in an acute care medical ward. The ward was reported by participants to be 'busy and demanding' due to the high level of patient acuity, complexity and variety of diagnoses (Chan et al. 2018, p. 457). Limited resources were reported as a lack of time, complexity of work in combination with the delivery of acute care priorities and complexity of teamwork required to cope with multiple challenges shaped care within this medical ward.

While adult palliative care is different to acute paediatric settings, again, time constraints and workload shaped and defined busyness. Time as a conceptual factor of busyness was found in studies related to research utilisation (Dalheim et al. 2012; Hutchinson & Johnston 2004; Thompson et al. 2008), medication administration (Benner et al. 2018; Seki & Yamazaki 2006) and adult palliative care (Chan et al. 2018). Importantly, these studies showed that perceptions of busyness influenced and gave shape to time constraints, workload and workplace culture. When time constraints generated discomfort and stress within individuals, experiences of time pressure surfaced. Nurse-perceived time pressure will now be explored in relation to busyness.

TIME PRESSURE AND BUSYNESS

Busyness represents tasks being done within a timeframe (Govasli & Solvoll 2020; Vinckx, Bossuyt & Dierckx de Casterlé 2018), suggesting that perceptions of time and workload can lead to time pressure. Furthermore, nurses have been reported to work towards making sure 'everything was done' by the end of the shift and that different tasks required different durations of time (Govasli & Solvoll 2020, p. 4). Nurses' experiences in relation to incomplete nursing care task due to time constraints was found to result in nurse-perceptions of time pressure (Vinckx, Bossuyt & Dierckx de Casterlé 2018) .

Vinckx, Bossuyt & Dierckx de Casterlé (2018), used grounded theory, to explore time pressure in adult oncology wards. Nurses (n=14) were recruited from five inpatient oncology wards in one Belgium academic hospital. Data were collected using a questionnaire and semi-structured interviews (duration one hour) over a six-month period. Time pressure was reportedly experienced by adult oncology nurses in their daily practice. However, there were nuances in how they experienced this reality; whether it was a lack of measurable clock time or feeling overwhelmed and rushed to achieve all their work within a certain time. The intensity of time pressure was also managed differently by nurses. Notably, those nurses that worked more positively with time pressure were described as being proactive and sought creative solutions for adequately and efficiently managing their work. In addition, ad hoc strategies reported to assist nurses to cope with time pressure included: working at a faster pace, working overtime and a focus on physical tasks.

Furthermore, a perceived notion of time pressure was influenced by: nurse personality; nurse values, beliefs and skills; nursing culture; and context (Vinckx, Bossuyt & Dierckx de Casterlé 2018). In addition, nursing culture facilitated or hindered care practices through unwritten social rules, Nurse Manager leadership style and team culture. Contextual factors such as staff shortages and complex patient case mix also played a role in perceptions of time pressure. However, the single site and small sample size, and risk of sample bias, limits the transferability of findings to other hospital settings such as paediatrics. Nevertheless, this rigorous study presented findings that need to be explored further in paediatric settings.

In the literature, busyness as a construct was defined and experienced as: a lack of time conceptualised as physical, psychological and sociological. Perceptions of time and workload were an interplay between personal, cultural and environmental factors.

CONCEPTUALISING BUSYNESS AND THERAPEUTIC RELATIONSHIPS

The following section, brings together, from the literature, the concepts of busyness; time constraints, time pressure and workload and how these are interwoven within therapeutic relationships between nurses and patients. Within the literature the therapeutic relationship was supported through the translation of research, prioritisation of tasks, and workplace culture. A UK critical ethnography explored children's experiences of hospitalisation (Livesley & Long 2013). Participants were recruited from a nephro-urology ward in a tertiary referral children's hospital. Data collection involved interviews with children (n=9; 5-14 years) and six months of fieldwork (100 hours total). After hospital discharge interviews (n=6; 9-15 years) were conducted at 18 months.

From the data four themes emerged: 1) transition to patients who are also children; 2) different worlds; 3) child-nurse relationship; 4) the challenge: children's voice and competence. Liversley and Long (2013) highlighted the limited time nurses had for being with and caring for children. The notion of different worlds highlighted the significant influence that limited time had on the child-nurse relationship. A perception of limited time was reported as unmet care needs expressed by children, such as analgesics. Perceptions of busyness were reported when trying to balance the needs of all ward patients and experiencing care delays or an inability to spend time at the bed side with a sick child. To manage busyness, the researchers argued, nurses identified children as patients rather than individuals, whereby the children's bodies became part of the nurse's daily work. This was postulated by the researchers as a coping mechanism for nurses to manage workload (busyness) and the unmet needs of children (Livesley & Long 2013).

Overall, this study showed that a perception of busyness was reported to influence social processes and therapeutic relationships. In these moments, inconsistences surfaced for nurses and challenged the establishment and maintenance of therapeutic relationships. Ward culture was influenced by organisational requirements, busyness and the staff on duty. During observation periods of busyness, Liversley and Long (2013) detailed, that on many occasions, children had difficulty attracting the attention of nursing staff. Furthermore, less resilient and sicker children were reported to be less able to ask for assistance, which further diminished therapeutic relationships. Within this social context, it was argued that the results showed a lack of person-centred care when time constraints and increased workload were present.

The study undertaken by Liversley and Long (2013) focused on paediatric inpatients in a nephro-urology ward within a tertiary children's hospital in England. Therefore, limitations exist regarding the transferability of findings into a general paediatric inpatient

unit in Australia. Whilst the focus of this study was to provide insights into the experiences of children in this acute care setting, exploring parental and nurse perceptions of the children's interpretations of their care would have provided a greater understanding of this social context. However, this study provided rich insight into busyness and its influence on time, workload and ward culture. Yet it remains unclear how perceptions of busyness are experienced within an Australian paediatric acute care environment.

An Australian study (Wilson, McCormack & Ives 2005) examined busyness and therapeutic relationships in a Special Care Nursery (SCN). This study used emancipatory practice development methodology and included nurses and midwives (n=27). Data collection included: a survey (n=19) with a 70% response rate; non-participant observation (60 hours over one month on all shifts); and interviews (average one hour in duration, n=unknown). From the data, four central themes emerged. Theme 2 Family-Centred Care (empowerment of families versus ownership of babies, continuity versus discontinuity and enabling environments versus busyness) related to the construct of busyness. Theme 2 highlighted that when nurses and midwives perceived busyness, their behaviours changed, which made parents less likely to approach or disturb them. Similar findings were identified by Liversley and Long (2013). From the SCN observation, busyness was noted as lights on 24 hours per day, cot covers being removed and high noise levels. Importantly, cultural complexities were brought to the surface showing that busyness was socially enacted by both parents and nurses in this setting (Wilson, McCormack & Ives 2005).

Within the literature, perceptions of busyness influenced the therapeutic relationship and shifted the centre of care away from patients and families towards a nurse-centred care focus, thereby reducing a nurse's capacity to establish well-connected relationships with families (Livesley & Long 2013; Wilson, McCormack & Ives 2005). Further exploration is required to determine if busyness influences family centred care across nurse activities in paediatric acute inpatient areas.

In a UK study, conducted by Martin (1998), participants were recruited from the English National Board for Nursing, Midwifery and Health Visiting-Death and Dying module course. Descriptive narrative accounts were collected with the aim of examining empowerment of dying adult patients. Nurse participants (n=30) had varying levels of experience (1-year post registration to 20 years) and worked in areas that involved dying adult patients. This study identified that busyness (time constraints) enabled nurses to assert control within the nurse-patient relationship. The behaviour tactics used to assert control between nurses and patients included: busyness, rituals, different language; and distancing themselves. These findings were also consistent with other researchers

(Martin 1998; Thompson et al. 2008; Wilson, McCormack & Ives 2005). Interestingly, Martin (1998) and Thompson et al. (2008) both implied that these behaviours assisted nurses to shield themselves from meaningful relationships.

Patient-perceived care and time pressure was explored in a medical health setting in Taiwan (Teng, Hsiao & Chou 2010). A cross-sectional survey of adult patients (n=687) and nurses (n=255) from inpatient medical units (medical centre: 3700 beds) was undertaken. Survey questions related to the perception of time pressure and experiences of busyness. Nurses perceived time pressure negatively, which related to patient perceptions of reliability and accountability, responsiveness and assurance (Teng, Hsiao & Chou 2010). However, given that paediatric nurses and patients were excluded in the study, it remains unclear if similar findings would be evident in a paediatric acute care setting. During episodes of busyness activities perceived by nurses as being low priority (such as basic care and emotional support) were often neglected. A perception of busyness appears to result in a shift from family centred care towards nurse-centred care. This was supported by other researchers (Livesley & Long 2013; Wilson, McCormack & Ives 2005).

Adding to the complexity of the construct of busyness within healthcare organisations, are the dominant ways of working that are heavily influenced by Fredrick Taylor and Henry Ford. These approaches are known as Taylorism and Fordism. Taylorism as an approach was first introduced into the manufacturing industry in the late eighteenth century moving from craft-based to factory-based production (Watson 2017). The aim of Taylorism was to more efficiently coordinate and improve work processes. Taylorism included characteristics that aimed at increasing productivity and efficiency through control of the workforce. These characteristics included: the technical division of labour whereby specialised roles and skills were executed, the coordination and management of work, and the standardisation of tasks which reduced worker autonomy (Berwick 2003).This scientific approach was used to standardise practice, reduce variation amongst workers and to minimise education and training costs (Watson 2017). Work processes that were previously undertaken by individual craftsman, were now divided between multiple workers that operated specialised industrial machinery to improve efficiency and reduce cost (Braverman 1998). Consequently, a Taylorist approach views labour as a commodity to be remodelled to increase output, despite the fragmentation and mechanisation of work.

In the twentieth century, Henry Ford implemented across factories the work design and management principles or Taylorism within car factories. However, Ford recognised that although mass-production improved efficiency it had the potential of damaging labour

relations through intensifying work and deskilling workers (Dassbach 1991). A Fordism approach recognised that the people employed are part of the product whereas Taylorism treated labour as a commodity. Nonetheless, job control through managerial control was an essential element of both Taylorism and Fordism (Braverman 1998; Dassbach 1991).

Traditionally, healthcare organisations have adopted a Fordism approach, whereby managerial and efficiency structures and processes are in place that regulate activities and routines. For example, tasks are often required to be undertaken at routine times during a day such as the administration of medications by nurses. Further, workforce requirements for nurses within contemporary healthcare organisations include regulated shift times and allocated time periods for the changeover of and between staff. The Fordism approach adopted within care organisations seeks to control and highly regulate the activities of all clinicians. However, what was lacking in the literature, was how Fordism has influenced family centred care and the therapeutic relationship. Furthermore, it remains unclear how busyness influences a clinician's workday within a structured Fordism hospital environment.

Many of the studies involved diverse clinical environments across a range of countries, yet all found elements that defined and shaped busyness within their workplace cultures (Chan et al. 2018; Livesley & Long 2013; Wilson, McCormack & Ives 2005). However, to date no study has explored the construct of busyness, cultural dimensions and influences on the therapeutic relationship between nurses and families of children and young people admitted to a paediatric acute care setting.

MORAL AGENCY, BUSYNESS AND THE THERAPEUTIC RELATIONSHIP

The cultural landscape within hospital environments is influenced by time constraints and increased workload. Indeed, busyness has been reported to inhibit moral agency within therapeutic relationships between nurses and patients. The capacity for moral agency when perceptions of busyness emerge can result in distress and ethical insensitivity (Haahr et al. 2019; Storaker, Nåden & Sæteren 2016). These dimensions also raised ethical challenges, which may inhibit nurses' ability to provide holistic (person or family centred) care (Haahr et al. 2019; Nagington, Luker & Walshe 2013; Storaker, Nåden & Sæteren 2016).

A Norwegian hermeneutical study explored the ethical challenges that nurses faced in daily practice (Storaker, Nåden & Sæteren 2016). The sample included nurses (N=9) with a minimum of two years' experience and an interest in the research area across three adult clinical wards (two surgical and one medical ward) within a university hospital.

Interviews (n=9) and questions were based on a thematic guide. Interview duration was unspecified. The hermeneutical approach identified four key themes, with two themes relevant to this review: the painful busyness and emotional immunisation. Participants described experiences of time pressure and increased workload, which led to perceived ethical challenges within practice. Furthermore, participants expressed that they worked within a culture of chaos, whereby their working day was subjected to caring for patients beyond the ward's bed capacity. Participants reported; feeling powerless from a lack of control, unable to practice according to their values, and limited time for reflection. These ethical issues led to emotional immunisation with entrenched beliefs that formed part of the ward culture and therapeutic relationships. Instead, nurses became unaffected by the fundamental needs of the patient (Storaker, Nåden & Sæteren 2016). Given the single site recruitment and the study's adult acute care environment, further research is needed to explore if ethical issues are experienced by paediatric nurses within their therapeutic relationships when busyness is experienced.

A systematic literature review explored ethical dilemmas that were described and experienced by nurses in their clinical practice (Haahr et al. 2019). The review incorporated 15 studies published between 2011 and 2016. A range of health settings were presented: neonatal, psychiatric, critical care and aged care. The review identified three themes that related to the nurse-patient relationship, organisational structure and collaboration with colleagues. The authors reported that heavy workload led to ethical insensitivity and that working continuously within time limits increased the risk of staff burnout (Haahr et al. 2019).

Similar findings were reported by Choe, Kang and Park (2015) who explored moral distress in critical care areas. Critical care nurses (n=14) from two university hospitals located in Seoul, South Korea were recruited. In-depth interviews were collected over 21 months and participants were interviewed twice (mean duration one hour). The study identified five themes associated with moral distress and critical care nursing. Importantly, ambivalence towards treatment and care related to the moral distress critical care nurses perceived when they prioritised task completion over other types of patient care (example, advocacy of the patient's rights or human dignity). Participants reported that moral distress was a consequence of heavy workload. These findings were supported by others Chen et al. (2018) and Storaker, Naden & Saeteren (2016).

A later study, from Taiwan, identified various types of moral distress experienced by nurses and found that excessive workload and time constraints affected the quality of patient care and led to moral distress (Chen et al. 2018). Moral distress in this study was defined as a nurse compromising their values. This study recruited (n=60) nurses across

medical, surgical and specialty ward (not defined) from a regional teaching hospital. A total of 15 interviews were conducted over a one-month period. Q methodology was used and incorporated a mixed method approach to data collection. These statements from the interviews were used to construct Q statements that the participants ranked using a Q grid that utilised a range from -4 (least distress) to +4 (most distress) with 0 representing neutrality. The findings supported that perceived workload and time constraints influenced the degree of moral distress and created a perception of insufficient capacity to deliver quality patient care. Also, compounding these perceptions of busyness was staffing levels, which appeared to reduce a nurses capacity to provide quality care, engage in post graduate education and optimise evidenced based practices (Chen et al. 2018).

A UK study explored end of life district home nursing care with patients and families (Nagington, Luker & Walshe 2013). Semi-structured interviews were conducted with patients (n=26) and families (n=13) over 13 months. The post-structural discourse analysis identified the word busy in 17 interviews. This term busy was then examined with other themes to ascertain how it interacted within the context of moral theory and the findings included three themes: 1) busyness: circulating and forming subjectivities; 2) docile-patient/immoral nurse; and 3) moral district nursing care: becoming-friend, becoming other. The themes illustrated that physical and psychosocial care was influenced by perceptions of busyness for patients and families potentially challenging the delivery of nursing care. For example, patients reported that when nurses appeared busy that they were unable to ask for care or assistance. Importantly, patients and carers internalised busy realities, which restricted therapeutic relationships.

This integrative review has identified that nurses, patients and families' experiences of care were influenced, regulated and impacted by a construct of busyness. Importantly, this review has identified that the establishment and maintenance of a therapeutic relationship was challenged in the presence of busyness. However, how busyness is perceived by paediatric nurses, patients (children and young people) and families in an acute paediatric setting remains unknown and presents a research gap.

SUMMARY

This chapter has presented an integrative review which has detailed the construct of busyness within western society and modern health care. Perceptions of busyness were subjective interpretations, which were shown to relate to time, physical environment, cultural, psychological and sociological dimensions. These dimensions were evident in nursing whereby time constraints, time pressure and workload influenced therapeutic

relationships across a diverse range of clinical settings, demonstrating that a notion of busyness exists within modern health care. This integrative review presented a critical gap for paediatric nursing research, as little is known about how busyness influences care practices and therapeutic relationships in paediatric acute care. The following chapter details the methodology selected for the study used to develop deeper insights into how busyness influenced cultural dimensions, care practices, and therapeutic relationships in everyday paediatric acute care.

CHAPTER 4: METHODOLOGY

INTRODUCTION

Ethnography is a research methodology and method that has been traditionally used to study groups and communities. Ethnography enables the exploration of social interactions and cultural notions that operate within a particular group of people. Realist tales was adopted for this ethnography to present data and for the first time to bring new understandings of paediatric nursing within an acute inpatient setting and more specifically, how busyness influenced the therapeutic relationship through parental engagement.

This chapter presents the philosophical underpinnings of ethnography as methodology and details the history of ethnography and how this relates to ethnographic research in modern nursing today. The following section presents ethnographic techniques, research processes, data analysis and interpretation. The final section presents ethnography as text and details the narrative style realist tales selected for the product, ethnography.

PHILOSOPHICAL UNDERPINNINGS OF ETHNOGRAPHY

Ethnography is a research methodology that was developed to explore and understand social contexts and has its origins in anthropology. It is characterised by distinct research methods that enable social dimensions to be understood that give shape to social and cultural contexts and processes. Ethnography as methodology seeks to understand the world through natural cultural scenes and defines this theoretical perspective. Consequently, ethnographic research can bring a deeper and richer understanding of a group's activities and processes and the cultural dimensions embedded in specific environments (Brewer 2000; Byrne 2001; Reeves, Kuper & Hodges 2008).

Brewer (2000) argues that ethnography is both a methodology as well as a method, describing the ethnographic methods as the procedural rules to follow for obtaining reliable and objective knowledge within a natural social context. These procedural rules within ethnographic methods not only include data collection techniques, such as fieldwork and interviews, but also guides data analysis. These procedural rules inform ethnographers on how best to conduct an ethnography.

Ethnography as methodology positions researchers to view the world through a specific epistemological framework. Within this epistemological framework, understanding by the

researcher is viewed through a lens, whereby meaning is socially constructed and shared (Norris 2005). Within any natural social context, shared meanings influence members' thoughts, actions and behaviour and brings recognisable cohesion to a setting or group (Brinkmann, Jacobsen & Kristiansen 2014). Hence, the shared social construction of meaning defines social relationships for particular groups. Ethnography provides a way of viewing and understanding shared meanings and seeks to characterise the nature of groups and settings (Brewer 2000; Howell 2013). Ethnographers are committed to an ontological position that constructs the shared nature of society.

Ethnography is positioned within the naturalism paradigm considered as the humanistic model in contrast to social positivism (based on the natural sciences) (Hughes 1990). Instead, ethnographers use naturalism to orientate understanding thereby always seeking to research in naturally occurring situations within everyday life (Guba & Lincoln 1985; Hughes 1990). Naturalism has three fundamental assumptions: i) that the social world is perceived and interpreted by the individuals within it and this is not what can only be externally observed, knowledge generated from the social world gives access to the individual's own account/s; ii) observations should be done in the natural setting; and iii) members of a scene are interconnected and meanings are embedded within context (Brewer 2000). Hence, the methodological position taken within this ethnography was naturalism and required the researcher to study specific group(s) (paediatric nurses and families) in their natural setting (acute paediatric inpatient setting).

According to Miles and Jozefowicz-Simbeni (2010), ethnographers guided by a naturalistic paradigm explore meanings and individual members' views from within a specific social context. To sustain this approach, ethnographers need to give attention to the social context, which connects members views and orchestrates social meaning. Ethnographers utilise techniques that capture members own words bringing clarity to social meanings. In this way, ethnography requires a researcher to be attentive to individual member's perceptions, feelings, ideas, behaviours and social scenes ensuring they are not controlled as is evident with a positivist experimental research approach (Hughes 1990). Ethnography has, for hundreds of years, sought to make visible social contexts and the meanings individual's share to bring cohesion to a scene.

HISTORY OF ETHNOGRAPHY

Since the 1800s, ethnography has been used to explore, understand and make visible social groups. Ethnography has its roots in social anthropology and has traditionally been focused on exploring distant exotic communities to understand their shared social

structures and belief systems (Reeves, Kuper & Hodges 2008; Savage 2000). Ethnographers travelled to distant communities, in remote locations, and would live within that community for extended periods of time. This immersion by ethnographers into naturalistic social scenes was thought to enable a deeper and more accurate understanding of a cultural group (De Chesnay 2015).

There have been a number of influential ethnographies conducted by eminent researchers and most notable are Malinowski, Boas, Radcliffe-Brown, Evans-Pritchard (Brewer 2000; O'Reilly 2009; Reeves, Kuper & Hodges 2008) and Margaret Mead (Aronson 2017; De Chesnay 2015). Bronislaw Malinowski (1884-1942) was a social anthropologist and considered the founder of ethnographic fieldwork (O'Reilly, 2009). Malinowski's most notable work sought to explore the 'natives' of the Tobriand Islands in Melanesia in the 1920s. Malinowski has been recognised for the systematic approach undertaken to record social interactions and perceptions of members of this social scene and has assisted to shape modern ethnography (O'Reilly 2009).

Further theoretical developments within ethnographic research were led by Margaret Mead's work in the 1960-70s. Mead's research influenced the character of ethnographies bringing for the first time to ethnography, a more inclusive approach, which highlighted gender issues. Specifically, Mead's anthropological ethnographic studies detailed women as a cultural group (De Chesnay 2015). Margaret Mead, the first female ethnographer, also undertook significant work that focused on theorising child rearing and learning patterns (Aronson 2017). Up to this point in time there had been a lack of women ethnographers globally (De Chesnay 2015; Newman 1996).

Since the 1800s, much philosophical debate had resulted in further refinement and development of ethnography as methodology and method. In particular, sociologists from the Chicago School of Sociology, in the 1920s and 1930s, began detailing local urban groups and communities such as street gangs, drug dealers, prostitutes, and migrant groups (Brewer 2000; Holloway & Galvin 2017). These urban ethnographers began to challenge the notion that ethnography was only useful to explore distant and exotic social groups.

Consequently, ethnography moved from its early anthropological roots where researchers travelled to exotic distant cultures to study primitive tribes to researching cultural groups within urban and contemporary settings. In post-modern times, the utility and value of ethnography as research methodology and method is well established and evident in fields such as nursing, social sciences, education, justice systems and health (Roper & Shapira 2000; Spradley 1980; Wolcott 1999).

Post-modern ethnography has seen new approaches to ethnographic inquiry and presentation which include: i) auto-ethnography whereby researchers present their personal accounts and experiences as central to the understanding of a phenomenon (O'Reilly 2009; Reeves, Kuper & Hodges 2008); ii) meta-ethnography in which qualitative research is synthesised and studies are translated into one another through concepts, metaphors and researcher understanding (Britten et al. 2002); iii) virtual ethnography, in which researcher-participant interaction is via technological mediums (Hine 2000); iv) focused ethnography, which involves adopting shorter in field time frames (weeks or months) and often focused on a problem or issue within a specific context (Morse 1991; Wolcott 1990); v) critical ethnography, which examines the social, political, and material disadvantage within a cultural group by understanding the influence of power relationships (Allen et al. 2008); vi) institutional ethnography aims to articulate and expose the institutional power present within social activities of everyday life in a certain cultural group (McGibbon, Peter & Gallop 2010); and lastly vii) practitioner ethnography, which aims to be highly interactive and suits the settings in which the practitioner is the central player (Barton 2008).

Today, while there are many different types of ethnographies, all continue to examine groups and communities from a cultural perspective within a naturalistic setting. Ethnography conducted within the health has assisted to give voice to group members' perspectives and bring to the surface the social realities and processes that are occurring.

ETHNOGRAPHY AND HEALTH CARE

Ethnography has been widely used within the health care sector to understand and explore social phenomena within different types of settings and across different clinical disciplines (Holloway & Galvin 2017; van der Geest & Finkler 2004). Specifically, ethnographies detailing health settings bring to the surface cultural meaning and how this can influence clinician behaviour, activities and practice more broadly (De Chesnay 2015; Roper & Shapira 2000). In these modern times, ethnographic research and specifically realist tales has become more widely accepted and used for health services research. Realist tales are evident by the use of thick narrative descriptions and verbatim participant quotes to convey social meanings of a particular cultural world (Brewer 2000; Van Maanen 2011). For this reason, realist tales were selected for this thesis.

Ethnographic research undertaken within health, has generated knowledge and understanding of the complex social systems operating within and across clinical settings (Holloway & Galvin 2017). For example, at the micro-level, what participants say and

how they act is ethnographically analysed against context and formal organisational structures to better understand clinical decision-making (Charmaz & Olesen 1997; Robinson 2013). Furthermore, insights into how professional knowledge is obtained, shared and practiced becomes clearer when using ethnography (Savage 2000). Hence, ethnography provides the most appropriate methodology and theoretical lens to understand cultural meanings and social processes.

Ethnography has been used to discover meaning within nursing practice, activities and patterns of behaviour to produce new knowledge and promote the wellbeing of patients and families (Robinson 2013; Roper & Shapira 2000). In more recent times, several nurse researchers have used ethnography to uncover cultural meanings within a variety of settings such as emergency departments, paediatrics and intensive care units (Fry 2012; Liu, Manias & Gerdtz 2012; Mahon 2014; McGibbon, Peter & Gallop 2010; Person, Spiva & Hart 2013).

The exploration of culture within different health settings has led to a greater understanding of social meanings. For example, Fry (2012) explored emergency nurses belief systems using ethnography, which was detailed as a realist tale. Observations and interviews, enabled the unpacking of unwritten rules, care beliefs and practices across multiple ED settings. Immersion in this field captured cultural patterns and contextual processes through emotional responses and perspectives of nurses. Understanding of emergency nurse belief systems facilitated reflection on triage practices and provided opportunities to improve and/or change how care was provided.

Ethnographic research has also been conducted in paediatric settings. For example, McGibbon et. al. (2010) explored the nature of stress in nursing. The institutional ethnography focused on the contextual aspects of nursing practices in a Canadian paediatric intensive care unit. Observations, interviews and focus groups were methods used to explore how nurses' socially organised and understood stress. Furthermore, this ethnography detailed how clinical placement at the bedside, family relationships, personal lives and gender affected the cultural environment, workplace behaviour and therapeutic relationships through experiences of stress.

Ethnography brings to the surface unwritten rules that form cultural norms and are embedded in practice and therapeutic relationships (Person, Spiva & Hart 2013) generating an understanding of everyday interactions, activities and context, which can be used to influence and drive better health outcomes and practices (Brinkmann, Jacobsen & Kristiansen 2014; Holloway & Galvin 2017; Robinson 2013). Undertaking ethnographic research within health settings enables the researcher to bring to the

surface meanings, social connections and processes between micro-level (individual and group) and macro-level (context and organisation) to enable understanding of a cultural context (Roper & Shapira 2000). Ethnography as methodology brings a theoretical lens that must align with research processes (Littlewood 2000).

ETHNOGRAPHY AS RESEARCH PROCESS

Ethnographic research processes must enable the researcher to be situated in the natural setting and to collect data in real time events, which will give meaning to the phenomena under investigation. Brewer (2000) suggested that it is important for ethnographers to select appropriately meaningful contexts and data collection techniques that enable the research question to be answered. Hence, ethnographers need to be immersed in a field, for a period of time, to allow the ethnographer to be exposed to phenomena and at the same time build rapport and a level of trust with participants (Brewer 2000; O'Reilly 2009). Field work maximises opportunities to view a large sample of activities, interactions and behaviour that are repeated over time and this enables the construction of realist tales (Schwandt 2011). Field work through a naturalistic lens leads to discovery and exploration of the social world and an understanding of group activities, processes and behaviour (Spradley 1980).

ETHNOGRAPHY AND SAMPLING

To ensure a richness of understanding is achieved, ethnographers need to select key informants who have extensive knowledge, experience of a cultural scene and social processes and are able to convey information (Wolcott 2008). Selecting key informants contributes towards the richness of ethnographic data, veracity, objectivity and perspicacity of the findings (Stewart 2011). Four types of sampling methods are commonly used in ethnography and include: theoretical, quota, snowball and purposive (Gobo 2008; Morse 2004). Purposive sampling was chosen for this study with the aim to select information rich participants with certain attributes or characteristics that will inform on specific settings or contexts (Fetterman 2010; Patton 2002; Ranney et al. 2015). Furthermore, the sampling of multiple key informants, within a social scene, ensures exposure to a range of phenomena (Morse 2004).

There are no methodological rules for determining sample size for ethnography, as is the case in the positivist's research paradigm. Instead, sample size is determined by the research question, the time required to become exposed to the range of phenomena under investigation and data saturation (Patton 2002). The appropriate sample size must enable sufficient depth of understanding and exposure to phenomena (de Laine 1997).

ETHNOGRAPHY AND DATA COLLECTION

Philosophical underpinnings of ethnography demand that a researcher be exposed to a context and its members to better understand social processes, behaviour and actions. Therefore, ethnographic data collection methods must enable the exploration and deep examination of data that will bring to the surface understanding of particular social groups and contexts. The methodological position of an ethnographer will influence the selection and use of data collection techniques to produce the ethnography (Miles & Jozefowicz-Simbeni 2010). However, common ethnographic data collection techniques include observation and interview.

OBSERVATIONS

Observation within the field is the foundation of ethnographic research and is a source of knowledge that differentiates ethnography from other methodologies (Gobo 2008). Observation is considered the cornerstone of ethnographic studies, as this data collection technique enables social meanings to emerge from fieldwork (Fetterman 2010; Hammersley & Atkinson 2019; O'Reilly 2012). The observed pattern of social interactions, behaviour, language and social processes enables the study of cultural notions (Wolcott 2008).

Ethnographers optimise understanding through extended periods of time in the field to obtain understanding of everyday activities and social meanings (Fetterman 2010; Hammersley & Atkinson 2019). Modern ethnographers continue to spend time in the field, with studies reporting hours, days, months or years observing phenomena (Byrne 2001; Hammersley & Atkinson 2019; Musante (DeWalt) & DeWalt 2010; Van Maanen 2011).

Gobo (2008) argued that observation brings meaning to tacit knowledge and that this knowledge is embodied within the repeated routines and behaviours carried out within a social scene and recommends that ethnographers focus on three key aspects: social structures, contextual action and the use of language. Furthermore, Wolcott (2008) recommends that the overt observer should only become involved in the scene when necessary, that is, when information needs to be clarified. The challenge for ethnographers during non-participatory overt observation is to decide whether they should interrupt key informants in the scene to seek understanding or stay silent and hope clarity unfolds over time (Wolcott 2008). Immersion in the field enables the ethnographer to observe and listen to what is naturally occurring, said, and done (Brewer 2000; Jeffrey & Troman 2004; Roper & Shapira 2000).

Wolcott (2008, p. 15) provides insight into the requirements of and for observational field work. Ethnographers need to be open to 'experiencing, enquiring and examining'. Wolcott's terms (experiencing, enquiring and examining) were constructed to assist the ethnographer to maximise information gathering by experiencing directly through all senses such as seeing and hearing while in the field. Today's ethnographer, during observation, needs to enquire actively to achieve understanding. Finally, the term examining refers to the ethnographer looking at what is already produced and giving attention within the contexts such as records, photographs, documents, policies. Wolcott's (2008) insights require the ethnographer to be more reflective when recording field notes. As a result, the ethnographer when seeking to understand context must be aware of interactions between themselves and the social context (Musante (DeWalt) & DeWalt 2010).

According to Atkinson (2017) ethnographer's need to be attentive to the boundaries that are both physical and symbolic. For example, institutions such as hospitals are defined by boundaries, such as the arrangement of wards and division between specialities. The physical arrangement of a hospital setting marks the professional division of labour and aspects of medical knowledge and known as symbolic boundaries. Atkinson (2017) further adds that these boundaries are more related to expert knowledge, cultural domains, academic specialties rather than physical walls or boundaries. These symbolic boundaries create subtle codes of distinction marking differences in social class and status, gender and ethnic differences. Consequently, ethnographers during observation need to be mindful and alert of and to existing boundaries within contexts.

ETHNOGRAPHIC INTERVIEWS

The interview is a common ethnographic technique and can be structured or unstructured, formal or informal (Fetterman 2010; Hammersley & Atkinson 2019; O'Reilly 2012). Undertaking Interviews with key informants enables the researcher to probe more deeply about contextual insights, which remain unclear or require further exploration (Morris 2015; Robinson 2013). Interviews provide opportunity for a deeper understanding and clarity of cultural meanings evident within contexts and portrayed by key informants during observations.

Wolcott (2008) outlined a variety of ethnographic interview approaches which include: casual conversation, life history and life cycle interview, key informant interviewing, semi-structured interview, household census and ethnogenealogy, questionnaire (oral or written), projective techniques and other measurement techniques. The casual conversation is also recognised as a form of ethnographic interview by Gobo (2008) and

usually occurs during observations and not scheduled but impromptu. This type of interview is often seamlessly integrated during observation using a friendly conversation style, with the focus of the questioning in relation to clarification about a behaviour or action behind what was communicated verbally.

The face to face key informant interview, adopted for this research, is described by Spradley (1980) and includes: explicit purpose, ethnographic explanations and ethnographic questions. Explicit purpose refers to the key informant and ethnographer meet specifically for an interview, whereby the ethnographer leads the conversation to seek clarity from the informant. Ethnographic explanation refers to explanations communicated by the ethnographer about the research project, when and why they are recording an interview and native language explanations to gather normal conversational style language. Ethnographic questions are noted as using three main types: i) descriptive, which assists the ethnographer in gaining samples of informant's language; ii) structural, which enables the ethnographer to uncover how informants have organised their cultural knowledge; and iii) contrast questions which aims to clarify meanings within native language.

In undertaking ethnographic interviews, Madison (2005) recommends that ethnographers should have a level of cultural understanding of the field before they commence. Therefore, ethnographers should conduct interviews in the middle and end stages of ethnographic data collection (Fetterman 2010; Hammersley & Atkinson 2019).

ETHNOGRAPHIC ANALYSIS AND INTERPRETATION

Ethnographers believe that the process of analysis is an iterative-inductive process (Brewer 2000; Gobo 2008; Wolcott 2008). The iterative-inductive approach is defined as the practice whereby data collection, analysis and writing are inevitably linked and not considered as separate phases (O'Reilly 2012). Ethnographic analysis should be undertaken as a continuous process rather than a sequence of discrete stages that occurs concurrently with data collection. All ethnographic processes lead to and inform the analysis phase (Holloway & Galvin 2017; Wolcott 2008).

Whilst ethnographic data may comprise of small sample sizes, the volume of data has significant scale and complexity. This large volume of data requires skilful analysis and ordered processes, which leads to the formation of data codes, patterns, themes and descriptions (Brewer 2000; Willig 2014).

Ethnographic interpretation occurs when the ethnographer attaches meaning and significance to the analysis, clarifying and consolidating patterns, categories and

relationships. Ensuring that the correct meanings are linked to the data is very important as this justifies and conveys cultural meaning and the complexity that surrounds context. Interestingly, Wolcott (2008) argued that the culturally orientated ethnographer does not just observe culture, but rather defines within the ethnography itself how culture is enacted within a social scene. The commitment to cultural interpretation is an important aspect for the ethnography. Discerning how behaviour, attitudes and activities make sense to key informants is an important step for analysis and interpretation. Ethnographic analysis is dedicated to capturing the insider's view conveying with accuracy the cultural meanings of a group. In this way analysis brings to the surface a reality by drawing attention to the subjective meanings of people (Holloway & Galvin 2017).

Furthermore, Atkinson (2017) believes that ethnographers must consider how the social reality fits into the context, stating that events are social in character and are a unit of analysis. Situations are formulated by boundaries and display cultural meaning for groups with analytic attention given to the different situations and realities that are produced by the key informants. However, there may be competing realities within a situation that cause confusion and conflict at times, it is therefore important to recognise that this may be present (Atkinson 2017). Therefore, what is conveyed as interpretation are multiple forms of participant tales and narratives. There is no single truth, but some aspects are less true than others. Multiple interpretations need to be captured by the ethnographer giving voice to those present in the scene (Atkinson 2017; Brewer 2000).

Critical analysis of the veracity of a voice when it conflicts with other voices is needed to be balanced within an ethnography (Brewer 2000). Nonetheless, ethnographic analysis and interpretation assist to unveil social patterns in a natural setting. The presentation of this social scene is through the writing of the text, realist tales, to enable the broader community to judge for themselves the truth, veracity, objectivity and perspicacity of the findings (Hammersley & Atkinson 2019).

ETHNOGRAPHY AS NARRATIVE

The presentation of ethnography details the interpretation of a social scene through narrative which provide evidence of its methodological positioning. For this thesis, the narrative is in the form of realist tales, which aligns with the naturalistic paradigm. The product of ethnography is text, defined by the act of writing. Gobo (2008) described three main types of ethnographic texts that are used to narrate an ethnography, which include: processual, reflexive and realist. According to Van Maanen (2011) realist tales – ethnography as product, is the most familiar, popular and recognised form of ethnographic writing. The realist account uses thick description and extensive verbatim

key informant quotations to convey authenticity to support the ethnographer's account. In addition, the use of thick description and verbatim quotes establishes the authority of the ethnographer's voice. Thick descriptions produce a realistic narrative of a social world (Brewer 2000).

Realist texts, referred to as realist tales, are embedded in realism as the narrative seeks to generate knowledge on the external world and brings cultural meaning and understanding to groups and communities. Realist tales assume that there is an external world beyond an individual's perceptions of it. Therefore, there is more to be understood about the social world than people's perceptions alone. A naturalistic perspective, a realist view, refers to a world that encompasses theory and knowledge, which cannot be directly sensed such as: attitudes, social class and political power (Gobo 2008).

Gobo (2008) described the realist tale as a snapshot of reality rather than a subjective interpretation. In the writing of realist tales, these elements are real and independent of individuals, even if they cannot be seen or felt directly. Realist tales seeks to convey dimensions of context beyond the spoken word. Hence, realist tales present narrative that makes it possible to formulate objective knowledge about the world fitting into a naturalistic paradigm (Brewer 2000; Gibbs 2007).

Importantly, the realist narrative hides the emotions, sympathies, likes and dislikes and personal characteristics of the ethnographer. All of which assures the reader that the narrative is not a personal view but rather a representation of the key informants' perspectives (Miller, Creswell & Olander 1998). Realist tales focus on the social experiences of the people being studied or use categories to discuss unfolding events within a social scene (Schwandt 2011). Realist tales connect the reader to a social account and make visible meanings of the participants within the natural setting. This gives rise to ethnographic narrative orientated by naturalism and guided by realism. The realist narrative is a snapshot of a reality that brings key informants' stories to the forefront.

ETHNOGRAPHER'S ROLE AND IDENTITY

Ethnographer's identity and role is an important consideration in the production of any ethnography. In the field the ethnographer's role is identified by the social actors and participants give meaning to their presence within the social group (Hammersley & Atkinson 2019). Hence, the ethnographer's identity is co-constructed during the research process (Hammersley & Atkinson 2019; Payne & Payne 2004). Specifically, as trust

develops and field relationships become established, participants' view of the ethnographer may change over time (Brewer 2000).

Overt observation is the most widely used approach by ethnographers and was selected for this study, as this approach enabled the ethnographer and key informants to establish a level of trust, which facilitated deep understanding of the social scene. During field work, overt observation requires the ethnographer to balance distance with authenticity, integrity and trust. In part, this is achieved through the researcher's considered reflexivity throughout the research process (O'Reilly 2009).

Importantly, an ethnographer should aim to be reflexive throughout the ethnography, being sensitive to the problems that relate to the representation, interpretation and validity of the study, whilst still allowing for the voice of participants to emerge from the social world (Brewer 2000). Throughout the ethnographic process researchers must consider what effect their role has on entering the field, being in the field, leaving the field and the writing of the ethnography. Constantly addressing the researcher's presence is important and ethnographers should remain unobtrusive to those participating in the scene (Spradley 1980).

The identity and role positioning of the ethnographer is always present during data collection, analysis and interpretation and can be a challenging and complex process to balance. However, ethnographer reflexivity can support a study's veracity, objectivity and perspicacity and strengthens the legitimacy of the study. The establishment of trust with participants throughout an ethnography and specifically during overt observation needs to be considered by all ethnographers. Consideration and reflexivity are required for distilling the impact of the researcher's presence during ethnographic data collection. For the purpose of this thesis this dimension will be discussed further in the section insider outsider perspectives.

SUMMARY

This chapter has presented ethnography as methodology, which has the methodological approach of naturalism. Ethnography has evolved over time and is commonly used to explore health care settings, bringing to the surface cultural meanings and social processes. The product of ethnography presents an interpretation of data collected from a social setting. Ethnographic data is usually collected through field work and interviews. Ethnographic narrative, such as realist tales, provides an opportunity to present the voices of individuals within a social setting. The positioning of an ethnographer and

reflexivity practice can assist to reduce bias and strengthen credibility, veracity, perspicacity and legitimacy of the study.

The following chapter presents the details of the ethnographic methods. Fieldwork and interview were selected to explore the construct of busyness within an acute paediatric inpatient setting. Specifically, how a construct of busyness influences the therapeutic relationship between paediatric nurses and families.

CHAPTER 5: METHODS

INTRODUCTION

This chapter details ethnography as methods and the research processes implemented to answer the research question. Ethnographic methods were used to achieve understanding and insight into a construct of busyness and how this influenced practice and activities within an acute paediatric inpatient setting. Specifically, to understand how key members of this scene share and convey a meaning of busyness.

The chapter begins with the selection of the field, followed by selection and recruitment of key informants. The next section details ethnographic data collection techniques, field relationships and leaving the field. The final section details data management, analysis and interpretation and ethnography as product - the writing of ethnography, and ethical considerations of the study.

SELECTION OF THE FIELD

This ethnography was undertaken in a tertiary referral hospital within metropolitan Sydney, New South Wales (NSW) Australia to maximise exposure to paediatric nursing. The setting selected was classified as a level four paediatric clinical service, that provides general paediatric clinical care and service to children and young people within the hospital's geographical catchment (NSW Ministry of Health 2018). The hospital was chosen as it manages a range of paediatric medical, surgical and mental health conditions. Children and young people present with families or parents/carers to this hospital with a range of conditions and/or presenting problem(s) that require short or lengthy hospital stays, expert nursing and multidisciplinary engagement.

The site selected was the inpatient paediatric acute care unit (beds n=31). The unit is divided into two clinical areas: paediatric unit which has 24 beds and the Child and young people Short Stay Unit which comprises of seven beds. The two clinical areas were staffed from the same pool of paediatric nurses and managed by a single Nursing Unit Manager (NUM). Given that paediatric nurses were employed to work across both areas, for the purposes of this ethnography, the clinical areas will be referred to as the paediatric inpatient unit. The unit enabled a range of phenomena to be explored as infants, children and young people (between the ages of birth to 18 years) were admitted to this clinical area. The unit was located on the top floor of the hospital, and was co-located with the maternity ward, neonatal intensive care, burns (adult) and orthopaedics (adult) units.

Admission of children to the unit occurred through the emergency department, pre-admission clinic, private medical consultant referral, or following surgery.

SELECTION OF KEY INFORMANTS

For this ethnographic study, purposive sampling was used to ensure key informants would have the experience, knowledge and confidence to convey information and meaning about this setting (O'Reilly 2009; Ranney et al. 2015). Therefore, the key informants selected to enable exploration of the research question were paediatric nurses and parents of children admitted to the unit. The number of paediatric nurse and parent participants selected was determined by the research question, inclusion criteria and consideration of the depth of understanding required. Research suggests that if groups are homogenous that sample size can be smaller with data saturation occurring with groups of 6 to 14 participants (Hammersley & Atkinson 2019; Willig 2014). Commonly homogenous groups between 6 to 12 have been shown to maximise opportunity for understanding of a social scene and achieve data saturation. The number of participants both paediatric nurses and parents selected for data collection and time in the field, enabled sufficient exposure and understanding of and within this social context.

PAEDIATRIC NURSES

Purposeful sampling was used to recruit experienced paediatric nurses, knowledgeable and skilled in the care of paediatric patients, engaged in family centred care and in the rituals of daily unit-based activities. A sample size of six to ten nurses was considered sufficient to enable data saturation to be reached (Hammersley & Atkinson 2019; Van Maanen 2011). The inclusion criteria for this group were the same for both observations and interviews and this included: nurses employed full time or part time; casual nurses contracted only to work in the paediatric inpatient unit; registered nurses with at least two years' postgraduate experience and a minimum of 12 months acute paediatric experience. Exclusion criteria included: agency nurses and Assistants in Nursing (non-registered nurses).

INPATIENT PARENTS

Purposeful sampling was also used to recruit parents present in the unit. For the purposes of this study, parents were considered key members of this social scene who engage with clinicians for prolonged periods of time and have a unique perspective of

this cultural setting. Parents were defined, for this study, as the parent that identified themselves as responsible for an infant, child or young person admitted to the paediatric inpatient unit.

A sample size of six to ten parents were selected to make visible the cultural context of this health care setting. A sample size of six to ten was considered appropriate to enable data saturation to be reached (Byrne 2001; Musante (DeWalt) & DeWalt 2010). The inclusion criteria for parent key informants included: biological, adoptive or foster parents that identified themselves as the parent of an infant, child or young person admitted for more than twelve hours to the paediatric inpatient unit. The exclusion criteria included: infants, children and young people in crisis with acute mental health illnesses; families that have suspected or confirmed risk of significant harm; families that are under the care of Family and Community Services; and infants, children or young people undergoing end of life care procedures. In addition, participants who spoke English as their second language were excluded from this ethnography due to the financial limitations of the researcher. These limitations included interpreter fees and transcription services for parental interviews.

ETHNOGRAPHIC DATA COLLECTION TECHNIQUES

Observation and interview are the cornerstone of ethnographic data collection (De Chesnay 2015; Fetterman 2010; Hammersley & Atkinson 2019). Therefore, to answer the research question the data collection techniques selected for this study were observation, in-depth face to face interviews and secondary data sources.

OBSERVATION

Observation in the field was conducted over a six-month period (September 2018 to March 2019). The six-month period was selected as this would enable sufficient exposure to the range of phenomena and the permanent and transitory members of this scene within the acute paediatric inpatient setting. Over the six-month period, 20-40 hours of observation was planned to maximise insights into the world of paediatric nursing. Across ethnographies the length of time in the field has varied significantly from hours to years (Leininger 1994; Whittemore, Chase & Mandle 2001).

Non-participant observation was chosen to observe paediatric nurses and develop an understanding of this setting. Observation periods targeted morning (7am-3:30pm) and afternoon shift (1:30pm-10pm) over weekdays and weekends. Paediatric nurses could self-select to participate in both or either observation and/or interview. Data collection

needs to maximise exposure to patterns and events therefore, morning and afternoon shifts were selected as these shifts provided more social interactions and activities. Night shift (10pm-7am) was excluded during observations. Spradley (1980) defends this approach arguing that the researcher needs to be exposed to repeated and recurrent activities during observation.

When undertaking observation, the researcher ensured that they were never an active member of this scene (non-participant observer) and always remained a respectful distance (at least one metre) during care activities and interactions from the key informant. This respectful distance ensured that key informants engaged naturally within their setting and for real life experiences to be observed. In this way a deeper and richer understanding of this social world could develop (O'Reilly 2012, p. 96).

To reduce participant fatigue, which is defined as a loss of concentration, the researcher constantly observed between the quantity of data collected and the quality of data collected (Martin & Bateson 2004). The researcher removed themselves from the participant's space every two hours (ranged from 15 minutes to 1 hour).

FIELD NOTES

Ethnography has traditionally used field notes to collect observable data. Detailed field notes describe the activities, behaviours, interactions and reflections in a timely manner (Fetterman 2010; Hammersley & Atkinson 2019). Field notes should contain conversations and natural language (body and spoken) in the form of direct quotes that are heard and observed. For this study handwritten field notes were recorded in a journal using a Smartpen Livescribe©. In seeking to answer the research question, the social context and its members both permanent and transiting through this scene were observed. As an observer within this context, some of the dimensions that formed part of the observations included the following: staffing, bed capacity, skill mix, sick leave, role of the Registered Nurse that was being observed (for example Team Leader or the details of their patient load), nurse's appearance, interactions that occurred between the registered nurse and the healthcare team, interactions with infants, children young people and families, environmental descriptions such as noise, lighting, clutter and interruptions, tasks related to nursing care and shift structures such as breaks and routines. Ethnographic fieldwork demands that researchers be open to all observable data from which to better understand the social context.

Spradley's (1980) framework was utilised for documenting fieldwork and this included: space (physical layout of the setting); actor/s (key informants) involved, activities that occur and frequency; objects or resources (such as the physical items that are present);

acts involving the single actions that participants or people undertake; events or activities that participants do, time outlining the sequencing of events; goals that participants are trying to achieve; and feelings or emotions felt and expressed.

The researcher paid particular attention to the language used, and the details of what a participant or other/s said and where (location) including background information (Brewer 2000). In field notes, verbatim quotations were written with quotation marks and apostrophes when paraphrasing and no marks for recall were used in the field notes as recommended by Roper and Shapira (2000). All field notes were read, reflected upon and transcribed within a week of the observation to enable the researcher to remain immersed and familiar with the data. Evidence suggests that this process assists with obtaining clarity and deeper meaning of a social scene and assists with transcription and analysis of data (O'Reilly 2009). Importantly, immersion in the data enabled hunches and reflections to be clarified and/or explored during observations (Flick 2018).

In the field notes, there was a section for personal memos that detailed reflective impressions, perceptions, patterns, concepts, analytic ideas and questions that were asked of the participant (Roper & Shapira 2000). In addition, data included drawings of physical layouts, outlining key structures, noting of space and place through mapping (Spradley 1980). Field memos are considered to be reflective documents with the intention of moving a researcher towards a deeper understanding of the data (Roper & Shapira 2000). The detailed transcription of field notes and memos is an important process in ethnographic data collection and interpretation. Therefore ensuring accuracy and credibility of data is essential to ethnographic veracity, objectivity and perspicacity (Roulston, deMarrais & Lewis 2003; Stewart 2011).

Observation is a key data collection technique within ethnographic research as it facilitates the understanding of the meanings that operate within this social scene. The documentation of fieldwork was collected using handwritten field notes. In-depth face to face interviews were also undertaken to gain further clarity and provided opportunity to confirm or disconfirm observational findings.

IN-DEPTH FACE TO FACE INTERVIEWS

In-depth face to face interviews provided opportunity to obtain information from a participant’s perspective and thereby to better understand their social setting (Morris 2015; Ranney et al. 2015; Roulston, deMarrais & Lewis 2003). Interviews were conducted with paediatric nurses and parents and used a semi-structured approach, which is a common ethnographic data collection technique. Interviews were conducted

(November 2018 to March 2019) with eligible paediatric nurses and parents after 25 hours of observations had been conducted. Undertaking in-depth interviews during the middle segment of data collection enabled the researcher to become familiar with this setting and for hunches and thoughts to emerge from the observational data.

PAEDIATRIC NURSE INTERVIEWS

To achieve sufficient understanding (data saturation) eight to ten in-depth face to face interviews were conducted over a six-month period. The first in-depth interview in the field was with a senior nurse. This was purposely done as a way of assessing and reflecting on how the interview questions flowed in real life. The interview duration was anticipated to last between 30 to 40 minutes and scheduled during business hours and at a time convenient to the paediatric nurse.

PARENT INTERVIEWS

Parents of inpatient infants, children and young people were selected as key informants. To achieve sufficient understanding (data saturation) six to ten in-depth face to face interviews were conducted over a period of four months. Parent interviews were conducted at the bedside with their infant, child or young person or in a private room on the Paediatric Inpatient Unit. Parents were provided with this choice so that they could attend to their infant, child or young person if the need arose.

For interviews conducted at the bedside privacy was maintained by ensuring that the curtains or door was closed, and a sign was put up requesting no interruptions unless urgent care was required. This process was agreed to by the NUM. Parent interviews were only undertaken when the infant, child or young person was considered stable by clinicians. Interview duration was anticipated to be 30 to 40 minutes and scheduled during business hours on weekdays and at a time convenient for the parent.

PREPARATION FOR INTERVIEWS

Preparation for interviews (paediatric nurses and parents) included two pilot interviews. Interviews were conducted with supervisors to ensure capability and confidence and as a way of reflecting on interview question flow and language. An interview guide was developed for both the nurses (Appendix 3) and parents (Appendix 4). Participants were asked the questions in the same order and the open-ended questions allowed for personal and professional perspectives to emerge. Ranney et al. (2015, p. 16) framework for conducting interviews was used as a guide and included: i) an introduction between the researcher and participant; ii) rules for the interview were established such as confidentiality and no interruptions (including mobile phone on silent or switched off); iii)

description of the research study (objectives, ethical guidelines and obtain consent); and iv) allow opportunity for participant questions.

A conversational tone was used for interviews to build rapport with participants and ensured consistency and rigour (O'Reilly 2012). While the flow of information between the researcher and participant was conversational there remained opportunity for probing and exploration of information (Morris 2015). Importantly, the conversational tone, flexibility and free flow of information between the researcher and participant allowed the participant to tell their story.

When conducting interviews, the strategies recommended by Ranney et al. (2015), were adopted. Sensitive questions were asked only once a rapport with the participant was developed, flexibility in relation to the wording (examples from fieldwork were given to assist the participant understanding) and relevant lines of enquiry were followed. Hence, interviews commenced with an icebreaker question to make the participant feel comfortable in sharing sensitive, controversial and emotional information about the social scene. Following the first question the interview questions moved into topic headings that were open-ended and contained: main questions (grand tour) which introduced the major topics; follow-up questions (prompts) to move the conversation into a deeper level through questioning and direction into pre-planned areas or inquiry; probes that invited further discussion or clarification that assisted with steering the conversation into specific areas; a closing statement and summary of key points that allow the participant an opportunity to clarify any information or points was also included.

SECONDARY DATA SOURCES

In addition, to the observations and interviews, secondary data were also collected. Secondary data sources included: information that assisted in understanding ways of working, thinking, perceptions and interactions within this setting. For example, secondary data sources included: paediatric inpatient unit staff rostering, policies, procedures and guidelines; medical and nursing medical forms; communication notices; parent or carer information pamphlets; and ward activities.

RECRUITMENT AND FIELD RELATIONSHIPS

To recruit participants for data collection the researcher established relationships with key gatekeepers who assisted in the navigation of this clinical setting and enabled access and recruitment of potential participants. Gatekeepers are known as the individuals that have the power to grant access to the field (Brewer 2000), which in this

study included Nurse Managers and Directors of Nursing and Midwifery. Importantly, informal gatekeepers such as nursing Team Leaders were also acknowledged as of significant importance within this social context to ensure that the researcher was not limited in terms of access to observational data. According to Long, Hunger and van der Geest (2008), gaining access to a hospital setting cannot be taken for granted and will often require significant time and negotiation.

To build a rapport with formal gatekeepers and seek support for this study the researcher met with the study site's Divisional Nurse Manager and the NUM. A series of meetings were arranged to ensure open discussion, agreed research processes and access to the field. All gatekeepers were provided with study documents (protocol, participant information sheet and consent forms for paediatric nurses and families and recruitment posters for paediatric nurses and families) prior to the meetings to allow time for reading and the raising of concerns.

The initial meeting focused on study related issues, such as the timing of access to the field for observations, recruitment strategies including the interviewing of key informants, study benefits and ethical considerations. Within ethnography, engagement with gatekeepers was an important consideration and needed to be facilitated with considered thought to gain access and ensure successful recruitment. Once access to the field was approved recruitment of participants was sought. The researcher understood the importance of establishing positive field relations early with the formal and informal gatekeepers and the fostering of these relationships continued from the initial stages of selecting the field until leaving the field. The establishment and fostering of relationships with gatekeepers was supported and achieved through ongoing effective communication, such as: communicating with the NUM and Team Leader who the researcher had planned to observe on a particular shift and/or interview that day; being overt during observations; and probing for information to enable understanding of the field and working within ethical boundaries.

PAEDIATRIC NURSE RECRUITMENT

To begin paediatric nurse recruitment, study posters were positioned within clinical areas and staff rooms to maximise information sharing about the study and to recruit nurses for both or either observation or interview. In addition, to the posters being visible in the relevant setting, a range of recruitment strategies were selected for the study. The NUM circulated an expression of interest in an email to paediatric nursing staff with a participant information sheet and consent form (PISCF) for observation (Appendix 5) and face to face interviews (Appendix 6). Prior to entering the field two information sessions

were conducted for interested and eligible nurses one week apart on different weekdays to maximise recruitment and interest for the study. The information session included; information about the research study (overview) and relevance to nursing practice.

Once confirmation that a nurse was interested in being involved in the study, the researcher requested that they complete the relevant written informed consent (observation and/or interview) form. Written consent was obtained prior to undertaking an observation and/or interview. Ongoing consent was an important element of the ethical considerations for this ethnography. In particular, the potential for participant distress during observations and/or interviews was addressed as part of the ethics approval process. Hence, during data collection, the researcher ensured that participants had a clear distress protocol in place for managing distress, should it occur during observations or interviews. The distress protocol included ceasing the observation and/or interview immediately and offering the participant support from their NUM or Employee Assistance Program (EAP). In addition, after field work episodes the researcher debriefed with supervisors and discussed events and emotions experienced.

PARENT RECRUITMENT

Initially, parent recruitment study posters were displayed in all clinical areas where potential parents could be informed about the study. Posters and researcher engagement at the bedside were methods used to recruit parents into the study. Recruitment of parents were supported by the NUM and Nurse Team Leader (TL). The researcher was informed by the TL of families that met the eligibility criteria. On these occasions (separate to observations of nurses) the researcher would discuss with parents their eligibility to be recruited for an interview.

The researcher only approached parents in this clinical space once approval was obtained from the relevant clinicians. Then the researcher would approach the bedside, introduce themselves and seek permission to speak with the parent about the study. Parents were provided with a PISCF for face to face interviews (Appendix 7) and given time to review the documents. The researcher encouraged the parent to ask any questions they may have about the study. For parents willing to be involved in the study, the researcher would obtain written consent and explain the interview process. A convenient time and interview space for the parent was arranged after completion of the ethics consent process.

The researcher remained sensitive and respectful of this setting during recruitment. Prior to any parent interview, the researcher approached the nurse caring for the patient and

TL and informed them that a parent had agreed to participate in an interview. This was important to maintain field relations and demonstrated respect for the clinical work that was occurring within this setting. In addition, participant distress protocols were in place for families that may become distressed during an interview. This included ceasing the interview immediately and offering the family support from the Paediatric NUM and/or Registered Nurse caring for the patient. In addition, the Paediatric Social Worker was also available for families should they have required further support.

LEAVING THE FIELD

During field work the time point for leaving the setting is usually determined by data saturation. Data saturation is reached when data is sufficiently detailed with rich description, and no new information is emerging. Specifically, patterns begin to surface that are repeated over and over again and it is at this point that the ethngrapher considers withdrawal (Bowen 2008). In this ethnographic study, data saturation was apparent when the researcher was constantly exposed to the same behaviours, voices and perspectives within this social context. Data saturation occurred for both the observations and the interviews evident by no new ideas coming through into the data.

Leaving the field can be challenging for an ethnographer, therefore strategies were considered to support positive field relationships on exiting this scene. Ethnography is a priviledge and it is important to leave the environment with respect and considered thought. To this end the researcher thanked and expressed their appreciation to each participant for the time they offered in being a part of this study. Thank you emails were sent to the; NUM, Clinical Nurse Consultant (CNC) and Clinical Nurse Educator (CNE). In addition, a separate email was sent to the NUM for distribution to all nursing staff, which formally thanked all participants involved in the research study. This was an important aspect to building and sustaining field relationships after leaving the field.

INSIDER OUTSIDER PERSPECTIVES

At the time of the study the researcher was employed in a different health care organisation as a Paediatric CNC. The researcher was unfamiliar with the setting selected for the study and was not involved in the care practices within this field. Therefore, the researcher was considered an outsider and not a member of this scene. As a paediatric CNC with 22 years' experience, I understood the language, nuances, utility of space and context of paediatric care. My knowledge and experience positioned me to understand the nuances displayed within this scene and enabled greater awareness and understanding of context and care activities within this setting.

The identity, role and reflexivity of the ethnographer is important when seeking to understand any social context. Therefore, in the undertaking of this ethnography continuous reinforcement of my role as researcher and not clinician was promoted during fieldwork. The researcher approach undertaken was to remain open, honest about the research process. A friendly approach enabled the researcher to build positive field relationships with the participants, further strengthening the validity of the study. The overt researcher approach fostered trust, integrity and authenticity, which commenced from selecting the field until leaving the field. As researcher, I constantly addressed my presence within the scene ensuring I was using the space in a way that did not encroach on the normal social interactions or activities of this social scene.

Whilst I was an outsider, as a paediatric CNC I brought insights that assisted with probing, clarification and understanding of the everyday life of the unit. As this was a new scene, I could remain open to new meanings and understandings to reduce the risk of researcher bias. Being familiar with the nuances of nursing and specifically paediatric nursing brought greater depth and richness to understanding this scene that other researchers could not bring.

Indeed, nurses should be viewed as having the qualities and skills needed to undertake research. Specifically, Roper & Shapira (2000) believe that nurses make excellent ethnographers as they use observation in their everyday practice, have expert communication skills, and are required to interact with a diverse group of individuals.

As an outsider, I sought to further reduce researcher bias throughout the ethnography by conducting daily reflective processes. Moments of reflexivity were documented as memos, which recorded personal responses, feelings and biases. These provided opportunity for discussions with research supervisors and participants. The following reflective excerpt from my field notes (observation 3) is an example that was discussed with my supervisors to support the reduction of biases, positive field relations, critical and reflective thinking and my researcher role.

'*I could feel the mother's distress and frustration of her child being fasted and not having a definitive time for him to have his operation done. This mother also had to pick up other children but didn't want to leave the child if theatres were going to be ready soon. During this conversation, the mother stood on one side of the nurses' station and the paediatric nurse stood on the other side (behind the desk). The paediatric nurse tried to alleviate the mother's concerns by calling theatres and was given information that an emergency caesarean section was being performed which had delayed other emergency cases. I wanted to step in and support the mother (Field Note, observation 3).*

Roper and Shapira (2000) believed that reflection should be practiced to facilitate the understanding of power relations and role differences between the researcher and participant, including participant perceptions of research outcomes. Nurse researchers are familiar with self-reflection as the practice is widely used in nursing and is a normal part of professional development. Self-reflection is important for any ethnography and can strengthen veracity and credibility (Mahon 2014). According to Hammersley & Atkinson (2019), reflexivity is an important part of ensuring the credibility of an ethnography. The process of self-reflection assisted to reduce researcher bias and ensure that the voices heard were those of the participants.

DATA MANAGEMENT

A data management plan was developed for the study, which detailed the processes to ensure participant and site privacy, confidentiality and beneficence. Data management included the secure storage and maintenance of confidential study data both paper and electronic. For the purposes of this thesis, documentation data included: field notes, memos and participant consent forms which were stored in a secure office in a locked filing cabinet in line with ethical requirements.

Fieldnotes were recorded in Livescribe© journals and these journals including the Smartpen© were stored in a protected locked filing cabinet. Two recording devices (Smartpen Livescribe© and HT recorder) were used to gather interview data and Dragon (voice recognition) software was used to assist with transcribing. Participant demographic data were collected and entered into Microsoft Excel™ for analysis, and de-identified to maintain to privacy, confidentiality and beneficence. Electronic audio recording data were secured on a password protected computer only accessible by the researcher. Audio recorded data were transcribed verbatim into Microsoft Word™ and on completion were uploaded, stored and coded in NVivo™ v12. All electronic data were

secured using encryption software. Audio recordings were deleted post transcribing into text.

Only the lead researcher had access to the names of potential/actual participants to ensure observation and interview times could be arranged and consent obtained. Participant names were needed to build rapport in the field and arrange data collection episodes. On completion of the field work all participants, in this scene, were allocated pseudonyms to ensure privacy, confidentiality and beneficence.

DATA ANALYSIS AND INTERPRETATION

Data analysis is about 'making meaning' whereby the researcher moves through a process of collecting, sorting, summarising, translating and organising via coding (O'Reilly 2009, p. 13). Analysing and interpreting ethnographic data requires a systematic and rigorous approach to ensure credibility, dependability and veracity of findings. Ethnographic data analysis utilising Brewer framework (2000) was commenced when data saturation was reached for both observational fieldwork and interviews. Ethnographic data saturation is evident when no new patterns emerge during data collection. Ethnographic analysis occurred prior to entering the field, during fieldwork and post data collection. Prior to entering the setting, analytical thought began with the development of the research question; *how do paediatric nurses and parents construct a notion of busyness within therapeutic relationships in a paediatric acute care setting?* During field work the researcher analysed insights that were occurring through data collection. Then a deeper level of analysis began as the field notes, audio recordings and interviews were transcribed verbatim and checked for data accuracy (Roulston, deMarrais & Lewis 2003). Transcription ensured that all participant's perspectives could be brought to the surface and cultural nuances were not lost in translation (Solomon et al. 2016).

This ethnography was guided by Brewer's (2000) framework for analysing and interpreting ethnographic data for both observational fieldwork and interviews. In keeping with Brewer's (2000) framework, the research question and insights in relation to analysis that occurred during data collection were focal points for the analysis process. The steps used for analysis recommended by Brewer (2000) began with the organisation of data into manageable units (coding), whereby data was indexed into categories, patterns and themes. The process started with descriptions of key events, people and behaviours, establishing patterns for example looking for recurring themes and relationships between the data. Next, the coding was developed into a broader classification system of open codes to understand and explain data. At this point confirmatory and dis-confirmatory

data were explored. It was important to examine all data including dis-confirmatory data such as negative cases to explain the exceptions where cases and voices diverged. In this study, the situations, cases and events that were coded as dis-confirmatory were balanced with other voices to bring clarity and a coherent understanding of this scene that would be recognisable to participants. These processes ensured that participants' perspectives were brought to the surface and cultural nuances were not lost (Solomon et al. 2016).

Each interview and observation dataset were reviewed multiple times by the researcher. This was suggested by Hammersley & Atkinson (2019) as a way to minimise researcher bias. The iterative-inductive process of constantly moving forwards and backwards from the research questions to the data enabled a process of deep enquiry and questioning which strengthened veracity, objectivity and perspicacity (O'Reilly 2012). Furthermore, exploration of what the participants said to ensure truth and honesty of their responses, looking for alternative explanations as to enable deep thought and reflection even if these explanations were dismissed and keeping the data and methods in context ensured that representation of the unit of voices from the field were accurate (Brewer 2000).

Throughout the analytical process, the researcher aimed to be descriptive, analytical and reflexive. Consideration was given to: the relevance of the topic and setting, and how this related to generalisations made within the setting; features of the setting and topics that were left un-researched with rationales as to why those decisions were made and implications in relation to the research findings; application of the theoretical framework - naturalism along with personal values that could influence the research product; and critical reflection of researcher integrity throughout the experience of the research process (Brewer 2000).

Finally, the researcher considered the complexity of the observation and interview data through the examination of social processes and activities including the contextual nature of participant's accounts and different voices. In addition, the analysis of negative cases, which were different to common patterns of data, and included contradictory cases between participants was also undertaken (Brewer 2000). The final themes were generated from in-depth engagement with the data that was gathered from the fieldwork observations and interviews. The iterative-inductive approach was conducted throughout data collection and analysis, coding processes and theme development. The validity of the findings were supported by the naturalistic methodological position adopted. Further, the researcher's supervisors, with expertise in qualitative research, were actively involved in data analysis, coding and interpretation, thereby strengthening the finding's

legitimacy, veracity and credibility. All coding and themes in NVivo^{TM} v12 were reviewed by the researcher's supervisors prior to the writing of ethnography.

ETHNOGRAPHY AS TEXT

Realist tales was the style of narrative chosen for this ethnography. Realist tales is the best way to present social accounts of nurses and parents within a paediatric inpatient unit. Realist tales seek to give voice to participants, convey a setting and the social understandings that are embedded within that context (Brewer 2000; Van Maanen 2011). Realist tales detail accounts of routine activities and natural language, which provided perspectives from the nurse's and parent's point of view. Importantly, the use of participants' own words, rather than those of the researcher, the reader can connect with the scene enabling the veracity of interpretation to be judged.

Importantly, realist tales can best present how nurses and parents perceived a notion of busyness within this paediatric acute care setting. The voice of different members in the scene, such as parents, strengthened the quality of this ethnography and further assisted to convey understanding of this social scene. Realist tales ensured the voice of participants remained at the centre of this narrative.

HUMAN ETHICAL CONSIDERATIONS

Ethical approval was granted by the Local Health District Human Research Executive Committee (HREC) reference number: LNR/17/HAWKE/443 (Appendix 5). This study was considered low and negligible risk (LNR) by the local Human Research Executive Committee. The researcher adhered to the national statement on ethical conduct in human research (National Health and Medical Research Council, Australian Research Council & Universities Australia 2018). Site Specific Approval was obtained from the local research governance unit (SSA-LNRSSA/17/HAWKE/444). University of Technology Sydney ethics ratification (UTS HREC Ref No: ETH18-2874) was obtained as a requirement for research students.

Posters (paediatric nurses and parents) and the information sessions were approved and conducted on site for eligible paediatric nurses and those that attended did so voluntarily. Ethical approval was granted for an email to be sent to paediatric nursing staff (by the NUM) containing study information. A consistent consent process was followed for each participant. The PISCF included: the purpose of the research study; participant inclusion criteria what participating involved; privacy and confidentiality; how to enrol in the study; support services available for participants that felt uncomfortable or

distressed during or after participating in the research study; withdrawal of consent and guidelines on the process; and contact details if there are any concerns the research process.

Privacy and confidentiality were maintained throughout all stages of the research process through appropriate data management; informed consent; working overtly with participants; establishing trust; understanding of the role of the researcher and through adherence to the ethical guidelines of the research study.

This study received financial support from the University of Technology, Faculty of Health Scholarships (The Centre for Nursing Research (CeNseR), Health Services and Practice (HSP) Research Student Development Award) and The Edith Cavell Trust for the transcribing of field notes and audio interviews into word documents to enable proper analysis and narrative development, equipment to assist with writing field notes, stationery and parking fees when undertaking fieldwork at the hospital.

Finally, as a Registered Nurse, the researcher had a professional obligation to act within accordance of legislation in relation to duty of care. All Registred Nurses are required to adhere to the Registered Nurse Standards and the Code of Conduct, which is enforced by the NSW Ministry of Health, Local Health District and the Australian Health Practitioner Regulation Agency (Australian Health Practitioner Regulation Agency 2016; NSW Ministry of Health 2015). During observations a researcher could be exposed to unpredictable and/or emergency situations, which may arise in the event of patient deterioration. If the researcher was exposed to an emergency situation during fieldwork, as a RN, the researcher would have a professional obligation to act immediately if a life threatening event occured for a patient, staff or family.

SUMMARY

This chapter has presented the methods conducted for this ethnography. Importantly, the ethnographic methods sought to explore how the construct of busyness within this social world was perceived, enacted and understood in this paediatric inpatient unit. The chapter detailed the selection of site and data collection techniques, recruitment strategies, field relationships, entering and leaving, and researcher position within the study were described. In addition, data analysis and interpretation processes were made clear. Finally, realist tales was selected for this ethnography to provide opportunity to connect the reader to a social account. The following chapter presents the first results chapter of this thesis. The findings presented address an important research gap first identified in the integrative literature review.

CHAPTER 6: FINDINGS
THE CONSTANTLY CHANGING LANDSCAPE

INTRODUCTION

This chapter presents the findings from observations and in-depth interviews with paediatric nurses and parents. This findings chapter brings to light the social understandings and meanings within therapeutic relationships between paediatric nurses and families and further, the influence of busyness. This chapter provides rich insight into paediatric care delivery within a constantly changing landscape and the shared practices that co-create a culture of care and give shape to the construct of busyness.

The chapter is presented in the following sections. Firstly, the paediatric unit environment including participant demographics are described. The following section presents three key themes: i) a shifting culture of care; ii) shared practices and the culture of care; and lastly iii) being a parent in hospital.

THE PAEDIATRIC UNIT DEMOGRAPHICS

The paediatric unit had both clinical and non-clinical spaces to optimise the delivery of care to sick infants, children, young people and families. The unit was set out in a u-shape design with long corridors on either side of the unit with the staff station and playroom in the middle of the unit. The entry door was on the left side of the unit and there were signs along this corridor showing where to find bed numbers. The two corridors off to the side were locked and required swipe access. Therefore, families that were staying or visiting children and young people on the right side of the unit needed to walk up to the staff station and follow the corridor around to the other side.

The unit had 24 beds including: 10 isolation rooms were located on both sides of the unit, two rooms of four beds and three rooms of two beds. Clinical spaces comprised of a: i) staff station; ii) medication room; iii) utility (pan room); iv) procedure room; and v) storeroom. The non-clinical spaces included: i) playroom; ii) adolescent room; iii) fairy garden; iv) the Ronald Macdonald room; v) communal staff tearoom; vi) Nurse Unit Manager office; vii) Clinical Nurse Educator office; and viii) two meeting rooms. There was also a co-located Child and Adolescent Short Stay Unit, Clinical Nurse Consultant and Clinical Nurse Specialist grade 2 offices. Allied health professionals employed at this hospital site provide care to both adult and paediatric patients.

During the study period the paediatric unit had 4,985 admissions (July 2018 to June 2019). The highest and lowest number of admissions were reported in September (n=467) and January (n=331) respectively. A mean of 415 admissions were reported for each month. More than half of the patients (n=3190, 64%) were admitted under the paediatric medical team (Table 2).

TABLE 2: PAEDIATRIC ADMISSIONS AND REFERRAL PATTERNS

Paediatric Admissions	**N**	**%**
Source of Referral		
Emergency Department	3905	78
Community Health practitioner	366	7
Non-emergency care	262	5
Other	236	6
Outpatient's department	216	4
Medical Specialty		
Paediatrics	3190	64
Other	488	10
Orthopaedic surgery	482	9
Ears, nose & throat surgery	283	6
Plastic surgery	239	5
Hand surgery	214	4
Psychiatry	89	2

The majority of admitted children (n=3041) were under six years of age (Table 3). Slightly more males were admitted (n=2915, 58%) than females (n=2070,42%).

TABLE 3: PAEDIATRIC UNIT CHILD CHARACTERISTICS

Characteristics (n=4,985)	N	%
Gender		
Male	2915	58
Female	2070	42
Age groups		
Infant (less than 1 year)	864	17
Toddler (1-2 years)	1238	25
Preschool (3-5 years)	939	19
Primary (6-12 years)	1147	23
Young person (13-18 years)	797	16

The medical team consisted of 11 Paediatrician physicians, a Paediatric Fellow, Paediatric Registrars and Paediatric Residents that provided care 24 hours per day seven days per week. Other specialist medical and surgical teams would consult on the unit but provided care to both paediatric and adult patients in the hospital site.

PAEDIATRIC NURSING TEAM

The nursing team comprised of 42 nurses (35.29 full time equivalent (FTE)). The nursing recruitment target was 44.57 creating a vacancy rate of 9.28 FTE. Of those 42 nurses, 2.0 FTE were Assistants in Nursing and 5.44 FTE were held by temporary nursing positions which included: Transitional RNs and RNs with no previous paediatric experience. In addition, to the 42 nurses, the paediatric nursing team included: Paediatric CNC, Adolescent CNC, NUM, CNE, Clinical Nurse Specialist grade 2 (Child and Adolescent Unit) and three Clinical Nurse Specialist (CNS) grade 2 (Hospital in The Home).

During the study period, the nursing team had undergone turn over within the past 12 months with 12 RN resignations. The reasons included the following: moved out of Sydney (n=4), retirement (n=2), promotions (n=2), obtained a non-shift work nursing

position Monday to Friday (n=1), family reasons (n=1), obtained a casual pool position (n=1) and Transitional RN position in another specialty (n=1).

PARTICIPANT DEMOGRAPHICS

Face to face interviews were conducted with paediatric nurses and parents. Observations were also conducted during this time to enable exposure to the phenomena.

NURSE PARTICIPANTS - OBSERVATIONS

Nurses (n=7) were observed for a total of 40 hours. Three nurses were observed once with four nurses observed twice. Paediatric nurses were observed for a maximum period of four hours with a brief break offered (15-30 minutes) before resumption of field observations. All nurses agreed to be interviewed. Nurse participant demographics specific to observations are presented in Table 4.

TABLE 4: PAEDIATRIC NURSE OBSERVATION DEMOGRAPHICS

Characteristics (n=7)	N	%	Median (Interquartile range)
Gender			
Female	6	86	
Male	1	14	
Age (years)			36 (23)
Participants nursing role			
Clinical Nurse Specialist grade 1	3	43	
Registered Nurse	3	43	
Endorsed Enrolled Nurse	1	14	
Education			
Master's Degree	2	29	
Postgraduate Diploma	0	0	
Postgraduate Certificate	2	29	
Bachelor's Degree	2	29	
Endorsed Enrolled Nurse Diploma	1	13	
Years in Nursing			14 (22)
Years in Paediatric Nursing			10 (22)
Years in Study Setting			5 (18)

PAEDIATRIC NURSE PARTICIPANTS - INTERVIEWS

A total of 10 nurses participated in an interview. Of the 10 nurses, seven nurses agreed to be participants in both observations and interviews. Three nurses agreed to only participate in an interview. In-depth face to face interviews with nurses commenced after five observation sessions had been conducted (November 2018 to March 2019).

Paediatric nurse interviews had a mean interview duration of 43 minutes. The majority of participants were female (90%), working part time (60%) and rostered to a rotating shift pattern (80%). The rotational roster included: mornings (0700-1530hrs), afternoons (1330-2200hrs) and night duty (2130-0730hrs). Postgraduate qualifications and paediatric nursing experience are detailed in Table 5.

TABLE 5: PAEDIATRIC NURSE INTERVIEW DEMOGRAPHICS

Characteristics (n=10)	N	%	Median (Interquartile range)
Gender			
Female	9	90	
Male	1	10	
Age (years)			34 (23)
Participants nursing role			
Nurse Unit Manager	1	10	
Clinical Nurse Educator	1	10	
Clinical Nurse Specialist grade 1	3	30	
Registered Nurse	4	40	
Endorsed Enrolled Nurse	1	10	
Education			
Master's Degree	3	30	
Postgraduate Diploma	1	10	
Postgraduate Certificate	2	20	
Bachelor's Degree	3	30	
Endorsed Enrolled Nurse Diploma	1	10	
Years in Nursing			11 (22)
Years in Paediatric Nursing			8 (22)
Years in Study Setting			5 (18)

PARENT PARTICIPANTS - INTERVIEWS

Ten parents agreed to participate in this study. Parent interviews commenced after seven nursing observation sessions had been conducted (November 2018 to March 2019). These interviews coincided with the ongoing nurse observations and interviews. The ten parent interviews had a mean interview time of 23 minutes.

All parent participants were either the birth mother or biological father of the infant, child or young person admitted to the paediatric unit. The majority of parents were female (n=8,80%) with a median age of 43 years. Participating parents came from diverse ethnic backgrounds (Table 6).

TABLE 6: PARENT INTERVIEW DEMOGRAPHICS

Characteristics (n=10)	**N**	**%**	**Median (Interquartile range)**
Gender			
Female	8	80	
Male	2	20	
Parent's age (years) (n=9)			43 (27)
Parent's country of birth by continent			
Australia	4	40	
Oceania	3	30	
Europe	1	10	
Africa	1	10	
South America	1	10	
Marital status			
Married or Defacto	8	80	
Single	2	20	

Participating parents and their hospitalised child's demographic information is detailed in Table 7. Children presented with a range of medical conditions.

TABLE 7: CHARACTERISTICS OF CHILD ADMISSION

Parent participant child characteristics	N	%	Median (Interquartile range)
Age of the child (years)			7 (17)
Child's number of siblings			1 (3)
Reason for admission			
Respiratory	3	30	
Infection (other than respiratory	2	20	
Gastrointestinal	1	10	
Neurological	1	10	
Endocrine	1	10	
Surgical	1	10	
Mental Health	1	10	
Length of stay (days)			2 (49)
Number of admissions during lifetime			0.5 (110)

A culture of care was embedded in this paediatric unit and was defined by processes and structures, which gave shape to and enabled the delivery of paediatric nursing. The following section details a shifting culture of care that is in response to perceptions of busyness.

A SHIFTING CULTURE OF CARE

Periods of busyness and quietness were perceived by both paediatric nurses and parents. For many participants they sensed busyness or quietness often at the moment of entry into the unit and on walking towards the staff station. An understanding or sense

of the unit's level of busyness or quietness emerged and hence defined these phenomena within paediatric care.

THE MEANING OF BUSYNESS

Within this space, parents conceptualised busyness when the environment changed in the number of patients on the ward, staff movement, work activities and demand for care or assistance. For example, the electronic journey board provided a visual representation of busyness.

> *'The electronic journey board was a large screen, wall mounted in front of the staff station, and provided information about patients admitted to the unit, the admitting physician and/or team, discharge plan, upcoming diagnostic tests and empty beds' (Field note observation 1).*

The electronic journey board's content was perceived by parents to determine the unit's busyness as Parent 3 illustrated during interview.

> *'[You] walk past the screen and everything was busy, just about all the beds had someone next to them' (Interview Parent 3).*

Parents conceptualised busyness within this landscape when all beds contained a patient, which was evident on the electronic journey board. For some parent's empty rooms created a sense of quiet. The following quote typifies,

> *'I have noticed that every time I walk by, at least a few rooms seem empty…I don't consider it busy' (Interview Parent 1).*

Other parents associated busyness with the presence of movement and activity '*lots of activity happening in corridor*' *(Interview Parent 3).* For many parents, staff movement was a signal for and of a level of busyness. Busyness was captured through a sense of rushing by staff as Parent 5 highlighted.

> *'There's very little traffic going on…you see the occasional person wandering up, even a little one wandering. There's no trolley, there's no rush in activity' (Interview Parent 5).*

Parents' detailed busyness when there was increased noise and activity upon entering the unit and in contrast, no noise or activity. The indicator of busyness reported by parents and nurses was the increase or decrease in noise and requests from families and other health professionals and workers (Field note observations 4 & 5). Indeed, '*noise conveyed busyness especially when babies and children are crying'* (Field note observations 1 & 4).

For paediatric nurses, times of busyness included:

> *'Simultaneous events such as telephones ringing, doorbell buzzing, patient buzzers ringing, team members and health care workers asking for help, parents seeking information, admissions, discharges and nurse handovers' (Field note observations 4 & 5).*

Paediatric nurses were observed to return frequently to the staff station during the shift to obtain support from other nurses with activities such as medication checks, clinical procedures, discuss their patients, handover and update the team leader and to sit and document in their notes. There was a sense that the station was a safe space for nurses to retreat throughout the shift (Field note observations 1-11). The occupation of this space was also an indication of a busy or quiet shift. The following quote illustrates.

> *'I know that if a nurse is not at the nurses' station, that means that they're busy as well' (Interview Nurse 4) and 'when you come to the desk, you find that at the desk, there is no one there, maybe there's a ward clerk, so when you say, can you help me, everyone is busy in that area, in their room, that's a busy shift' (Interview Nurse 2).*

However, Nurse 2 goes on to explain that a quiet shift will mean nursing staff will be found sitting at the station. When nurses are found at the station then there is help and/or assistance close at hand.

> *'In a quiet shift, you find that someone is sitting at the desk… because it is quiet, everyone is able to help' (Field note observation 5, Nurse 2).*

During observations, the tone and focus of conversations, behaviours and associated activities changed depending on whether the shift was perceived as busy or quiet.

> *'Voices were softer and slower, and nurses would comfortably sit for longer periods of time at the staff station when the unit was quiet' (Field note observations 1 & 4).*

Interestingly, both nurses and parents believed that the type of activities and the number of nurses at the staff station conveyed a quiet or a busy shift.

Parents perceived busyness by the way paediatric nurses used the staff station space. '*The nurses were sitting in chairs at the desk' (*Interview *Parent 6)* was reported as a behaviour that parents believed to be associated with the unit being quiet. Similarly, the focus of conversations and behaviours at the staff station were portrayed as a quiet unit. The more nurses located at the staff station conveyed a sense of quiet for parents as typified by Parent 8.

> *'It was quiet after lunch…It hasn't been absolutely chaotic…so there seemed to be more at the nurse's station, writing notes…They're all doing something, seem to be having a laugh' (Interview Parent 8).*

Parent's spoke of the preference for walking to the staff station to ask for assistance over pressing the bedside buzzer. For some parents seeking assistance could be achieved through different strategies, which they would determine by their child's wellness and a sense of busyness.

> *'I would normally go out to the nurse's station. I wouldn't press the buzzer, because I'd feel that was probably inappropriate...I figure I'm able to get up and go, and I look at my son and go okay, he's not that bad. If someone's out there [corridor] I'd wait until she came in' (Interview Parent 10).*

However, during times of busyness the need to assist parents was perceived as an interruption. Nurses suggested that interruptions increased the likelihood of forgetting what task they were in the middle of completing or adding the new task to their increasing list of priorities during these busy times.

> *'Interruptions were observed to vary from requests that were easily attended to, to tasks that required more thought action and/or assistance from another colleague' (Field note observations 2, 4 & 9).*

Nurse 1 described the nature of busyness and its impact of nursing activities.

> *'Sometimes when parents ask you for things, no problem and you go off doing something else and before you know it the parent will look at you…I'm so sorry I forgot to get…because you get distracted doing other things' (Interview Nurse 1).*

Interruptions appeared to be constant and difficult to avoid as paediatric nurses perceived themselves to be the *'go-to person'* for individuals requiring assistance and this was intensified when the ward clerk was absent (Field note observation 3). The intensity of workload was increased by the interruptions and requests for assistance. These requests could be at the bedside or back at the staff station.

> *'Then, I have to go back to do my checking, then another parent is standing by the desk or my child has vomited on the bed, can I have the sheets changed? You see, some parents they don't buzz, they come straight to the desk, so you have deal with that person' (Interview Nurse 2).*

In this place, to limit nurse interruptions and reduce a sense of busyness the ward clerk played a pivotal role in orchestrating and filtering interruptions. All nurses spoke frequently of the importance of having a ward clerk on a shift who would filter the number of interruptions for nurses. Nurse 2 provides insight.

> *'You feel it when she [ward clerk] is not there…they help a lot if they [ward clerk] are there' (Field note observation 3, Nurse 2).*

During observations, the ward clerk was observed to:

> *'Answer the telephone, let staff and families into the unit, assist with non-clinical family requests and support the team, especially the Team Leader with admission and discharge paperwork and processes' (Field note observation 3).*

Nurses remained the focus of parent requests. Allied health and other transitory members of this scene rhythm of work was often uninterrupted. However, both busyness and a sense of quiet shifted the culture of care within this paediatric setting for all.

THE MEANING OF QUIET

The absence of busyness did not always reconcile with a family centred approach. For some nurse participants the absence of busyness created a space to recollect themselves and rest. Whilst there was a perception that more time would support a family centred approach and more individualised care, there was also an underlying desire for some nurse participants to rest and recuperate. The juggling of personal and professional needs created tension, as during quiet periods there was increased opportunity to provide family centred care.

'In the back of your mind you think I should do this, but at the same time, you're thinking beautiful, I can put my feet up and then automatically, you'd go to putting your feet up, because you are use to it being go, go, go, go. So, it's just something you do' (Interview Nurse 5).

Quiet periods created space for a lack of movement and stillness for many nurses. During interviews nurses described how periods of quiet could reduce motivation and responsiveness to patients' needs and bring to the surface a sense of inertia that influenced the culture of care. Nurse 1 illustrates the voice of many.

'Sometimes you can even become a little bit complacent, when it's a bit quieter. I'd put that off, I'll do that in a little bit. And then it comes to 3:30 and I've forgotten to do this because you're moving outside of momentum' (Interview Nurse 1).

Motivation appeared more heavily influenced by perceptions of quietness when compared to busyness. Indeed, for many nurse participants' quiet times reduced their productivity and could led to missing care or delayed care. Nurse 5 echoes the view of many nurse participants.

'Whether there's the motivation to get it all done on time is different... and it comes back to that you're more productive when you're busier than when you're quiet, because you do procrastinate more when you're quiet… I think we pay more attention when it's busy, because we're more concerned that something's going to happen when we're busy' (Interview Nurse 5).

The culture of care was influenced by a sense of quiet or busyness with negative and positive emotions emerging. Positive perceptions of a quiet shift surfaced when paediatric nurses were able to achieve the health care goals and needs of the family. During periods of quiet nurses recognised that the delivery of all care activities should be completed but importantly, that the quality of care was expected to be higher.

'When it's quiet because you've got time to do everything there is no excuse to say, I did not do that…it is achievable when it's quiet' (Interview Nurse 2).

Nurses also voiced other implications associated with a quiet unit such as complexities with staffing and skill mix.

> *'It makes it hard capping beds because they take your staffing away and it effects skill mix' (Field note observation 4, Nurse 3).*

The reduction in staffing numbers added complexity to a quiet shift meaning that paediatric nurses would be sent to work in other units. These other units were usually adult acute care and sometimes paediatric emergency or neonatal intensive care. '*Some units required a different skill set to what these paediatric nurses entailed' (Field note observation 2)*. This experience is described by Nurse 1.

> *'I find that hard sometimes because you never really get a rest and it can be extremely stressful going to adults' (Field note observation 2, Nurse 1).*

Nurses experienced stress when one of their team members were sent to other units. What started out as a quiet shift often morphed into a busy shift and this added extra pressure to the team as staffing was unobtainable at short notice.

> *'Night shift could only be staffed to 20, and it was at critical staffing, there was no way they could get anyone extra. We could only take up to 20, unless we knew people over 20 would go home. We ended up at 20, full' (Field note observation 9, Nurse 9).*

Periods of quiet changed the culture of care, whereby nurses were able to reclaim time and enable activities, which were actively shared with patients and families. In contrast, quiet times could raise challenges with sustaining staffing, skill mix, keeping up momentum and missed or delayed care. The following section explores the shared practices embedded in a culture of care.

SHARED PRACTICES AND THE CULTURE OF CARE

Dimensions of busyness emerged to influence everyday working practices for paediatric nurses. As busyness increased work activities, the flexibility of shared practices was reduced. Instead, nurses reported that activities became more task focused with conflicting priorities surfacing. To manage care activities, the team and its members was an important dimension frequently spoken of in this workplace. As each shift began, those arriving perceived themselves to be part of a team and the embedded relationships could influence a sense of busyness on a shift.

RELATIONSHIPS WITHIN THE PAEDIATRIC NURSING TEAM

Perceptions of busyness were influenced by the relationships between members of the paediatric nursing team. Importantly the individual rostered on that shift could infuse the shift with elements of quiet or busyness. The following quote was supported across the interviews.

> *'I think that calm team leaders can affect so much of what goes on out there and can actually make a busy shift feel a lot calmer' (Interview Nurse 4).*

Sharing the workload within the team was perceived as an important way of working within this cultural group. During observations nurses would offer help and support to other members of the team when able.

> *'The team leaders were also observed to reallocate nurses to areas of need to support sicker patients and those nurses with higher workloads' (Field note observations 1 and 7).*

Nurses spoke of the importance of having good relationships within the team and how relationships could change a sense of team. However, a culture of support was regulated by busyness with individuals shifting care practices from a team approach to individual preferences. This perception is highlighted by Nurse 7.

> *'I think it comes down to the individual and the ward, sometimes the culture isn't that great in helping each other that way. It comes down to individual people [for example], I'm just sitting here colouring in, why don't I go and help? And it doesn't happen that often. But then there's people who are their close friends who are working with them on the ward and if that's the case, we all rally together and help each other' (Interview Nurse 7).*

Within this context of care a team was perceived to assist, collaborate and help each other during the shift. Yet, during times of busyness team relationships were perceived as either a barrier or enabler to how care was delivered.

> *'It really depends on who you're working with. Sometimes it can be busy, it'll flow beautifully, sometimes it will be busy and it will be manic. But if you're working and people are only answering their own buzzers or even waiting for other people to do it, palming off tasks, choosing their break time so that you have to do all their medications. That makes it a chaotic shift' (Interview Nurse 10).*

During periods of busyness a perceived lack of team collaboration led to an absence of shared care goals across the shift. The notion of sharing the load and supporting team members were reported to be different during times of busyness. Nurse 2 echoes the thoughts of others.

> *'If it is quiet it is easier and it's easy to get someone to help you' (Field note observation 5, Nurse 2).*

Busyness changed the context of care and working as a team. Beliefs around the inequality of workload and sharing the load was described by paediatric nurses.

> *'If you're busy all the time and it's your one shift where you do get to sit down, you do want to take that opportunity, so you can see both sides. We all try and help each other, but I wouldn't say we're really, really good at it' (Interview Nurse 7).*

However, despite team relationships perceptions of busyness and stress are often perceived at an individual level. In this context, busyness was perceived as stress. Importantly the intensity of busyness escalated with a sense of unfinished tasks.

> *'A very busy shift is very stressful… I say stressful because you are trying hard to finish, to do everything' (Interview Nurse 2).*

Yet workload pressures such as stress, were perceived to be alleviated if team members were known and trusted. For many nurses if the team created a sense of support, collaboration and assistance then the rostered shift was viewed positively despite a perception of busyness.

> *'It's also that feeling of knowing the other guys you're working with would have your back and help you out' (Interview Nurse 5).*

Hence, getting to know your colleagues was an important part of this cultural context. Team bonding was observed to occur during meal breaks in the common room. All nurses shared the common room with medical officers, administration staff, staff support officers and allied health. During meal breaks nurses would share informal conversations to build positive team experiences.

'You want to hang out with others, because you really haven't met your colleagues. Because you've met them coming past, and you might be lucky and actually gone to break at the same time and had a chat with them' (Interview Nurse 7).

Informal interactions would provide opportunities to build capacity within the team creating a sense of belonging and togetherness. Being in the common room provided opportunities to share meanings and understandings and strengthen team bonds and teamwork. The following participant voiced the importance of informal interactions, which were raised frequently during interviews.

'It's good to build up your relationship, your rapport with other colleagues and spend time talking to them if there's time' (Interview 4 Nurse).

The bonds developed between team members led to, overt observations, in which nurses would ask for help from a trusted colleague. The notion of trust was an attribute of teamwork, which was established and maintained during times of busyness and quietness.

'If you didn't know the person you're working with, that feeling wouldn't be there, or the trust and then that would make you feel like you can't give safe care' (Field note observation 6, Nurse 5).

Indeed, during periods of busyness individual members of this team would adapt and find creative workarounds to manage the care needs of families. Busyness created the need to change care activities to seek ways to save time. For some team members finding time meant that completion of care activities required shortcuts to be found. However, shortcuts were not perceived as compromising safety. Nurse 1, an experienced paediatric nurse, explains.

'You're still providing safeness and care but it's probably harder to do when it's busy…so you cut corners or do things differently just to be quicker' (Interview Nurse 1).

Informal social talk was noted to be more frequent during quiet times such as *'conversations about leave, planned holidays and rosters' (Field note observation 1).* Whereas interactions between nurses during busy times were rushed and directly related to patient care or tasks for example *'can I have a check [medication] please?'* and *'he's got a temp'* when undertaking medication administration *(Field note observation 4)*.

Within this scene working as a team and the establishment of relationships assisted with managing busyness. Trust was a dimension of the team that could lessen the intensity of busyness and create a perception of calm and control a buffer to busyness. Nonetheless, the team could act as a barrier and heighten a sense of busyness influencing the ability to provide care to families.

TURNING TO A TASK FOCUSED CULTURE OF CARE

During times of busyness, nurses shifted their focus from a family centred care approach towards task completion. Nurses spoke of the importance of family centred care and yet when there was a perception of busyness the clinical task became the focus and the family centred approach faded into the background. The following quote typifies the views of participants.

> *'You're busy doing tasks, rather than providing holistic care' (Interview Nurse 7).*

During perceived periods of busyness all nurse participants emphasised completing nursing tasks. However, tensions would surface for individual nurses when there was an inability to complete the expected tasks due to busyness. For many nurses a sense of internal pressure and disempowerment emerged. Nurse 1 gives voice to these feelings.

> *'Sometimes I think you're just doing your bare minimums to keep everything running…like meds [medications], obs [observations], I mean it does involve the family as well sometimes, you don't have time for things like bathing the patients or maybe changing them… complete a task, get out of the room, go to the next' (Interview Nurse 1).*

Tensions and feelings surfaced in the presence of busyness that was in opposition to beliefs about paediatric care delivery and the importance of delivering holistic family centred care. In these moments, nurses experienced negative emotions and role satisfaction was diminished. Instead, a perception of busyness brought a sense of challenges whereby nurses actively tried to control busyness but often perceived personal challenge when tasks and care practices were left unfinished or sub-optimally delivered. In this way, the expectations of routine workflow were restructured and a sense of letting the team down emerged. The following quote provides insight into the tension of busyness for nurses.

'It feels like you've got a list of things to do and it just gets longer and longer and no matter how many things you do, it doesn't feel like it's gotten any smaller or you've accomplished anything, it's just that constant circle of go, go, go' (Field note observation 7, Nurse 5).

Task focused care became the response to busyness for all nurse participants. In these situations, the participants were conscious that engaging with families and delivery of holistic care needed to fade into the background. During observations when the unit was experiencing busyness completing a task became the focus and the list of activities were always being updated by individual nurses.

'I don't think I would have the time to stand and talk with someone about, I know your kid doesn't like antibiotics, I know he's crying when it goes in, it's really serious…by sitting with this parent, or whoever, you're also potentially compromising the care of the other five or six kids that you're now looking after' (Interview Nurse 9).

During episodes of busyness nurse participants increased the pace of physical movement from task to task allowing habitual practice to give speed to activities within this culture of care. This is illustrated further by Nurse 5.

'It's like you're not really seeing…you don't really think about much as you're running round on the busy days, you're literally just on auto pilot doing what needs doing' (Interview Nurse 5).

Busyness shifted the character and delivery of care. Instead, within this culture of care practices shifted towards being task focused, which was perceived to fragment the quality care. All nurse participants spoke of prioritising biomedical tasks over psychosocial and emotional needs of the patient and family during times of busyness. Busyness required nurses to prioritise activities whereby some tasks were valued more highly than others as Nurse 2 echoed during an observational shift.

'I will fight to finish my medications, my obs [observations] by finishing time, then my notes. I'll do them after the handover. But I'm trying to make sure the important things like obs and medications are done on time' (Interview Nurse 2).

When care became task focused and fragmented during times of busyness, the needs of the families were not prioritised or valued as less important to the biomedical tasks such as administering medication. Instead, busyness gave priority to biomedical tasks and tensions developed when time restrictions were imposed on other activities, which reduced the nurse's capacity to engage. Nurse 8 clarifies.

'Quite often you've got 15-minute checks, and you're just literally eye-balling them. You don't have the time to do anything' (Interview Nurse 8).

The shift during busyness towards task focused cultures of care influenced how parents' needs were also met. For some parents in this space the importance of their needs was minimised during periods of perceived busyness. Parent's priorities and requests for assistance also changed during perceived periods of busyness similar to that of the paediatric nurse participants. For some parents requesting support or assistance when the unit was busy was perceived as being a difficult patient. Parent 7 highlighted the decision to request support and assistance from nurses when busyness was evident and this was weighted with tension.

'This morning I would have loved to jump in the shower for two seconds. I feel like that's being a difficult patient and they have a lot of other things more important to do. I can sacrifice my shower. Whereas if they had time, they could ask - Do you want to shower quickly? We can take him for ten minutes. I'd be yes!' (Interview Parent 7).

However, within this cultural scene there was a shared understanding by nurses and parents that certain care needs, such as a shower, would have been done if the unit had not been busy. Outside of busyness these tasks, such as a shower, remerged as important and requests for assistance or support by parents were meet freely by paediatric nurses. Engaging with parents was actively undertaken by nurse participants as Nurse 2 explains.

'You do things that you normally wouldn't do like maybe take the parent around, show them the room. Or maybe offer to stay with the baby while they go out to the cafeteria and have something to eat. I'll do that on a quiet shift' (Interview Nurse 2).

For most parents, a sense of busyness shifted the culture of care limiting interactions to the task at hand. Yet for parents' quiet periods on the unit presented opportunities for paediatric nurses to purse activities that built rapport and established relationships with parents. In contrast to busy periods, nurses would actively seek out parents to engage in social interactions and offer assistance as detailed by Parent 10.

'If it's quiet, the service is amazing because they're here. They come sooner…because they come here all the time. They even come here just to say hello, to see if I need something, they're really helpful' (Interview Parent 10).

During busy periods conflicting priorities meant that nurses juggled the needs of others and this was at the centre of these shared practices. The constant prioritising and re-prioritising of patient care was influenced by time and workload.

'I think if they're all important, urgent, immediate, and you need them all done and you've got fifty other [things to do]…generally you have a hierarchy and you know what can wait and what can't' (Interview Nurse 9).

Busyness created tension and negative emotions of guilt when activities were reprioritised. For many paediatric nurses they spoke about feelings of guilt; not being able to provide equal care to families due to busyness.

'It's almost that feeling of guilt, when you know what needs doing, but you can't physically be there' (Interview Nurse 5).

The reality of shared practices, which shifted during busy periods highlighted how nurses and parents managed these situations and showed changes in behaviour, values and activities. Importantly, tensions emerged as the burden of the nurses' workload led to time constraints. In these moments, task focused care surfaced.

'But you may not always get back there in time. Again, it gets prioritised…you've got to prioritise an airway over anything else' (Field note observation 10, Nurse 10).

Quality care was defined as family centred care and exposed through the offering of time to parents and patients. Yet in moments of busyness, prioritising certain care tasks made episodes of busyness manageable.

BEING A PARENT IN HOSPITAL

For many parents, their arrival into the paediatric unit was unexpected and brought to the surface many negative emotions. According to many participants, being a parent in hospital was a stressful experience. Many reported that they were sleep deprived often after being admitted through the Emergency Department. For some parents, an unexpected arrival onto the unit made for a challenging adjustment. Many parents spoke of being admitted to the unit during the night.

> *'I was a little sleep deprived initially, because we were admitted at midnight and got on the ward at 7:30am' (Interview Parent 3).*

Parents, despite being sleep deprived on admission to the unit, needed to transition into a new environment. Transition involved moving into different units, which demanded personal adjustment as each new setting was perceived to have different rules and ways of being as Parent 3 highlights.

> *'Initially, when [name] was first admitted for her first week or so, we were in the high dependency, which was a little bit confronting, more so for [name], because she had all her liberties, all her things taken away from her, like her phone and her contact, and people. That was a strict environment for her' (Interview Parent 3).*

Parenting a hospitalised child or young person was a new experience for some. Parents spoke of needing to navigate the care needs of their children or young person. The challenge for many parents was not simply adjusting to a new environment but managing the wellbeing of their child. For example, a young person admitted to the unit communicated distress and the desire to return home often to their parent, which escalated tension and stress.

> *'We didn't really know what we were doing before we came in here, we were given some guidelines and explained why [and] what they were doing, even though it was confronting because your child is in pain and your child is distressed and is begging you to get them out of here and you know there is no alternative and that can be distressing' (Interview Parent 3).*

Children and young people of parent participants often behaved and communicated differently in the hospital compared to their 'normal' way.

> *'He gets quite anxious because they're poking and prodding, they ask him a lot of questions that he doesn't understand. He doesn't understand what they're talking about, so he'll just answer whatever…he doesn't want them to get angry, he just wants them to go' (Interview Parent 9).*

Parents had their own expectations of care but so did the children and young people that required negotiations of a parent. Therefore, for many parents they were required to work with both sets of expectations and this was further challenged during times of busyness.

> *'When it was busy…he was agitated and he didn't know what was going on…I didn't find what he needed, who he needed to see …they [nurses] couldn't just turn up with the goods because they didn't know what he needed…[nurses] were slowed down by the fact that there were doctors rounds…it's the unknown, and for him being out of [his] environment' (Interview Parent 8).*

Interestingly, all the parents spoke of making decisions about how to prioritise when and how they asked nurses for help. The timing of a care request was an important consideration for many parents, as Parent 4 describes.

> *'Each time we had to call at one stage [patient name] said, they're going to hate me, because you don't want to bother people. But they came each time, and it wasn't an issue' (Interview Parent 4).*

Parents would seek out nurses to assist them in the care of their child. However, for many parents they were concerned that they may be viewed as over-reacting or incorrectly watching their child's deteriorating health and not reacting.

> *'I'm always conscious of being one of those parents that are being difficult and maybe being a bit too overprotective…and you think your child's going to die and they are absolutely fine, I'm always conscious of being one of those. And even now, I'd wait to make sure, yes, that's definitely a seizure before I pressed it, whereas maybe I probably should press it even [before it] starts, thinking he's waking up, but it could be a seizure' (Interview Parent 7).*

For parents, their role in this culture of care was challenging and changing. A balancing act that required them to seek assistance and work within the timing and rhythm of care. The presence of busyness added further challenges to the parent role in this setting. Parents changed their behaviour during episodes of busyness. Some parents reported that the way they asked for help was different during periods of busyness and quietness. Parents also noted that calling for assistance and the response to assistance changed during these times. Parent 7 explained.

'I think everyone is just a bit more relaxed, it's empty, so they have got time, they can have a chat to you, you press the yellow buzzer and about five people come in as opposed to one…I probably would have been a bit more reluctant to press the buttons, I used to just pop my head out and see if someone was free at the front desk, whereas this time I just pressed the button…each time it was a seizure so they had to come anyway' (Interview Parent 7).

In learning the rhythm of care, some parents would alter their behaviour and the decision to seek assistance. A few parents perceived that the time of nursing handover was a difficult and challenging time and were reluctant to seek assistance. Reduced opportunities to seek help raised feelings of uncertainty which challenged their sense of being a parent in this setting. Importantly, these parents needed to feel secure that assistance requests were legitimate in the eye of clinicians as Parent 9 highlighted.

'During change of shift [I wouldn't] just press the button. It's drawing unwanted attention. It lights up out there and you don't want everyone coming in and, especially if you're wrong…you might be overreacting, and they might come in and go oh no, it's okay. And then you feel like you've taken them away from something else' (Interview Parent 9).

For some parents, tension surfaced when considering if their care requests took nurses away from other sicker children. Decisions to call for help could undermine their sense of being a parent. For parents taking care away from others who might really need it was a significant concern.

'You think if there's someone else, they need it more' (Interview Parent 9).

Parents perceived, that when nurses were busy, calling for assistance needed to be appropriate. This was especially so when a parent called for assistance and the child or young person was considered stable after being assessed by a paediatric nurse. Parents sensed their decision in these situations were potentially inaccurate.

In contrast, some of the nurses spoke of the pressure to answer calls from parents for assistance when busy. For nurses in this setting, parents have roles to perform and one is to understand the rhythm of care and the nursing workload. A conflict of expectations arose for nurses as they encountered parents requesting assistance. Paediatric nurses spoke of conflict that could surface when they perceived that they did not meet the expectations of the parents.

'I think sometimes they forget you've got quite a few patients and they think that as soon as you hit that buzzer it's pop like a genie' (Interview Nurse 1).

During observations there was no specific timeframe for answering parents call for assistance. Instead, the busyness of a shift influenced the timing of care and so the rhythm of care fluctuated and remained unpredictable. Therefore, how long nurses would take to answer patient buzzers and calls for assistance was unclear to parents within this scene. Yet, nurses experienced pressure when trying to keep up with the demands for assistance by parents during times of increased workload and time pressure recognised as busyness. Tensions emerged between parents and nurses in this time pressured setting and was displayed when responding to patient buzzers.

'I've been buzzing you for ages, what is the use of having the buzzer if you're not attending to it…she didn't understand that I was busy with another patient who needed me, she just assumed that if it says buzzer, then in minutes, I'll be there…some people don't realize that if I'm not with you, that means I'm with someone else, I'm not just sitting' (Interview Nurse 2).

Parents held expectations that nurses would respond in a timely way to the activation of a patient buzzer. For some nurses they were torn between the professionalism of the role and the reality of answering bedside calls during busy times. The challenge of different expectations and meaning led to tensions during busy periods and the inability for paediatric nurses to meet these requests.

Nurse and parent participant groups had embedded expectations, which were more likely to clash during times of busyness. For nurses' busyness brought new ways of prioritising care and responding to calls for assistance. For parents, a decision to ask for help came with embedded expectations for the delivery of that assistance. In this case, many parents perceived busyness to influence how care was prioritised and altered the prompt delivery of assistance.

SUMMARY

This chapter described the constantly changing landscape of paediatric care and the different tensions that surfaced during episodes of busyness. The shifting culture of care brought to the surface shared practices, which were interconnected and led to paediatric nurses and parents negotiating their relationships. Importantly, in the presence of busyness the relationships within the nursing team played a significant role in how well

individual nurses coped with increased workload and perceptions of time constraints. However, busyness played a pivotal role in how care was delivered by paediatric nurses and further how this care was received and perceived by families.

The next chapter describes the cultural dimensions of paediatric care and how busyness influenced and shaped the therapeutic relationship. At times this brought to the surface the emotional cost of busyness for members of this setting.

CHAPTER 7: FINDINGS
THE SHAPING OF PRACTICE

INTRODUCTION

The findings from observations and in-depth interviews with paediatric nurses and parents are presented in this chapter and brings to the surface cultural dimensions, which give shape to paediatric nursing care. Importantly how the therapeutic relationship is influenced by episodes of busyness.

Three themes emerged from the data, which detail how busyness influenced interactions between paediatric nurses and parents and altered the rhythm of care. The findings are presented in the following three themes: i) cultural dimensions of paediatric care; ii) shaping the therapeutic relationship; and iii) the emotional cost of busyness.

CULTURAL DIMENSIONS OF PAEDIATRIC CARE

During observations and interviews the role of nurses and parents in this setting was influenced by periods of busyness. The chaos of busyness was spoken of by both parents and nurses and together all voices raised the negative impact of busyness. For nurses during observation and interviews, busyness altered their response to the needs of families and their approach to care activities. Importantly busyness altered how nurses understood and perceived paediatric nursing.

FAMILY CENTRED CARE

For participating nurses, the culture of care was centred around caring for the whole family. This influenced interactions and the character of the therapeutic relationship and for some, defined what it was to be a paediatric nurse. However, the desire to engage therapeutically with parents and the child were challenged during periods of busyness. Instead, nurses were influenced by perceptions of busyness, which challenged their desire to engage therapeutically with the family. Taking on the needs of the parent or carer as well as the child or young person during busy times heightened tensions and led to negative feelings emerging - the influence of being busy. Nurse 5 gives voice to these concerns.

> *'[When the] unit is busy and a parent or carer is concerned or stressed and you need to support them, but you're feeling busy at the time…it's one of those things that you have to make the time' (Interview Nurse 5).*

For nurses, care practices were centred on a family centred approach and so in moments of busyness a sense of a lack of time emerged, which raised tensions for many participants. However, nurses sought during episodes of busyness to find space to be with families. Specifically, to find time to engage and support family members on a shift, different ways of working emerged. For example, a few nurses spoke of not taking breaks throughout their shift to support this culture of care in this setting. Within this culture of care paediatric nurses were willing to care for others at the expense of self.

> *'If that means missing a break or something, you just make the time…and deal with the consequences later' (Interview Nurse 5).*

Two nurses spoke of choosing to work through their breaks to complete care activities. However, this would also mean that they could leave on time and go home. The balance of work and personal life remained important in this culture of care. Completing care needs were important and given priority. Nurse 1 gives voice to this notion.

> *'For me just to keep going and get through it and get home, is more important than going to have a break and stopping…I prefer to go on time or as near the time as possible' (Interview Nurse 1).*

Balancing care activities and being able to finish on time was important for many nurses. During periods of busyness the workload could often be overwhelming and delayed opportunities, despite missing breaks, to go home on time. Importantly, during periods of busyness not taking a shift break did not guarantee that the nurse would go home on time.

> *'You find that you don't go home on time, most of the time. It's rare that you go before time. Most of the time, we go home maybe 15, 30 minutes late because you are trying to finish the things that you didn't do' (Interview Nurse 5).*

During observations nurses were often delayed leaving their shift to provide holistic care to families. Indeed, going home on time was often delayed when caring for the whole family, which was perceived by many as appropriate. During most observation periods nurses were often observed not to go home on time across the different shifts. However, for many nurses' busy shifts created a sense of exhaustion. As Nurse 1 highlights.

'I think when you're really busy you probably don't notice until you get home, and then you think I'm exhausted' (Field note observation 2, Nurse 1).

Not taking breaks and leaving work late was perceived negatively by many nurses and tensions would surface. Consequently, most of the nurses spoke of the negative impacts of a busy shift after leaving work.

'How you feel and after that busy shift, when you are going home, you are not settled, even if you are sitting on the train on your way home you think, did I sign that medication? Did I do that? At times you end up calling someone, talking on the phone…can you please check if I explained that…to have peace and get some sleep. Otherwise, you don't sleep. That is a busy shift (Interview Nurse 2).

However, despite busyness there remained opportunities to engage with families and complete the care activities required. For some, if the team was well organised by the team leader, the organisation of work was achievable despite busyness. Working together and being organised should support care activities being completed and together all can get home.

'If you're organised and you organise together with the team you're working with, everyone still gets to break and everyone gets home on time and I think that's probably an important thing' (Interview Nurse 10).

In part working as a team required the TL to provide oversight and support the activities of the unit. The TL should also support staff breaks and leaving on time. For some of the nurses, being the TL meant that they needed to ensure the shift ran smoothly and team had breaks.

'I always make sure everyone's had tea. Sometimes I might miss tea to make sure everything's done that's how I like to run, make sure everyone's sorted out before I am and then make sure the ward's comfortable' (Field note observation 2, Nurse 1).

Perceptions of busyness were influenced by the professional experience of the nurse working on a shift. Looking after team members often meant supporting staff with less paediatric experience. But for many participants supporting less experienced staff lead to a perception of having less time for engaging with families.

‘Some days the skill mix may not be as good as it should be. I think that can impact on our care. It means the people who work here regularly are busier trying to support the people who don't. Therefore, [this] doesn't give us much time with the patients. The person who is looking after them isn't as qualified and doesn't have the same level of understanding of what that child and family needs’ (Interview Nurse 10).

Hence, skill mix in the presence of busyness jeopardised the approach to care and desire to engage with families. For all nurses’ tension was perceived during episodes of busyness and this was intensified when the skill mix was considered inadequate to deliver care considered important to paediatric nurses. The following exemplar illustrates.

‘Because sometimes when you've got all juniors, it's really hard when it's busy because they ask you something, you are basically telling them how to do it and they go off and do it. Whereas if it's quiet, you can show them and run them through it a little bit more, whereas otherwise you just say, well quick, go and do that. Because there’s just not the time to explain it and show them’ (Interview Nurse 1).

Skill mix was perceived as important and was an enabler for learning and building the skills for creating the space to practice how to be a paediatric nurse. Time created opportunities to be with families and enabled the enactment of a family centred approach. Yet during shifts with inadequate skill mix the culture of care was threaten and created tension between and among nurses. The skill mix challenges were perceived as a result of experienced nurse turnover and increased novice nurses and who once relied on these more experienced nurses.

‘I think with the staff turnover that we've had losing a lot of the senior nurses who I felt were my role models and people I could look up to felt like a safety net. The place could be burned down and they were here, it will be fine. And then realising that because they're gone, that's becoming my role. I think sometimes stepping into that [role] does make me a bit anxious especially if the skill mix isn't great, if there's me and one other senior person and everyone else is new to nursing’ (Interview Nurse 10).

Within this culture of care a family centred approach was important and yet busyness altered the care approach and influenced practice activities. Importantly, workload and

skill mix were perceived to shape time pressure that shifted behaviours and actions and contributed to a sense of busyness. Despite the challenges of busyness nurses described ways to deliver care and meet their own expectations and beliefs of what it is to be a paediatric nurse. However, this was not the view of parents who perceived during periods of busyness a sense of powerlessness especially when their expectations were left unmet as the following section details.

BUSYNESS AND PARENTAL DECISION-MAKING

Most of the parents spoke during interviews of how they would consult nursing staff on decisions that involved their child or young person. Decisions included care needs but also about their presence at the bed side. For some parents leaving their child unattended at the bedside was always a considered decision. Parents would weigh the needs of the child, the timing of their presence at the bedside and need to attend their own care. For parents' even short episodes away from their child created personal tension and brought to the surface expectations of what it was to be a parent. For example, parent 10 illustrated.

> *'If he [baby] is sleeping, it's the time that I'll sneak out and go to the kitchen, clean up my bottles, I get a biscuit. But I don't take long, not five minutes, it's really quick, 1-2 minutes then I come back' (Interview Parent 10).*

For some parents they did not feel comfortable leaving their child for long periods of time on the unit. During interviews, parents spoke of how busyness influenced their decision to stay or leave the unit. Parent decision-making was adaptable and likely to change when the unit was perceived to be busy. In these moments different behaviour decisions surfaced. Busyness altered parent decision-making with shifting concerns about leaving a child on the unit without a parent. Busyness could become a barrier, whereby leaving their child without a parent emerged as a concern. For some the concern of their absence was focused on adding to the paediatric nurse's workload.

> *'I wouldn't want to make their jobs any harder. I wouldn't give them something else to do…I know they're probably busy enough as it is so I probably wouldn't have asked. Not a reflection of their ability but more out of politeness for them' (Interview Parent 6).*

To help overcome parental concerns of busyness and leaving their child on the unit, a few parent participants were observed to ask the paediatric nurse whether it was alright

for them leave. In this setting, the parenting role at times was abdicated and yielded to the paediatric nurse's expertise.

> *'I did ask the nurse if it was a good time and when was a good time to go…and she said, just go' (Interview Parent 9).*

However, parent decision-making about leaving the unit was not only influenced by a perception of busyness and the perceived increase in nurse's workload but also about the safety of their child. Parents spoke of the need to stay by the bedside to ensure the safety of their child as not all members in this scene were known or wanted. One parent voiced their concerns about busyness and child safety.

> *'I was more worried about people that I didn't know coming in to talk to him…because I know that they might get busy...that's what I was worried about, is him being here alone and someone saying that they are somebody but they're not that somebody…and because it's so open, I don't know...because we've met a lot of people, different people, someone could walk in and tell him they're a doctor but not be a doctor…that's why I was a bit more concerned' (Interview Parent 8).*

Within this setting the culture of care supported parents' decision to leave the unit. Most of the nurses expressed an understanding of the importance of parents leaving their infant, child or young person. Often parents had other children to care for and/or were a single parent.

> *'They might need to go and pick up a sibling or they might just need to go have something to eat and it does happen' (Field note observation 11, Nurse 10).*

However, nurse participants qualified the rules and expectations of care for parents while they were gone. For example, most nurses explained that they would communicate with the parent what they were able to provide in addition to their normal care. The rules of care were detailed by Nurse 3.

> *'I usually ask if they're aware that I can't sit with them. If it's a baby, we'll put them on a monitor or keep the door open. If it's a child or adolescent, I usually make sure they're okay with it and when they'll be back' (Interview Nurse 3).*

The decision of a parent to leave while supported by nurses created internal tensions. There was conflict between their values and beliefs about family centred care and the capacity to provide additional care in the presence of routine nursing activities. Paediatric

nurses perceived in the absence of a parent, children needed more assistance than the delivery of routine care. There was a desire to support the parent's decision to leave the unit, although when busy they felt burdened by this extra pressure.

> *'If it's busy you can't be in there holding a child…but if they're going to be gone for a period of half an hour, an hour, we don't have time' (Interview Nurse 10).*

Having a hospitalised child posed the need to adapt to a new parent role, whereby decision-making and the role of parenthood shifted. In moments of busyness the care and safety of their child became challenging for parents in this study.

The culture of care established an environment with its own rules and rhythm that parents needed to understand and navigate to reduce distress for their sick infant, child and young person. During periods of busyness, parents were alert to the need to advocate for their child or young person's needs, optimise safety and be adaptable to the rhythm of care. In addition, parents would often make the decision to ignore their own needs in an effort to fit into this scene. Indeed, parents and nurses negotiated a relationship within this culture of care that defined and gave meaning to care activities and behaviours. The following section presents the shaping of the therapeutic relationship.

SHAPING THE THERAPEUTIC RELATIONSHIP

The therapeutic relationship was observable between parents and nurses and yet was influenced by periods of busyness. In this scene, the defining feature of a therapeutic relationship from paediatric nurse participants' viewpoint was the embedding of trust and opportunities to engage. Time was perceived to be important to enable the establishment of a therapeutic relationship and yet in the presence of busyness this was jeopardised. The majority of nurses expressed the difficulty in establishing a trusting relationship with the paediatric patient and parent when it was busy. Participating nurses voiced that the loss of time was a barrier to establishing a therapeutic relationship within this scene.

> *'Less time to interact with the kids' and I felt they were not really engaging' (Field note observation 10 Nurse 10).*

Time was perceived to be woven into the building of trust. Nursing position and delivery of care were not sufficient to build a therapeutic relationship; considered essential to paediatric nursing. Trust was perceived to be an essential component in building therapeutic relationships with families by participating nurses. Time was compromised during busy periods undermining the very rhythm of care. Wellbeing was linked to the

therapeutic relationship and perceived to improve outcomes and gave shape to the desired culture of care. For example, nurse 4 echoed the thoughts of many.

> *'I think it's very important to build rapport with the patients and their families if you've got that extra time, especially if you know that they're going to be in more than the next 24 hours, building up that trust with them, the people who they're going to be working with, is really important. So, I try and spend time doing that' (Interview Nurse 4).*

The way that nurses established a therapeutic relationship, which was layered with trust, was through play an activity that required time. Hence, busyness compromised the nurse's capacity to engage with patients and establish a therapeutic relationship.

> *'If play is not a part of it, you're not going to build a rapport, you're not able to get them to trust you. It just doesn't work when you just try and go in and do obs [observations] without any play' (Interview Nurse 4).*

Play was a method used, by nurses, to establish a therapeutic relationship, which defined them as different from adult nursing disciplines. Contributing towards the therapeutic relationship was not only activities of play but the *'wearing fun scrubs, smiling and approaching the family in a gentle empathetic manner'* (Field note observation 4). There were perceived benefits in establishing a therapeutic relationship with children and parents that assisted with care activities within this scene. The establishment of a therapeutic relationship was perceived by all participants to make work easier. The following quote illustrates.

> *'That makes my job easy when I am doing my observations…[he/she] is not distressed, is not crying. Even when I take the temperature, come with my thermometer… because [he/she] knows me, and we have been playing together, I'm not a stranger now I'm like a friend…so that makes life easy…it was nice, we had good rapport and it was good (Interview Nurse 2).*

A therapeutic relationship between the nurse and patient was established, through play. Play enabled the emergence of trust and formed an integral part of the interaction. However, opportunities for play were observed to be reduced or even absent during busyness. Whereas, when it was quiet nurses voiced how they had time to play and interact more with families to form an important therapeutic connection.

'If it's quiet, then I can do more or even play with the kids, which I like…I get time to play with my patient and create a good relationship…so next time, the patient is not scared, they are happy to see me…he lights up and is happy' (Interview Nurse 2).

Yet busyness impacted on the time available to spend with families challenging the therapeutic relationship. For many nurses during busy periods, it was important to limit play time and minimise interactions. During periods of busyness the rhythm of care shifted altering behaviour as Nurse 1 highlights.

'If anyone would talk to you, you think, I've got to go, I've got things to do, but you don't want to cut off too quickly... but often the parents will know, I find' (Field note observation 2, Nurse 1).

During busy periods internal conflict surfaced as the majority of nurses desired that their behaviours and interactions did not change with families. Yet this was not always viewed as possible and in these moments a therapeutic relationship could be jeopardised.

'I would hope that my tone and their feeling wouldn't be changed' (Interview Nurse 9).

Busyness for many participants was evident at a personal level and visible to parents and nurses. The therapeutic relationship could be altered during periods of busyness, with a change of behaviour evident. Nurse 2 described the impact of busyness.

'I look stressed or in a hurry. I don't look like I've got time to talk to them…I don't have time to talk…and spend time…someone might think, this nurse, she has changed, she is not nice like before. Not knowing that I'm still nice but I'm just rushing to do something' (Field note observation 5, Nurse 2).

While time, play and engagement were essential for building a therapeutic relationship changes in paediatric nurse behaviour could undermine the culture of care. Busyness led many nurses to experience a shift in the rhythm of care, which changed behaviour and undermined the therapeutic relationship. Nurse 4 comment typifies the influence of busyness on behaviour, which undermined the therapeutic relationship deemed desirable in this scene.

'I think your body language is so much more open to it. Look at people's body language when they're in a rush. It's so closed off…even though you don't mean it, it's just your busy face…whereas when you're not busy you're just calmer' (Interview Nurse 4).

For some parents, nurse behaviour was perceived to change during periods of quietness when compared to busyness. Opportunities for parents to engage with nurses was noted to be reduced during busy episodes. For parents the therapeutic relationship and interactions with their child provided both time and space to be with the nurse. However, this was challenged during episodes of busyness as Parent 10 explained.

'We can have a chat, its warmer with the nurses. I think they look more relaxed and [are] more smiley because they're not under pressure. It is much better when it is quiet, because I have been here for a while so we can have a quick chat and they play with him, if he is awake so it is nice' (Interview Parent 10).

In establishing a therapeutic relationship within this scene elements were required to converge, which would assist to build trust. Nurse behaviours needed to be aligned with time to be with families and engage in ways that enabled caring opportunities and supported nursing work. For nurse participants appearing relaxed with the ability to spend more time and communicate with families placed the infant, child, young person and parent at the centre of care and gave shape and meaning to being a paediatric nurse. Importantly, to establish a therapeutic relationship mutual trust and understanding was required.

'There's a mutual understanding that you'll be able to be in there for as long as they need' (Field note observation 6, Nurse 5).

However, parents also recognised the importance of time to establish the therapeutic relationship. During observations the response by nurses to the needs of the paediatric patients and family varied. During parent interviews voices spoke of the loss of time and its impact on the therapeutic relationship as the following quote exemplifies.

'I noticed, especially during the day when they have new admissions and if I press the bell to call them for assistance, they take a little longer to come here. They don't come fast; they usually take a few good minutes to come. He is stable now, but I know if it was something urgent, they wouldn't come fast' (Interview Parent 10).

All parents spoke of situations when their needs were left unmet, and this occurred during periods of perceived busyness. Similarly, nurses spoke of the need to provide time for

particularly vulnerable groups, such as young people with mental health issues. During periods of busyness the therapeutic relationship was viewed as compromised, and potential health outcomes reduced. Importantly, time was viewed as limited during periods of busyness, which limited nurses' opportunities to fulfill their own beliefs of what it is to be a paediatric nurse.

> *'Mental health teenagers need so much more time than we can provide them with here. They really need someone to just sit down with them for a good half an hour, 45 minutes and build rapport...but a lot of the time they are the ones who get, pushed aside but because they're medically stable…I feel for them it's probably their care when I'm a busy that is impacted the most' (Interview Nurse 10).*

However, within in this culture of care time could be reclaimed and the therapeutic relationship restored in moments of medical urgency. Most of the parent's voiced in periods of busyness nurses would be there when medical urgency demanded. Parents voiced their belief that if the situation were urgent then the child would receive the care they required, but still noted changes during busy times.

> *'If it was urgent, I think people would come… I mean if it's urgent, it's an arrest or something like that, things can happen of course' (Interview Parent 1).*

Yet the majority of parents spoke of delays in nurse responsiveness during handover and shift changes. At certain times in the day busyness surfaced as a result of patient handover. Whereby nurses removed themselves from the bedside to deliver the handover to arriving staff.

> *'I know from my own experience when it's handover and rounds time, things slow down. But obviously there are times when I've pressed the buzzer and you know, someone's on break, or they're doing their handover, and no one turns up for a while' (Interview Parent 1).*

Within this culture of care behavioural responses to these normal events were predictable and yet defined differently during episodes of busyness. Busyness altered behaviour and for both parent and nurse comprised the therapeutic relationship. The contrast was noted by many parents when episodes of quiet were experienced. Instead, opportunities to develop a therapeutic relationship surfaced and care was viewed as different, yet the give and take was evident between the two groups as discussed by Parent 10.

'If it's quiet, the service is amazing because they're here. They come sooner. But if they're busy I get a little frustrated. It's not nice, from my point of view, but for them, they're doing as much as they can. So, I can't push them harder. I actually understand even though I'm needing them, I need to understand their side as well' (Interview Parent 10).

Within this scene the therapeutic relationship was impacted by busyness. The impact of busyness was often experienced at a personal level for both nurses and parents. The following section presents the emotional impact experienced by participants during periods of busyness.

THE EMOTIONAL COST OF BUSYNESS

Within this paediatric inpatient unit, an emotional cost of busyness appeared at times to surface. For many nurses, during periods of busyness, the inability to respond to the needs of the family led to negative emotions being experienced. Within this context of care being responsive to both child and parents was important and assisted to define paediatric nursing. Yet busyness led to a clash of these beliefs and for some nurses they could not achieve their desired rhythm of care.

'He [baby] was screaming across the whole ward, so I was worried…but I remember saying those words to that woman. I wish I could sit down here and care for the baby, the sickly baby for you, you go and have a cup of tea. It's all right. But you could see that she needed help, if there was someone that could do that' (Field note observation 5, Nurse 2).

The emotional impact of not being able to provide expected paediatric care, created a sense of personal conflict for nurses that surfaced within their behaviour, interactions and care delivery. For some parents, this nurse change was noted and spoken of as contributing to the breakdown in their relationship with a nurse. However, both parent and nurse had the potential to build and/or damage the therapeutic relationship. Parent 6 illustrated.

'[The nurse was] a little bit more direct, not as patient as others. I still think she was doing her job. But I think I was less likely to build a relationship with her than the others. And then when I saw her today, I still had that clouding me a little bit. But then last night for example, I didn't really get that feeling from her again, maybe she was having a bad day. At the time it just prevented me from building a relationship with her. I think that was a combination of me being quite emotional and over-tired as well…because [patient name] was crying constantly all night' (Interview Parent 6).

The co-production of the therapeutic relationship was a shared experience for both parents and nurses. However, the emotional toll of busyness influenced parents' perceptions of care and challenged their expectations for how care should be delivered. The result was that busyness impacted on the interactions between the nurse and parent. Busyness exacted an emotional toll clashing with expectations and undermining the expected rhythm of care.

'Everyday they [nurses] are busy and I notice when he needs to take the medicine. Sometimes they are a bit late because they are with another patient. I understand, but last night they were late for one hour to give him the medication…it's hard but I understand, I know that there are not many of them and they busy and yesterday they had someone really sick. He was a priority so I understand' (Interview Parent 10).

Parents also experienced the emotional cost of busyness, which led to negative emotions surfacing. Frustration would emerge and lead to a level of dissatisfaction for many parents. The feelings of frustration would subsequently infuse their interactions. At a personal level this was experienced as powerless as Parent 10 described.

'Frustrated because I know that he needs it [medication], but I know that someone also needs [help], so I know they can't do anything about it. It's a bit hopeless… there is nothing I can do' (Interview Parent 10).

However, powerlessness was also experienced by many nurses. During periods of busyness, nurses felt powerless when parents declined care activities such as medication administration.

'It becomes difficult because I can't force that parent but at the same time I have to do my job, I have to do obs. I feel it's important for me to do my obs and see if there's anything wrong with the patient, if there is any situation where we have to act quickly but some parents they just say no' (Field note Observation 5, Nurse 2).

When parents that declined having a nurse undertake activities there appeared to surface an emotional cost for parent and nurse. Busyness disrupted the rhythm of care and then added tension was experienced by nurses when parents rejected care activities. Hence, the emotional cost of busyness was exacerbated during these times.

If you come with the antibiotics, [the parent says] can you give it later, he is sleeping. I say it has to be every six hours… it is difficult because if they say can you come back in 30 minutes he has just gone to sleep now, then you have to stick to that 30 minutes whether you've got time or not' (Field note Observation 5, Nurse 2).

Busyness reduced flexibility in the schedule of care and resulted in a clash of expectations, which was experienced at a personal level for both parents and nurses. These moments brought to the surface frustration and tension for nurses and parents. Embedded within this scene were expectations of care, which when left unmet brought negative emotions to the surface that influenced and directed interactions.

'I think they'd be reasonably supportive. Obviously, it's not like they'd sit here and play when I went downstairs to get a 20-minute lunch, I don't think that would happen. But that's not expected. I'm sure they'd make sure that I had blankets or if I need to go have coffee, they'd sit here while I went and got coffee. Small things like that, which I think those make the difference' (Interview Parent 1).

The emotional cost of busyness was present and spoken of by many nurses. The balancing of emotional tensions and busyness was evident but placed aside during moments of medical urgency. Nurses were driven to provide support and care to distressed families regardless of a perception of busyness.

'I would try to help that person with their other patients if they had to sit for a little bit with the patient to chat to them or try and calm them down…I don't think it changes whether it's busy or quiet, just someone's difficult to deal with or not nice…it can be upsetting sometimes (Interview Nurse 1).

The emotional cost of busyness led to the notion of 'must' provide compared with 'nice to provide'. Indeed, workload and time constraints shifted nurses' priorities within this setting and (re)shaped paediatric nursing.

'I probably would choose to ignore some of the signs that a parent might be getting frustrated or pacing up and down. I'd probably just walk past them, rather than if I wasn't so busy, I'd say, Are you okay?... I'd be more relaxed and open to offering help or seeing what they need' (Interview Nurse 5).

Within this cultural context, nurses viewed responsiveness to families and the sick child or young person as important. During periods of busyness these beliefs were challenged, and emotional tensions emerged. Nurse participants viewed the provision of care as dependent on being with the family and child or young person and yet busyness shifted the rhythm of care. Being present with family was a central element of paediatric nursing and when left unmet brought to the surface an emotional cost for all. A family centred approach defined and gave shape to the desired rhythm of care. However, during times of busyness the focus turned to basic medical activities, which were reluctantly given prioritisation. However, all nurses were aware that this detracted from what it was to be a paediatric nurse. Nurse 6 echoed the view for all.

'That's what annoys me, is that you only have time to do the basics' (Interview Nurse 6).

Within this culture of care, busyness shifted nursing activities towards delivery of basic care instead of the desired family centred approach. During these moments' busyness was often perceived by both parents and nurses as undesirable and negative.

SUMMARY

This chapter described the cultural dimensions of care that were embedded in this scene and how parents and paediatric nurses shared understandings and meanings of busyness. However, in this scene busyness shifted behaviour and actions for both parents and paediatric nurses, which impacted negatively on the therapeutic relationship. Importantly, busyness compromised the development of trust and altered

the rhythm of nursing work. This finding chapter identified that for both parents and paediatric nurses, busyness brought to the surface an emotional cost that was perceived at a personal level and which were reported to inhibit the desired delivery of paediatric nursing care.

The following discussion chapter presents and details ethnography interpretations. The chapter examines the ethnographic findings and relevant literature so as to answer the research question presented by this thesis.

CHAPTER 8: DISCUSSION

INTRODUCTION

This chapter brings together, through a naturalistic lens, the interpretation of ethnographic data to understand the cultural behaviour and social meanings of busyness within paediatric acute care nursing. Importantly, the study highlighted the complex relationship between paediatric nurses and parents, which was influenced by a construction of busyness. This study is the first to conceptualise busyness and quietness from the perspective of the paediatric nurse and parent.

The discussion chapter presents the interpretation of the ethnographic findings. The chapter is presented in five sections, which include: i) busyness and cultural considerations of care, which highlight how busyness and quietness were constructed and shared by nurses and parents; ii) busyness and teamwork, which brings to the fore how roles were negotiated between nurses and parents; iii) busyness and partnerships in care, which brings to the fore how busyness influenced and shaped therapeutic relationships; iv) busyness and balancing workload, which brings to the surface tensions for nurses and parents that change ways of working; v) busyness and the emotional cost of care limiting members of the scene to deliver family centred care. The chapter concludes with a summary of the strengths and limitations of this ethnography.

BUSYNESS AND CULTURAL CONSIDERATIONS OF CARE

The ethnography detailed how busyness created a shared sense of meaning for nurses and parents. Busyness defined a culture of care for parents and nurses, whereby the flow and rhythm of the paediatric unit shifted. Importantly, busyness led parents and nurses to recalibrate their role within the unit and this changed the perceived culture of care.

For parents, the rhythm of care during times of busyness was influenced also by the environment such as: a full ward, loud noises or the accelerated movement by staff. Within the literature, time and resource limitations, such as bed capacity and occupancy were found to be indicators of increased workload by nurses (Chan et al. 2018; Storaker, Nåden & Sæteren 2016). However, in this ethnography increased patient acuity was noted to be more important than a full ward for paediatric nurses. A full ward did not always raise a sense of busyness as it did for parents. Instead, for nurse participants patient acuity underpinned a sense of busyness and added to the complexity of care.

The ethnography supported an understanding of how clinical practice shifted and interactions between parents, paediatric patients and nurses were recalibrated to accommodate a sense of busyness. In this ethnography, busyness was influenced by fluctuating workloads such as: a high turn-over of paediatric admissions and discharges; inadequate staffing; an imbalance in nursing skill mix; complex or high acuity patients; distressed paediatric patients and/or parents; complex medication administration; age-appropriate patient assessment and management; documentation; and communication with family members. Similar cultural dimensions have been described in the literature reinforcing, that perceived increases in workload, time constraints and a sense of busyness created a barrier for nurses to deliver quality care (Alomari et al. 2018; Seki 2008; Thompson et al. 2008; Vinckx, Bossuyt & Dierckx de Casterlé 2018). These studies concluded that changes in the rhythm of workload (busyness) and temporal perceptions of time loss reduced nurses' perceived capacity to provide quality care.

A culture of care shifted when nurses perceived a rostered shift as chaotic or frantic. In these moments, care was (re)shaped and embedded with internal and external pressures that provoked negative emotions. Paediatric nurses in this setting internalised busyness, which altered behaviour and created a sense of stress and anxiety. Intolerable busyness resulted in the nurse's harbouring negative emotions and reduced energy levels (Govasli & Solvoll 2020; Thompson et al. 2008).

In contrast, this ethnography has also brought to the surface the impact of quietness, which was found to have equal importance in defining a culture of care. This ethnography identified that in quiet moments nurses were enabled and perceived that time was present to build positive therapeutic relationships and make meaningful connections with families. Conversely, episodes of quietness were reported to challenge nurses to remain motivated and/or to actively pursue therapeutic engagement with parents.

Within this hospital setting alternating periods of perceived busyness or quietness were common phenomena. The ethnography has highlighted the way that busyness or quietness shifted perceptions of care, practices and altered a nurse's or parent's capacity to sustain or build a therapeutic relationship. There was paucity of literature that had explored the social meaning of quietness and busyness and how this influenced interactions and care delivery within a paediatric setting. However, for nurses these constructs shifted the culture of care and were often recognised as barriers to paediatric nursing. Importantly, the culture of care was shown to be in constant flux, shifting with environmental changes and the perception of busyness and quietness. This ethnography is the first study to detail the influence and social meanings of quietness and busyness that shaped a paediatric culture of acute care.

Nonetheless, a small number of studies have examined quietness in a range of settings such as intensive care units, adult acute care and a paediatric acute care unit (Bergner 2014; Bevan et al. 2017; Joseph et al. 2016; McAndrew et al. 2016; Olson et al. 2001). However, these studies were only focused on promoting quiet time to improve patient satisfaction. The range of interventions tested included: decreased clinical interventions; dimming of lights at a fixed time; and an intentional reduction of noise. Similarly, the findings of this ethnography identified how nurses and parents perceived that quietness and busyness co-existed temporally and brought complexity to individual roles and infused interactions.

The findings of this ethnography highlighted that for nurses and parents, busyness influenced and gave shape to a culture of care. For nurses, at times the rhythm change was not conducive with paediatric nursing values. In this ethnography, nurses sought a desirable culture of care that was defined by having time to balance work activities and be present for colleagues, patients and parents. The ethnography identified that for nurses, teamwork was made possible and sustained when appropriate staffing levels and the right skill mix were rostered to a shift, thereby making it possible to safely manage patient acuity. In contrast to perceived busyness, a constant work pace enabled a sense of teamwork to surface; the delivery of family centred care; the completion of tasks; and job satisfaction. Within this ethnography a constant work pace was a positive phenomenon, which was reported to be situated between busyness and quietness.

The ethnography also identified that for paediatric nurses and parents, the construct of busyness comprised of different levels of complexity which influenced a culture of care. Indeed, differing levels of busyness were reported by nurses to be bearable or unbearable dependent on the complexities that were present within the scene. Busyness brought to the surface how negative emotions were understood and internalised for both paediatric nurses and parents. At these times busyness brought to the surface undesirable emotions, which were often considered out of the control of the nurse or parent.

An important finding of this ethnography was how different levels of busyness influenced not only the wellbeing of nurses, but how they cared for families. Similarly, the presence of both positive and negative dimensions of busyness were classified as acceptable and intolerable which both impacted the rhythm of care (Govasli & Solvoll 2020). Nonetheless, there was a paucity of evidence that had explored the level busyness and the impact on practice, activities or interactions within health care.

BUSYNESS AND TEAMWORK

The culture of care also gave shape to the social construction of teamwork during periods of busyness in this setting. In part, the balancing and completion of work activities sustained a sense of teamwork. Comparably, cooperation amongst nursing team members and the balancing of tasks formed acceptable busyness (Govasli & Solvoll 2020). Within the literature, team work synergy (defined as group cohesion, quest of common goal/s and positive achievement within a group) was found to influence patient care and outcomes, professional development in nurses, greater job satisfaction and positive and economic results (Witges & Scanlan 2015).

The findings of this ethnography have shown that busyness redefined team activities within this culture of care. More importantly during perceived periods of busyness nurses had to adjust their ways of working to cope with a constantly changing environment. During times of busyness nurses became more reliant on their own knowledge, skills, and experience. Importantly, nurses reported that busyness often meant that they became isolated from the team and instead had to rely on greater flexibility within their practice. Consequently, during times of busyness team collaboration and nurse wellbeing was often challenged.

However, busyness was perceived as more manageable when paediatric nurses felt supported within their team bringing cohesion to the delivery of paediatric care. The findings of this study identified that team relations, trust, sharing the load, team member support and team leadership shifted in the presence of busyness. Teamwork was important to these nurses, yet the impact of busyness was internalised by individuals and externalised visually through the social interactions within this setting.

In this study, the findings highlight shared meanings and understandings about nursing teamwork and of how busyness altered the desired notion of teamwork. Paediatric nurses in this ethnography, monitored and supported the workload of others within this unit. However, inner conflict or tension became present when all members were busy and unable to assist each other resulting on a lack of team cohesion. Although this study was not focused on measuring teamwork, this dimension was a key finding in relation to busyness. Importantly, the findings suggest that teamwork changed with perceptions of busyness and played a significant role in the ability of a nurse to cope with time pressure and high workloads. Teamwork in the literature was influenced by workload, fatigue and stress leading to a breakdown in communication and interpersonal skills (Kalisch & Lee 2009). A later study identified perceptions of staffing adequacy and high levels of teamwork to be associated with greater job satisfaction (Kalisch, Lee & Rochman 2010).

Hence, the disintegration of teamwork can be perceived as a burden, which must be coped with at an individual level and may result in job dissatisfaction if unresolved.

Several studies from the USA and Canada have explored nursing teamwork. For example, researchers have reported using the Nursing Teamwork Survey to evaluate staff characteristics, work schedules and staffing levels (Andrea Rochon & Michele 2015; Kalisch & Lee 2009), job satisfaction (Andrea Rochon & Michele 2015; Kalisch, Lee & Rochman 2010), and care delivery (Kalisch & Lee 2010). Interestingly, the highest nursing teamwork scores were found in: paediatrics, maternity and critical care environments; nurses working part time; and participants with higher perceptions of adequate staffing (Andrea Rochon & Michele 2015; Kalisch & Lee 2009). Similarly, this ethnography has identified the importance of teamwork for paediatric nurses.

Further, Salas, Sims and Burke (2005) constructed a framework to define components of teamwork which included: a shared mental load, trust and closed loop communication, team leadership, mutual performance monitoring, backup behaviour, adaptability and team orientation. Similarly, a recent Australian study examined teamwork using the Nursing Teamwork Survey tool across multiple care environments (Polis et al. 2017). Leadership and communication between nurses in a hospital setting were found to be significant predictors of teamwork (Polis et al. 2017). The findings of this ethnography also showed how the presence of busyness influenced communication and teamwork.

Paediatric nurses reported, in this ethnography, that their ability to cope with a busy shift was supported by effective team leadership. In the literature an effective team leader monitors the internal and external environment of the team, which then supports and/or facilitates team adaptability when changes in the environment occur (Salas, Sims & Burke 2005). In addition, effective leaders have knowledge and skills to manage complex problems (Salas, Sims & Burke 2005) and are expert in the delegation of work tasks (Polis et al. 2017). The ethnography highlighted that fluctuations in busyness, workload and time constraints were shown to be interconnected and demanded team adaptability. Consequently, the role of the team leader and their influence on teamwork could be either perceived to hinder or enable teamwork within this study setting.

Further, the ethnography showed that shared care processes involving nurse to patient interactions were found to be impacted by the team leader's delegation of care activities. Nurse team leadership influenced teamwork flexibility in adult and paediatric settings (including critical care, neonatal, paediatric, maternity, surgical and rehabilitation) (Kaiser & Westers 2018). In addition, socially constructed ways of working such as the assigning of specific patients to individual nurses was found to influence perceptions of

internalised pressure, as nurses sought to complete tasks for their own patient. Individuals could no longer focus on broader team nursing activities or monitor the function of other members of the team outside of their own individual work demands (Kaiser & Westers 2018).

In this study, the constant pressure to get everything done before the next shift was ingrained within the culture of care. This belief system generated tension and the understanding of teamwork thereby impacting on the rhythm of care. This shared belief system has also been reported by Kaiser and Westers (2018). Importantly, together these findings show how cultural norms exist within nursing teams and across acute care settings and give shape to the rhythm of care.

The social construct of busyness was an important finding of this ethnography. Further, busyness altered interactions and the desired ways of working both as a team and during nurse to parent interactions. Parents and nurses, in this study, defined busyness and its influence on the culture of care. Parents negotiated care requests and interactions differently when busyness was perceived. Furthermore, busyness brought to the surface at times undesirable ways of working that required nurses to manage conflicting priorities, multi-task and manage unwanted interruptions shifting them away from a desirable culture of care.

BUSYNESS AND PARTNERSHIPS IN CARE

This ethnography has highlighted that busyness shifted the culture of care, which impacted directly on the therapeutic relationship involving nurses and parents reshaping the notion of partnership. A partnership in care has been defined as a relationship involving two or more people that share the same goals (Reis et al. 2010). Partnerships between nurses and parents, for example the therapeutic relationship, are complex and characterised by challenging interpersonal relationships and interactions (Hendson, Reis & Nicholas 2015). A successful therapeutic partnership depends on a goal centred, collaborative approach that is negotiated and agreed upon between both nurses and parents (Reis et al. 2010). Yet evident in the ethnography was that when busyness was present, the perceived lack of time and increased workload changed therapeutic relationships between the parent and paediatric nurse. Consequently, busyness reshaped the value of paediatric nursing as it demanded a shift away from a family centred approach towards a task focused culture of care. These results suggest that the role of the nurse and parent within the therapeutic relationship were subjected to changes that were driven by perceptions of busyness.

The parent-nurse relationship is considered to be a fundamental part of a family centred approach (Shields, Young & McCann 2008). Few studies have examined parental participation in the therapeutic relationship in a hospital setting (Aarthun & Akerjordet 2014; Butler, Copnell & Willetts 2014; Darbyshire 1994; Kristensson-Hallstrom & Elander 1997; Roden 2005). However, studies have examined a construct of busyness, increased workload and impact on the therapeutic relationship (Ceci & McIntyre 2001; Paliadelis et al. 2005), time constraints and staff shortages (Paliadelis et al. 2005). These studies identified that workload, time and staffing levels influenced parental participation in the building of therapeutic partnerships. This ethnography supports these findings.

In addition, researchers have also explored partnerships between nurses and parents in paediatric intensive care and neonatal intensive care settings. Yet, the majority of published studies undertaken in paediatric acute care are dated (Blower & Morgan 2000; Evans 1996; Hallström 2004; Power & Franck 2008; Shields, Kristensson-Hallström & O'Callaghan 2003). More recent literature (Brødsgaard et al. 2019; Butler, Copnell & Willetts 2014; Hendson, Reis & Nicholas 2015; Reis et al. 2010) explored partnerships between nurses and parents. However, researchers (Blower & Morgan 2000; Evans 1996; Hallström 2004; Power & Franck 2008; Shields, Kristensson-Hallström & O'Callaghan 2003) have highlighted the need to examine the complexities of therapeutic partnerships within a modern paediatric acute care setting. This ethnography has generated new knowledge that has gone some way to answering this research gap.

For nurses in this setting, a collaborative partnership between themselves and parents was highly valued and gave meaning and shape to therapeutic partnerships for paediatric nursing. Therapeutic partnerships were driven by a desire for collaboration. For nurses, a collaborative partnership enabled care to be centred around the family. However, busyness was a barrier to enabling the formation of therapeutic collaborative partnerships between paediatric nurses and parents in this ethnography.

However, for parents a collaborative partnership could be hindered by other factors not just busyness. A critical care study identified that parents' capacity to collaborate could be hindered by a lack of familiarity with the environment, complexity of medical language, ineffective communication, and redefined parental roles (Cescutti-Butler & Galvin 2003; Fegran, Fagermoen & Helseth 2008). In this ethnography, busyness reshaped expectations and roles with a disruption to the routine meanings of the therapeutic partnership. Importantly, findings suggested that parents hesitated to approach nurses and nurses avoided collaborative interactions as a mechanism to save time. Yet therapeutic partnerships required the nurse and parent to interact and collaborate to build rapport and trust.

The ethnography reported that therapeutic partnerships between paediatric nurses and parents were viewed as positive, especially when nurse or parent expectations were met or perceived to be exceeded. Likewise, interactions between nurses and parents were positive when the parent's needs were met (Espezel & Canam 2003). The findings identified that patient complexity impacted on the establishment of rapport with parents and diminished the collaborative partnership with the setting (Espezel & Canam 2003). The influence of patient complexity was also an important finding in this ethnography and contributed to perceptions of busyness, changing interactions, collaborative ways of working and ultimately negatively impacting on therapeutic partnerships.

Establishing rapport was found to be a key component of a collaborative partnership between paediatric nurses and families in this ethnography. To support collaborative partnerships, nurses need opportunity and time for play to establish patient and family trust and rapport. This individualised care was deemed important by both nurses and parents and underpinned a therapeutic partnership. This concept has been reported in the literature as knowing the child and the parent/s, and the parent knowing the nurse (Espezel & Canam 2003). These social interactions formed important connections and framed a collaborative partnership. Busyness was a barrier to forming collaborative connections and, in this ethnography, nurse behaviour changed during periods of busyness and included: closed communication techniques, avoiding eye contact on movement and a focus on task delivery. These behaviours negatively affected therapeutic partnerships and prevented opportunities to build rapport with families. While, little is known about the factors that fracture partnerships between paediatric nurses and parents, the negotiation of roles, co-creation of knowledge and development of competencies were elements identified to support a successful partnership (Brødsgaard et al. 2019).

In part, therapeutic partnerships require effective collaboration and communication of roles and expectations, which assist to shape interactions. Interactions provide the space and opportunity for shared decision-making and opportunity for parenteral advocacy within the partnership. The findings identified that communication was essential to creating nurse and parent role meaning for establishing therapeutic partnerships. However, busyness in this setting, led to misunderstandings, which could not always be effectively negotiated. Busyness altered communication patterns within partnerships and raised perceptions of time constraints, increased workload, poor nursing skill mix, and reduced wellbeing.

Studies undertaken in paediatric and neonatal intensive care units identified that collaboration was negatively influenced by poor clarification of role expectations and

opportunities for negotiation between groups (Brødsgaard et al. 2019; Butler, Copnell & Willetts 2014; Fegran, Fagermoen & Helseth 2008). Similarly, an older UK study conducted across three children's wards found that parents wanted to be involved in caring for their child (Kawik 1996). However, ineffective communication was cited as a barrier to therapeutic partnerships along with inadequate negotiation skills and poor role clarification.

This ethnography has detailed new knowledge in relation to busyness and of how social processes, behaviours and perceptions altered the therapeutic partnerships. Within this culture of care the ability and capacity for nurses and parents to collaboratively interact was challenged during periods of busyness. A richer understanding of the complexity of collaborative partnerships and how the construct of busyness changed interactions and altered dimensions of care are an important ethnographic finding.

BUSYNESS AND BALANCING WORKLOAD

Busyness emerged as a social construct well defined, shared and understood by all members of this scene. Busyness impacted on parents balancing their desire for assistance or support against a sense of nurse busyness. Parents reported prioritising their need for assistance and instead would actively avoid approaching or disturbing the nurse during periods of busyness. Indeed, parents would seek ways to support nurses during perceived times of busyness. As a result, busyness shifted expectations, altered behaviour and at times led to parental resistance to ask a nurse for help and/or support.

The phenomena of parents supporting busy nurses and having to balance their own expectations and advocacy roles has been explored in the literature (Beach 2001; Blower & Morgan 2000; Darbyshire 1994). Parents sought to assist nurses by becoming actively involved in their child's care and further, parental support was found to enable nurses to attend to other clinical tasks thereby reducing the nurse's workload. Parental support was recognised in this ethnography to also reduce the paediatric nurse's workload.

The findings from this ethnography showed that parents valued nurse time over their own time. In part supported in the knowledge that the nurses used this extra time to provide education and support. Paediatric nurse and parent expectations shifted when busyness was present bringing to the surface tensions in the balancing of time with parents' capacity to participate in the delivery of care and the time available for paediatric nurses to facilitate the partnership.

Busyness not only added to the complexity of parents seeking to reduce the paediatric nurse workload, but increased parents' reluctance to leave the ward and child or young

person in the study setting. Importantly, most parents were not comfortable leaving their child or young person regardless of busyness. However, this further validated their need to stay close to their child or young person. Recent studies undertaken in paediatric acute care settings have found that parental perceptions of safety increased their need to oversee care (Cox et al. 2013; Rosenberg et al. 2016; Shala et al. 2019). Security concerns, falls, medication errors, handover, communication, openness of staff and transitions were characterised as dimensions of safety across both studies. All studies suggested the need to provide strategies to reduce parental burden to watch over care in hospital settings (Cox et al. 2013; Rosenberg et al. 2016; Shala et al. 2019).

Similarly, for parents in this ethnography being present near their child optimised safety and was perceived as a priority. Parents believed that their role involved advocating for their child or young person's needs, which required them to be present at the bedside. Comparably, parents believed they needed to be close to their child to provide safety and that they were the best security for their child (Hallström, Runesson & Elander 2002). Parents within this ethnography prioritised their child or young person's wellbeing and needs over their own. Providing consistent advocacy at the bedside was a key parenteral role within this culture of care.

In this ethnography, parents reported a need to balance the safety of their decision to leave their child unattended in the unit. Instead, during perceived busyness parents would negotiate with nurses on the decision to leave their child or young person alone on the unit. Nurses during busyness were less able to provide basic care and emotional support to their child or young person and so parents were reluctant to leave. Nurses who were experiencing busyness voiced that distressed children with no parent present required more support and escalated their level of stress. Further, during perceived busyness when parental participation at the bedside was absent, conflict could surface within the therapeutic relationship for nurses. In part this was clarified by other studies, which have reported that paediatric nurses voiced to parents that they would be unable to stay with their child at the bedside when they left the unit due to busyness (Beach 2001; Roden 2005). The ethnography has brought to the surface how parents and nurses balanced beliefs and expectations to negotiate the workload during periods of busyness to sustain a rhythm of care that was desirable for both groups and which sustained a therapeutic relationship.

BUSYNESS AND THE EMOTIONAL COST OF CARE

Busyness was found, in this ethnography, to affect emotions for both nurses and parents. In this setting, time constraints and increased workload were reported to burden nurses

and bring to the surface stress, fatigue and a reduced ability to provide emotional support to families. Within this culture of care were strong beliefs of what it was to be a paediatric nurse and tensions arose with an inability to enact these shared beliefs.

In this ethnography, stress emerged for all nurses in times of busyness. There is also evidence that sustained stress can have direct physiological effects, which can result in exhaustion and illness (McBride 2003). Further, increased nursing workload, which related to multi-tasking, interruptions and experiences of feeling rushed were also associated with burnout. Comparably, inadequate staffing levels led to job dissatisfaction for paediatric nurses (Holden et al. 2011). These findings were supported by others who have identified that work stress was related to patient acuity, complex cases, skill mix and staffing ratios (Berger et al. 2015; Robins, Meltzer & Zelikovsky 2009). These findings are also supported by this ethnography.

In addition, continually managing the biopsychosocial needs of others led to experiences of stress for paediatric nurses (Berger et al. 2015). The results in this ethnography noted the pressure perceived by some nurses whose role had changed due to an increase in less experienced staffing levels. As a result, greater expectations were placed upon experienced nurses to work in leadership roles and mentor junior nurses within the setting. The pressure to work in more flexible ways, changes in nurses' roles or skill mix can affect nurse integrity and patient care (Alomari et al. 2018; McIntosh & Sheppy 2013). These pressures were evident in this ethnography and dimensions of busyness amplified the intensity of pressure that led to experiences of stress for nurses. Interestingly, there is evidence that the inability to adapt to organisational fluxes could be significant factor in burnout and interpersonal conflict (McBride 2003).

Similarly, for parents' busyness lessened opportunities for emotional support and required an adjustment to new ways of being within this setting that led to increased experiences of stress for some. Experiences of parental stress during the hospitalisation of a child, is well recognised in the literature (Hallström, Runesson & Elander 2002). Importantly, parental involvement in care was found to be one of the biggest stressors for parents (Power & Franck 2008). Furthermore, parents put their child's or young person's needs before their own (Hallström, Runesson & Elander 2002) adding to the complexity of hospitalisation. In this ethnography the wellbeing of parents was compromised by the requirement to adhere to social rules, sleep deprivation and hypervigilant advocacy. Parental needs and wellbeing were woven around the needs of their child or young person in this ethnography.

STRENGTHS AND LIMITATIONS

There are a number of strengths that should be noted for this study. Importantly, ethnography made possible the generation of new cultural knowledge, processes, and expectations of everyday paediatric nursing. This ethnography addressed a research gap within the literature, adding to the body of knowledge of paediatric nursing, and paediatric nurse and parent partnerships. To date, this is the first study that has examined the construct of busyness and quietness and how these socially constructed phenomena shaped a culture of care, thereby influencing nurse and parental behaviours, expectations and beliefs within in a paediatric acute care setting. Another strength included the methodological approach, which enabled the exploration of social interactions, social processes, perceptions and cultural norms embedded within care practices. This theoretical lens enabled the gathering of rich data from the differing viewpoints of members within these therapeutic relationships. Importantly, deep immersion into the scene over a prolonged period of time supported the building of trust and rapport with the nurses and parents. Data saturation was reached, and rich observation of natural behaviours and interactions achieved within a paediatric setting. Finally, the analysis undertaken by the researcher and supervisors strengthened the quality, rigor and credibility of the ethnography.

There are a number of limitations, which should be considered for this study. The sample groups (parents and paediatric nurses) were homogenous and different voices might have resulted in different findings. Male paediatric nurses and fathers were under-represented in this study and therefore, gender-specific differences were not explored in this ethnography. In addition, most parents were born in Australia and New Zealand. Some voices were also silenced in this setting, such as children and young persons, and medical and allied health staff, which may have led to different findings for this thesis. Finally, sampling bias may be present due to the small sample size, gender and single site, which limits generalisability and relevance to other paediatric specialist care settings.

SUMMARY

This ethnography has identified a culture of care infused with embedded meanings, defined roles, expectations and beliefs that influenced nurse and parental behaviours within a paediatric acute care setting. This study has examined and described the construct of busyness and how the socially constructed phenomena shaped cultural knowledge, processes, and expectations. The ethnography has generated new

knowledge and has given shape to social understandings of busyness and the complexities of nurse and parent therapeutic relationship.

The findings of this ethnography highlighted that busyness when present led parents and nurses to work together to reduce the impact of busyness. These collective ways of working emerged through social processes such as teamwork, prioritising, staying at the bedside and striving to meet expectations. Yet, internal and external conflict arose when these collective ways of working were unable to be sustained during busyness. This ethnography has addressed a research gap within the literature, adding to the body of knowledge of paediatric nursing, and paediatric nurse and parent partnerships. The final chapter addresses the implications that this ethnography has raised for professional nursing practice, education and future research.

CHAPTER 9: IMPLICATIONS AND CONCLUSION

INTRODUCTION

This ethnography has presented the socio-cultural dimensions of busyness as a construct in one paediatric inpatient setting. The ethnographic findings have significant implications for paediatric nursing, education and research. The following section details strategies for clinical paediatric nursing practice, education and training and future research.

PAEDIATRIC NURSING PRACTICE

Busyness as a construct had an underlying effect on this context, which suggests that an organisational approach is required to address the challenges busyness poses for paediatric nurses. At an organisational level, fostering a positive workplace culture that shares the same values and vision for family centred care and the wellbeing of paediatric nurses should form part of a service plan. In addition, emphasis should be placed on investing in resources to reduce the fluctuations of busyness such as: reliable volunteers that could assist and emotionally support families during hospitalisation. Having volunteers available could support parents taking time out for self-care and other family needs whilst alleviating the pressure experienced by paediatric nurses.

Other organisational strategies should be aimed at developing a nursing team with a diverse skill mix. Such diversity enables the sharing of strengths and experiences to address the care delivery challenges associated with busyness. Team development strategies support the ways of working that enable ongoing communication between team members such as huddles with the team leader. Instigating a teamwork model that could be used when the setting is perceived as busy would reduce environmental stressors.

Additionally, guidelines and procedures should be developed by nursing leaders to provide best practice standards on effective teamwork and resource led strategies in paediatric acute care. Increasing the coping abilities of paediatric nurses during stressful busy situations would enable nurses to work more efficiently and promote self-well-being.

Finally, strategies that enhance parent orientation to the ward, shared expectations of care and role responsibilities would better support the therapeutic relationship. In addition, parents' concern for safety may be better supported by web camera technology. For example, a NicView is a web camera specifically designed for use in the Neonatal

Intensive Care (NICU). The NicView allows a parent to see their baby in NICU at any time from home and this strategy could be adopted more widely across the paediatric setting.

EDUCATION AND TRAINING

Education such as simulated learning would assist in developing nurse-nurse, nurse-parent and nurse-paediatric patient communication skills to enable nursing roles to be confidently and consistently promoted. Further, to develop communication skills short education sessions in the paediatric unit, such as role modelling scenarios, could be implemented.

It is paramount that tertiary nursing education provides modules related to; time management, prioritising and working in stressful health care environments. This ethnography did not include new graduate nurses, although experienced nurses in this study found coping with busyness challenging. Therefore, equipping new graduate nurses and nurses undertaking post graduate study with the knowledge and skills on how to work in environments with time pressure and high workloads would be beneficial. Finally, as part of a team development strategy, education should also form part of this initiative. Team building sessions to enhance effective teamwork and training in dealing with the complexities of busyness should be provided to paediatric nurses.

FUTURE RESEARCH

The ethnography highlighted how the construct of busyness influenced therapeutic relationships between paediatric nurses and parents and challenged communication processes. Further research is needed to explore a communication framework that supports and/or improves authentic engagement between paediatric nurses and parents. A new framework is needed that would address the complexities of busyness and enhance the space required to build therapeutic relationships.

In addition, further research is needed to determine the influence of role negotiation, active parental participation including expectations and ways of working that better support a family centred care during periods of busyness. Future research also needs to explore the perspectives of children and young people and their notion of busyness. Children and young peoples' voices are important and future research should explore strategies that could improve practice and relationships within a family centred care model. The research outcomes could be used in collaboration with the findings from this

ethnography, providing a more holistic account of all member experiences within this setting.

This ethnography did not explore the implementation of formal quiet times in paediatric acute care. Formal quiet times could be explored in relation to the effects on providing downtime for paediatric nurses to rest, take breaks, catch up on work and have space to critically think and plan care. Additionally, this protected quiet time could allow time for families to rest and sleep and children and young people to have a break from care interventions, activity and noise. The value of examining the implementation of formal quiet times in this setting would add to the body of knowledge and further enhance the recommendations from this ethnography.

CONCLUSION

This thesis has generated new knowledge and answered the research question. Specifically, *how do paediatric nurses and parents construct a notion of busyness within therapeutic relationships in a paediatric acute care setting?* This ethnography has identified a culture of care that changed in moments of busyness and gave shape to parent and nursing roles, expectations and beliefs. The findings highlighted the importance of family centred care to paediatric nurses and gave shape to social understandings and insights into the complexities of paediatric nurse–parent partnerships, which assisted to define dimensions of the therapeutic relationship. Importantly, the ethnography has brought to the surface how paediatric nurses and parents negotiated and balanced their partnership to achieve a desired therapeutic relationship.

In the paediatric setting parents and paediatric nurses worked collectively together to reduce the impact of busyness which reshaped the therapeutic relationship. The new ways of working brought to the surface changes in behaviour, expectations, interactions and social processes. Yet, moments of internal and external conflict arose when expected ways of working shifted and collided during periods of busyness. This ethnography has addressed a significant research gap and provided new insights and implications into paediatric nursing practice, education and research.

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APPENDIX 1: QUALITATIVE RESEARCH RELATED TO THE CONSTRUCT OF BUSYNESS

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
Chan et al. (2018) Canada Busyness and constraints of care for the dying	Focused ethnography using interviews and observations	Interviews (n=35) Adult sample: 10 patients 11 family members 14 health professionals 600 hours of observations over 98 visits within a 10-month period	Busyness, teamwork and acute priorities: Medical ward was busy and demanding due to variety of patients, diagnosis and acuity Limited resources Not having enough time Nurses 'forced' to be task orientated – managing acute medical crises and biomedical tasks instead of meeting patient's actual needs Teamwork supported staff with busyness and challenges of limited resources	How the philosophical divide between curative and palliative care constructed the logic of care in that medical ward. Busyness on the ward in combination with complex demands, acute care priorities and teamwork required to cope with challenges all formed the basis of logic of care which characterised working on that acute care medical ward. General acceptance of workload and the priorities of care which included: biomedical tasks over emotional and basic care. Belief that palliative care could only be delivered in palliative care settings
Choe, Kang and Park (2015)	Phenomenology using in-depth	Critical care nurses (n=14) with at least one-year critical care	One out of the five themes related to busyness; ambivalence towards treatment and care	Ambivalence towards prioritising tasks over human dignity occurred during times when nurses felt uncomfortable

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
South Korea Moral distress experienced by critical care nurses	interviews over a 21-month period	experience were recruited from two university hospitals located in Seoul		with work processes and tasks that prevented them from respecting human dignity and advocating for the patient's autonomy
Govasli and Solvoll (2020) Norway Nurses' experiences of busyness	Phenomenology and hermeneutical method	Nurse participants (n=4) from medical, surgical, intensive care and aged care were recruited from a small geographical area	Characteristics included: i) busyness, disparity between tasks and time available ii) outer and inner dimensions of busyness and the interaction between them iii) acceptable busyness iv) intolerable busyness v) interruptions reinforce the experience of busyness	Differing levels of busyness and nurses' perceptions of completing care requirements Acceptable busyness was conceptualised from task completion within the nursing team Intolerable busyness was generated from the nurse participants feeling like they were unable to manage their care plans and associated tasks Feelings of inner chaos and despair were generated from tasks that were perceived as important and remained undone Experiences of busyness were amplified by interruptions in work

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
Livesley & Long (2013) UK Children's experiences in a hospital environment this being nephro-urology ward in a tertiary referral children's hospital	Critical ethnography	Paediatric sample: Interviews (n=17) Phase 1 (interviews in the family home post discharge): Six children (aged 9-15). Phase 2 (in-hospital fieldwork over 100 hours in 6 months): Nine children and adolescents (aged 5-14)	Child-nurse relationships: Limited time nurses had to spend with children Too busy to attend to the needs of the children; changing a pad and analgesia administration Busyness of the ward influenced the ward rules	Different realities between the children and nursing staff. These two worlds clashed at times Children's voices and competence were challenging for the nursing staff and parent/carers Missed opportunities for engaging in a participatory model of practice Less resilient, sicker, introverted children were less able to call on the nurses for help leading to their needs being overlooked
Martin (1998) UK Empowering dying adult patients through nursing care	Descriptive narrative accounts	30 student nurses were undertaking post graduate education which included a module on death and dying	Lack of time, series of routines and short encounters were defined as busyness within this context Nurse's busyness and shortage of time reflected authority of the role and the patient's endurance	Busyness and time constraints were a way of nurses asserting control within the nurse-patient relationship Busyness, special language and rituals were believed to be ways that nurses shield themselves from interactions with patients

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
Nagington, Luker & Walsh (2013) UK Busyness and palliative district nursing care	Post-structural discourse analysis	Semi-structured interviews: Adult patients (n=26) and carers (n=13) recruited across five community healthcare trusts requiring palliative or supportive care	Circulating and forming subjectivities The reduction of busyness	Busyness affected how patients and carers conceptualised and accessed psychosocial and physical care including medications Busyness influences power and control within the therapeutic relationship Slowing down nursing care may cease the task orientated, measured efficiency that nurses practiced
Storaker, Naden & Saeteren (2016) Norway Ethical challenges that nurses face in daily practice	Qualitative interview using hermeneutical approach to analysis	Nine registered nurses were interviewed from three different adult clinical wards at a university hospital	The painfulness of busyness	A normal working day was characterised as chaotic without opportunities to have input into improvements Constant pressures of time and increased patient numbers Staff shortages also added to the perceptions of busyness Lack of time for reflection and evaluation contributed to feelings of painful busyness

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
Thompson et al. (2008) Canada Busyness and research utilisation	Ethnography using multiple case study examining how nurses use research for adult and paediatric pain	235 nurses: paediatric and adult Open-ended interviews (n=119) Observations recorded as fieldnotes (n=213) Focus group interviews (n=17)	Environmental factors: restricted resources, moving patients (admissions, transfers and discharges), nursing shortage, tasks (medication administration), physical layout (congested areas nurses' desk, medication room and report room) Interpersonal factors: relationships between nurses and patients, nurses and peers, nurses and other health professionals. Leadership roles and responsibilities (lack of control over time and interruptions) Intrapersonal factors: personal attributes of nurses' including their personal life demands (family life, professional development such as higher education) Individual perceptions of busyness Culture: busyness was seen to be valued and rewarded Value placed on highly observable nursing care	Lack of time and busyness interferes with nurses seeking, reading and utilising research Creating a culture of busyness within nursing that supports familiarity of nursing tasks over unfamiliarity of research utilisation Lack of energy and mental time from a culture of busyness limits research utilisation

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
			Effects: unable to attend or achieve due to workload and time Missed opportunities: (nursing in-services, meetings and rounds) Compromised safety (feeling of powerlessness	
Vinckx, Bossuyt and Dierckx de Casterlé (2018) Belgium Working under time pressure	Grounded theory	Adult oncology nurses (n=14) were recruited from five inpatient oncology nursing wards in one academic hospital	A shared yet nuanced reality A broad range of individual strategies Ad hoc strategies Perceived impact of time pressure on nursing care Underlying factors: personality of the nurse, nursing culture and context	Time pressure was experienced by these adult oncology nurses in their daily practice through a lack of measurable clock time, feeling overwhelmed and rushed to achieve all their work within a certain time frame The intensity of time pressure was managed differently according to coping strategies
Wilson, McCormack and Ives (2005) Australia	Emancipatory practice development	Nurses and midwives that worked in this SCN (n=27) were included and of these 27 nurses and midwives, 19 also completed a survey	Family-centred care: Empowerment of families versus ownership of babies Continuity versus discontinuity	Busyness formed barriers between nurses and parents when nurses and midwives felt busy, their behaviours changed which made parents less likely to approach or disturb them

Authors, year, country and study focus	Design	Participants and sample size	Themes related to busyness	Findings related to the construct of busyness
Understanding workplace culture of a Special Care Nursery (SCN)			Enabling environments versus busyness	Environmental elements heightened images of busyness such as the lights being on and increased noise levels Ritual and nurse-centred practices showed the cultural complexities and impacted the nurse and family partnership in care

APPENDIX 2: QUANTITATIVE RESEARCH RELATED TO THE CONSTRUCT OF BUSYNESS

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
Benner et al. (2018) USA Emergency department busyness and time to antibiotics in febrile paediatric oncology patients	QI initiative using regression modelling and scatterplot analysis to examine baseline data (prior to implementation of a new model of care) and post intervention data	The sample included paediatric participants (n=253) up to age 21 years with a known inherited or acquired immunodeficiency at risk of neutropenia, that presented to the Emergency Department with complaints of fever or triage temperature 380C or higher	To evaluate whether time to antibiotic administration was delayed due to Emergency Department busyness Measurement of time and workload was also used to determine busyness defined as concurrent hourly Emergency Department arrivals	No delays were found in relation to time to antibiotic and emergency department busyness. Workload and time can be positively influenced by team engagement, evidenced based practice and upskilling of staff
Chen et al. (2018) Taiwan Perceptions of moral distress experienced by nurses	Mixed methods using Q methodology and interviews	60 nurses across medical, surgical and special ward (not defined) from a regional teaching hospital were recruited to rank 40 moral distress Q statements Eligibility criteria included: nurses over 20 years of age with more than one-year experience in clinical nursing and a general	To identify and describe varying perceptions of moral distress experienced by nurses Phase one included in-depth interviews with 15 participants Phase two utilised the statements from the interviews to construct Q statements that the participants ranked using a Q grid which utilised a range from -4 (least distress) to +4	Moral distress intensifies when ethical dilemmas are present with other conceptual factors such as: limited resources and time pressure Five response types from 52 participants were identified: i) Conflict with personal values (19 nurses) ii) Excessive workload (11 nurses) iii) Curbing of autonomy (12 nurses)

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
		awareness of ethical issues	(most distress) with 0 representing neutrality	iv) Constraint engendered by organisational norms (8 nurses) v) Self-expectation frustration (2 nurses)
Dalheim et al.(2012) Norway Factors that influence evidenced based practice in a hospital environment	Cross-sectional data from questionnaires using the Developing Evidence-based Practice questionnaire (DEBP)	407 nurses, a total of 661 nurses were invited Nurses were recruited from across 20 selected units from a University Hospital for one month (November to December 2010)	To examine factors that influence nurses to implement evidenced based practice The DEBP included data on support in practice, potential barriers and self-reported skills The Norwegian version included 50 pre-structured and four open-ended questions using a five-point Likert scale The questionnaire was divided into five sections: sources of knowledge rated never (1) to always (5), possible barriers rated strongly agree (1) to strongly disagree (5), skills in finding reviewing and using research based-evidence rated beginner (1) to expert (5) and	Of the five barriers reported insufficient time to find research articles, organisational information and implement changes in practice were found There was insufficient time or lack of time to utilise research and implement research into practice The least barrier to evidenced-based practice was culture in the healthcare team

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
			demographic variables were examined	
Festini et al. (2019) USA Predictors of perceived busyness across the adult lifespan	The Martin and Park Environmental Demands Questionnaire was used in this cross-sectional study to provide an average busyness score	Participants (n=463) were recruited from the Dallas Lifespan Brain Study Ages of the participants ranged from 20-89 years	To evaluate three hypotheses: i) Age differences in perceived busyness ii) Whether gender, personality, health and lifestyle factors significantly predict perceived busyness iii) Whether gender, personality, health and lifestyle are predictors of self-reported busyness and age	Full-time workers reported being busier than part-time workers who were busier than retired or unemployed individuals Perceived busyness declined with age until 60 years and this then remained stable until 80 years of age Women reported feeling busier than men despite age Greater extraversion, agreeableness and neuroticism predicted greater busyness Openness and conscientiousness were not independent predictors of busyness Being busy was associated with better health, lower blood pressure, lower BMI and more frequent exercise Participants that engaged in more lifestyle activities reported greater busyness

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
Festini, McDonough and Park (2016) USA Greater busyness is associated with better cognition	Cognitive battery and the Martin and Park Environmental Demands Questionnaire	Participants (n=330) from the Dallas Lifespan Brain Study were recruited for this study	To examine the relationship between busyness and cognition in adults aged 50-89 years Determine whether a busy schedule would be a proxy for an engaged lifestyle and facilitate cognition Bivariate correlations between busyness and the five cognitive constructs were conducted Hierarchical regressions were also used to determine whether busyness predicted significant additional variance in cognition	Busier people tended to have better cognitive performance; specifically, better cognitive performance was associated with greater busyness Cognitive performance included: faster processing speed, better working and episodic memory, better reasoning and better crystalized knowledge
Hsee, Yang and Wang (2010) USA Actual versus perceived consumption of time with a focus on	Experimental study	98 college students from a large public university	To test two hypotheses; i) choice between busyness and idleness ii) experiences in relation to busyness and idleness Participants completed two separate confidential surveys about their school and they	The results of this study focused on the two dependent variables which were choice (location) and experience (feelings from the 15-minute duration) More participants 32% chose the far away (busy) option. In addition, those participants defined as busy reported

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
busyness and idleness			were not able to do any other activities during this time	greater happiness than idle participants
			Post completing the first survey, the participants were told that the second survey would not be ready for 15 minutes and that they could drop their survey at a nearby or faraway designated location (either outside the room or 12-15 minute round-trip walk). The nearby location represented the idle option and the far away option represented the busy option	Choice and experience showed that most individuals chose the same-Candy condition at the nearby location, however those who experienced the far away location reported feeling happier
			The second questionnaire post experiment 1 (at the end of the 15-min period) asked how they felt in the last 15 minutes using a scale of 1 (not good at all) to 5 (very good)	
Hutchinson and Johnston (2004) Australia	Survey design using the 29-item validated questionnaire using barriers to research	Surveys were distributed to 761 Registered Nurses and 49% responded	To gain an understanding of perceived influences in relation to nurses' utilisation of research and further explore the differences and commonalities that were found in this study and	Nurses reported that they do not have time to read research (78.3%) and that there is insufficient time on the job to implement new ideas (73.8%)

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
Barriers and facilitators of research utilisation in the practice setting	utilisation (BARRIERS scale)		similar studies conducted within the past 10 years This eight-item scale of facilitators records additional barriers and/or facilitators including demographic questions	Participants (89.6%) classified that increasing the time available for reviewing and implementing research findings as a moderate or great facilitator
Martin and Park (2003) Not specified (authors from Switzerland and USA) Busyness and its impact on medication adherence in community-dwelling individuals	Questionnaire that measured busyness as defined by environmental demands such as routines and its impact on medication adherence	121 community-dwelling individuals with rheumatoid arthritis aged 34 to 84 participated	To examine the usefulness of an instrument the Martin and Park Environmental Demands (MPED) Questionnaire in measuring the level of self-reported environmental demands of daily activities and medication adherence In addition to the questionnaire, demographic information (seven questions) was included; employment, education, household size and medication taking errors Sample busyness questions in the questionnaire included: how busy are you during the average day? How often do you have too	There was a significant independent association between adherence errors and busyness Medication-taking errors were associated with busyness and not age The authors concluded that this questionnaire is valid and reliable when assessing general daily level environmental demands

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
			many things to do each day to actually get them done? Each question required a response using the 5-point Likert scale, for example 1= not busy at all, 2= rarely busy, 3=somewhat busy, 4= very busy and 5= extremely busy. Higher scores indicated a greater perception of busyness	
Seki and Yamazaki (2006) Japan Working conditions and the impact on medication administration	A self-reported questionnaire was used to report the following variables: workload, busyness, shifts, work experience, fatigue and sleep deprivation	90 nurses were recruited and 88 responded to the questionnaire from four adult wards (nephrology, cardiovascular, neurosurgery and haematology) in one public hospital	To explore working conditions that influence the occurrence of near-miss errors related to intravenous medication The survey measured: years of experience as a nurse and current ward, data from three shifts (day, evening and night), sleep duration before work including nap hours and workload as the number of patient's per nurse	Workload was reported as busier during the day shift as organisational processes governed the nurses time whereby additional tasks were required This led to a higher frequency of near-miss errors when nursing services were delayed due to busyness Higher frequencies of near-miss errors also occurred when nursing services were delayed due to busyness in combination with less experienced nurses

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
			Fatigue was measured using a 100mm visual analogue scale prior to starting work	
Teng, Hsiao and Chou (2010) Taiwan Time pressure experienced by nurses and patient-perceived care	Cross-sectional design and survey method	The sample included patients (n=765) and nurses (n=255) who were recruited from 45 inpatient units within a medical centre that comprised of more than 3700 beds. Paediatric psychiatric, private and intensive care patients were excluded Eligibility for nursing participants included; working full-time including day shifts and employed on one of the 45 units that the patient sample was collected. Patients who were cared for by the nurse participant for one day shift were randomly sampled (n=3) this enabled the examination of time	To examine how time pressure experienced by nurses influenced the quality of patient-perceived care To test the following hypotheses: i) time pressure experienced by nurses is negatively related to patient perception of reliability/accountability ii) time pressure experienced by nurses is negatively related to patient perception of responsiveness iii) time pressure is experienced by nurses is negatively related to patient perception of assurance	The findings supported hypotheses i, ii and iii There was no significant negative association between nurse-perceived time pressure and patient-perceived empathy and reported tangibles (included physical presentation of the nurse such as clean and tidy uniform, mood and neat medical supplies)

Authors, year, country and research focus	Design	Participants and sample size	Aim and Method	Findings related to the construct of busyness
		pressure described by the nurse and quality of care expressed by the patients	iv) time pressure experienced by nurses is negatively related to patient perception of empathy v) time pressure experienced by nurses is negatively related to patient perception of tangibles	

APPENDIX 3: PAEDIATRIC NURSE INTERVIEW GUIDE

Demographic information

What is your role? EN RN CNS CNS2 CNE
CNC NUM

What is the highest education level you have achieved?

Hospital certificate ◯ Bachelor degree ◯ Graduate certificate◯

Graduate diploma ◯ Masters ◯ Doctoral ◯

Gender Female Male Other

What is your age? _____years

What is your country of birth?

_____

What language do you mainly speak at home?

_____

Do you have any dependents at home?

_____

How many years have you worked as a nurse? _____

How many years have you worked in paediatric nursing? _____

How many years have you worked in your current role? _____

How many shifts do you normally work in a fortnight?

_____

Which best describes the hours you mostly work? Days Evenings Nights

Do you do rotating shifts between days, nights or evenings Yes No

In the past month, how many hours of overtime did you work? _____

INTERVIEW QUESTIONS

1. Why did you choose to work in paediatrics?
2. How would you describe the nursing care provided on the paediatric unit?
3. Can you describe to me what your last shift was like?
4. When you think about being a paediatric nurse on this unit, can you describe to me what most of your shifts are like?
5. How do you find the workload on most shifts?
6. Have you experienced a busy shift on the paediatric unit?
7. What does a busy shift feel like for you on the paediatric unit?
8. What makes a quiet shift on the paediatric unit?
9. How do you feel at the end of a busy shift?
10. Do you think paediatric nursing is becoming busier?
11. When it is busy, does your behaviour towards families change?
12. When it is quiet, does your behaviour towards families change?
13. Do you feel you have enough time to complete the nursing activities when it is busy?
14. What about when it is quiet, is there enough time to complete the nursing activities?
15. What are your perceptions on the time you spend with the families when it is busy compared to quiet times?
16. When thinking about busyness do you feel you can provide safe nursing care?
17. Does this feeling of providing safe nursing care change when it is quiet?
18. How do you see the involvement of families in the health care decision-making?
19. Does this involvement change when the unit is busy?
20. When the unit is busy what is it like caring for a child or adolescent that has periods of distress?
21. When the unit is quiet what is it like caring for a child or adolescent that has periods of distress?

22. How do you feel when the unit is busy and a parent or carer is concerned and stressed and you need to support them?
23. Do your feelings about this situation change when the paediatric unit is quiet?
24. How do you feel when the parent/s or carer/s leave their child or adolescent for a period of time on the paediatric unit when it is busy?
25. How does this compare to when the paediatric unit is quiet?
26. What is the impact of busyness when evaluating and monitoring care practices?
27. Do you have any comments you would like to add?

APPENDIX 4: PARENT INTERVIEW GUIDE

Demographic information

Gender Female Male Other

What is your age?

What is your country of birth?

What language do you mainly speak at home?

What is your marital status? Married De-facto Single

What is your occupation?

What is your relationship to the infant, child or adolescent?

Biological parent Adoptive parent Foster carer

Relative ◯ Other (please specify)

What is the age of your infant, child or adolescent?

How many siblings does your infant, child or adolescent have in your family?

What is the reason for your infant, child or adolescent's admission?

What your current length of stay?

Have you had any previous admissions to this paediatric unit or other paediatric units?

No ◯ Yes ◯ If yes, how many admissions?

INTERVIEW QUESTIONS

1. Have you experienced the paediatric unit when it has been busy?
2. What made the paediatric unit feel like it was busy?
3. Have you experienced the paediatric unit when it is quiet?
4. What made the paediatric unit feel quiet to you?
5. Do you feel you can call for help and support during times of busyness?
6. How have you found the nursing care provided to you and your child or adolescent on this paediatric unit?
7. Was the responsiveness of the nurses different during busy times compared to quiet times?
8. What do you think of the responsiveness of the nurses on this paediatric unit when you are in need of immediate care and support?
9. How has the nursing support been in relation to enabling you to care for yourself and your child or adolescent?
10. When thinking about the healthcare relationships you have with nursing staff, do you think the nurses understand what is important to you and your child or adolescent?
11. Do you feel your health care preferences and choices are respected by nursing staff?
12. How safe do you and your child or adolescent feel when the paediatric unit is busy?
13. What about when it is quiet do you and your child or adolescent feel safe?
14. How do you feel about the amount of time that nurses spend with you and your child/adolescent?
15. Are there differences in the amount of time spent with you by nurses when comparing busy and quiet times?
16. Does your child or adolescent's behaviour change when the unit is busy compared to when it is quiet times?

17. How do you feel when your child or adolescent has periods of distress or being unsettled on the paediatric unit?
18. How do you feel about leaving your child or adolescent alone on the paediatric unit when the unit is busy?
19. How do you feel about leaving your child or adolescent alone on the paediatric unit when the unit is quiet?
20. How are you and your family involved in decision-making in relation to your care?
21. Does your family involvement in decision-making with the health team change during times of busyness?
22. Does your family involvement in decision-making with the health team change during quiet times?
23. When you made decisions with the healthcare team, are the outcomes any different after those conversations?
24. Do you have any comments you would like to add?

APPENDIX 5: PARTICIPANT INFORMATION SHEET AND CONSENT FORM (PISCF) FOR PAEDIATRIC NURSE OBSERVATIONS

[redacted] **Hospital**
PARTICIPANT INFORMATION SHEET AND CONSENT FORM
Observational Study for Nurses

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

Invitation

You are invited to participate in a research study that will be exploring what busyness is and how this affects nursing care and relationships with the families that you care for within your paediatric inpatient unit.

The study is being conducted by Melinda Simpson-Collins Master of Nursing (Research) student at the University of Technology Sydney. The study will be overseen by University of Technology Sydney research supervisors:

Primary Supervisor
Professor Margaret Fry
Director Research and Practice Development Northern Sydney Local Health District
[redacted]

Co- Supervisor
Dr Suzanne Sheppard-Law (formerly Polis)
Senior Research Fellow
University of Technology Sydney
[redacted]

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. ‘What is the purpose of this study?’

The purpose of this study is to explore how nurses perceive busyness within their daily nursing activities and interactions when working with families of children admitted to a paediatric inpatient unit.

2. ‘Why have I been invited to participate in this study?’

You are eligible to participate in this study because you are a nurse that is permanently employed to work or a contracted casual nurse that only works in the paediatric inpatient unit at [redacted]. In addition, you have two years’ postgraduate experience with a minimum of twelve months’ paediatric practice.

3. What if I don’t want to take part in this study, or if I want to withdraw later?’

Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your employment within the organisation now or in the future. Whatever your decision, it will not affect your relationship with other staff or families.

4. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

If you elect to withdraw your consent prior to analysing and theming of observations, your observation can be removed and destroyed. Following analysis and theming we will not be able to remove your observational data because the data will be de-identified.

5. ‘What does this study involve?’

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. This study will be conducted over a 12-month period. Your involvement in the study will involve you being shadowed by the researcher at a discrete distance (1-3 metres) to enable the noting of all activities. To reduce the incidence of observer fatigue, which is defined by as the loss of concentration through fatigue if the session lasts too long. The researcher observing will balance the quantity of data collected in each session against the quality of data. In addition, observer fatigue will be managed by limiting each observation session for participants to four-eight hours with a 15-30minute break every 120 minutes between each session. Willing participants may be observed more than once over the fieldwork period.

6. ‘How is this study being paid for?’

The study is not receiving funding or sponsorship from any entity.

7. ‘What are the alternatives to participating in this study?’

If you decide not to participate it will not affect your employment within the organisation now or in the future.

8. ‘Are there risks to me in taking part in this study?’

This study is minimal risk, if you become distressed during the observation, then the observation will immediately cease. The Employee Assistance Program (EAP) will be offered to you and their role would be to help you manage your distress. In addition, your Nurse Unit Manager can be notified with your consent to help support you. If you feel distressed after the observation, EAP can provide support for you.

9. ‘What happens if I suffer injury or complications as a result of the study?’

If you suffer any injuries or complications as a result of this study, you should contact the researcher as soon as possible, who will assist you in arranging appropriate medical treatment.

10. ‘Will I benefit from the study?’

It may not directly benefit you. This study will generate new knowledge in relation to ‘busyness’ and how this impacts the therapeutic relationship between nurses and families of children admitted to paediatric inpatient units. There is limited research available that specifically looks at the impact of ‘busyness’ from the nurse’s perspective, the child, adolescent and parent/carer perspective. A better understanding of these phenomena could lead to innovative strategies and resources being implemented to enable: effective therapeutic relationships, better holistic care, a greater culture of compassionate care while reducing stress, moral distress, and compassion fatigue.

11. ‘Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything and there is no payment for participation

12. ‘How will my confidentiality be protected?’

No identifiable information will be collected about you in connection with this study. All study data will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researchers named above and the Human Research Ethics Committee (HREC) for monitoring purposes, will have access to your details and

results that will be held securely within [redacted] Local Health District. All research data will be stored in Mrs Melinda Simpson-Collins office at [redacted] Hospital, [redacted] Local Health District. The research data includes: all paper data (consent forms, field and interview notes) and electronic data. The paper data will be stored in a locked filing cabinet and all electronic data will be stored on a password protected computer. The data will only be accessible by the research team. All research data will be retained for a minimum of five years post study completion or last publication.

13. 'What happens with the results?'

If you give us your permission by signing the consent document, we plan to discuss/publish the results in the researcher's Master of Nursing (Research) thesis for the University of Technology Sydney and national/international journals. In addition, the results will be presented at conferences or other professional forums. In any publication, information will be provided in such a way that you cannot be identified. Your name will not be published.

14. 'What should I do if I want to discuss this study further before I decide?'

When you have read this information, the researcher Melinda Simpson-Collins will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her at [redacted] The researcher's primary supervisor can also be contacted on [redacted]

15. 'Who should I contact if I have concerns about the conduct of this study?'

This study has been approved by the Northern Sydney Local Health District HREC. Any person with concerns or complaints about the conduct of this study should contact the Research Office who is nominated to receive complaints from research participants. You should contact them on 02 9926 4590 or email: nslhd-research@health.nsw.gov.au and quote HREC reference number: LNR/17/HAWKE/443

Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.

[redacted] **Hospital**

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Observational Study

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

I,.....of.....

agree to participate as a subject in the study described in the Participant Information Sheet set out above (or: attached to this form).

I acknowledge that I have read the Participant Information Sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

I understand that I can withdraw from the study at any time without prejudice to my relationship to the investigators or my employer Royal North Shore Hospital

I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact Melinda Simpson-Collins at [redacted] or Margaret Fry at [redacted] who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Participant Information Sheet. Complaints may be directed to the Research Office on [redacted] Hospital, [redacted] Phone [redacted] | email [redacted]

Signature of participant	Please PRINT name	Date
Signature of witness	Please PRINT name	Date
Signature of investigator	Please PRINT name	Date

[redacted] **Hospital**

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Observational Study

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

REVOCATION OF CONSENT

I hereby wish to WITHDRAW my consent to participate in the study described above and understand that such withdrawal WILL NOT jeopardise my relationship with my employer [redacted] Hospital

Signature Date

Please PRINT Name

The section for Revocation of Consent should be forwarded to:

Melinda Simpson-Collins

Research Student University of Technology Sydney

[redacted]

[redacted]

[redacted]

[redacted]

Phone: [redacted]

Email: [redacted]

APPENDIX 6: PARTICIPANT INFORMATION SHEET AND CONSENT FORM (PISCF) FOR PAEDIATRIC NURSE FACE TO FACE INTERVIEWS

[redacted] **Hospital**

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Face to Face Nursing Interviews

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

Invitation

You are invited to participate in a research study that will be exploring what busyness is and how this affects nursing care and relationships with the families that you care for within your paediatric inpatient unit.

The study is being conducted by Melinda Simpson-Collins Master of Nursing (Research) student at the University of Technology Sydney. The study will be overseen by University of Technology Sydney research supervisors:

Primary Supervisor

Professor Margaret Fry

Director Research and Practice Development Northern Sydney Local Health District

[redacted]

Co- Supervisor

Dr Suzanne Sheppard-Law (formerly Polis)

Senior Research Fellow

University of Technology Sydney

[redacted]

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. ‘What is the purpose of this study?’

The purpose of this study is to explore how nurses perceive busyness within their daily nursing activities and interactions when working with families of children admitted to a paediatric inpatient unit.

2. ‘Why have I been invited to participate in this study?’

You are eligible to participate in this study because you are a nurse that is permanently employed to work or a contracted casual nurse that only works in the paediatric inpatient unit at [redacted] Hospital ([redacted]). In addition, you have two years’ postgraduate experience with a minimum of twelve months’ paediatric practice.

3. ‘What if I don’t want to take part in this study, or if I want to withdraw later?’

Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your employment within the organisation now or in the future. Whatever your decision, it will not affect your relationship with other staff or families.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

If you elect to withdraw your consent prior to analysing and theming of interviews, your interview can be removed and destroyed. Following analysis and theming we will not be able to remove your interview data because the data will be de-identified.

4. ‘What does this study involve?’

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. Face to face nursing interviews will be conducted over a 6 month period near the paediatric ward area in a private room away from the clinical area. Interview duration will be thirty to forty minutes and conducted at a time convenient for you and your roster. Only one interview per participant is required. Questions will be open ended and you will be supported to describe your experiences freely. The interview questions will be about your perceptions of busyness when working on the paediatric unit and how this makes you feel in relation to: your wellbeing, building therapeutic relationships with families, time spent with families, safe nursing care, family involvement in the care of their child or adolescent, and supporting families with increased stress. The interview will be audio recorded for transcription. Interviews will be transcribed word by word by the researcher.

All personal details such as names will be removed and replaced with pseudonym names.

5. ‘How is this study being paid for?’

The study is not receiving funding or sponsorship from any entity.

6. ‘What are the alternatives to participating in this study?’

If you decide not to participate it will not affect your employment within the organisation now or in the future.

7. ‘Are there risks to me in taking part in this study?’

This study is minimal risk, if you become distressed during the face to face interview, then the interview will immediately cease. The Employee Assistance Program (EAP) will be offered to you and their role would be to help you manage your distress. In addition, your Nurse Unit Manager can be notified with your consent to help support you. If you feel distressed after the interview, EAP can provide support for you.

8. ‘What happens if I suffer injury or complications as a result of the study?’

If you suffer any injuries or complications as a result of this study, you should contact the researcher as soon as possible, who will assist you in arranging appropriate medical treatment.

9. ‘Will I benefit from the study?’

This study will generate new knowledge in relation to ‘busyness’ and how this impacts the therapeutic relationship between nurses and families in a paediatric inpatient unit. It may not directly benefit you. There is limited research available that specifically looks at the impact of ‘busyness’ from the nurse’s perspective, the child, adolescent and parent/carer perspective. A better understanding of these phenomena could lead to innovative strategies and resources being implemented to enable: effective therapeutic relationships, better holistic care, a greater culture of compassionate care while reducing stress, moral distress, and compassion fatigue.

10. ‘Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything and there is no payment for participation.

11. ‘How will my confidentiality be protected?’

No identifiable information will be collected about you in connection with this study. All study data will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researchers named above and the Human Research Ethics Committee (HREC) for monitoring purposes, will have access to your details and results that will be held securely within [redacted] Local Health District.

All research data will be stored in Mrs Melinda Simpson-Collins office at [redacted] Hospital, [redacted] Local Health District. The research data includes: all paper data (consent forms, field and interview notes) and electronic data. The paper data will be stored in a locked filing cabinet and all electronic data will be stored on a password protected computer. The data will only be accessible by the research team. All research data will be retained for a minimum of five years post study completion or last publication.

12. 'What happens with the results?'

If you give us your permission by signing the consent document, we plan to discuss/publish the results in the researcher's Master of Nursing (Research) thesis for the University of Technology Sydney and national/international journals. In addition, the results will be presented at conferences or other professional forums. In any publication, information will be provided in such a way that you cannot be identified. Your name will not be published.

13. 'What should I do if I want to discuss this study further before I decide?'

When you have read this information, the researcher Melinda Simpson-Collins will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her at [redacted] The researcher's primary supervisor can also be contacted on [redacted]

14. 'Who should I contact if I have concerns about the conduct of this study?'

This study has been approved by the [redacted] Local Health District HREC. Any person with concerns or complaints about the conduct of this study should contact the Research Office who is nominated to receive complaints from research participants. You should contact them on [redacted] or email: [redacted] and quote HREC reference number: LNR/17/HAWKE/443

Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.

[redacted] Hospital

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Face to Face Nursing Interviews

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

I,.....of.....

agree to participate as a subject in the study described in the Participant Information Sheet set out above

I acknowledge that I have read the Participant Information Sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

I understand that I can withdraw from the study at any time without prejudice to my relationship to the investigators or my employer [redacted] Hospital

I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact Melinda Simpson-Collins at [redacted] or Margaret Fry at [redacted] who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Participant Information Sheet. Complaints may be directed to the Research Office on [redacted] [redacted] Hospital, [redacted] Phone [redacted] | email [redacted]

Signature of participant	Please PRINT name	Date
Signature of witness	Please PRINT name	Date
Signature of investigator	Please PRINT name	Date

[redacted] **Hospital**

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Face to Face Nursing Interviews

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

REVOCATION OF CONSENT

I hereby wish to WITHDRAW my consent to participate in the study described above and understand that such withdrawal WILL NOT jeopardise my relationship with my employer [redacted] Hospital

Signature Date

Please PRINT Name

The section for Revocation of Consent should be forwarded to:

Melinda Simpson-Collins
Research Student University of Technology Sydney
[redacted]
[redacted]
[redacted]
[redacted]
Phone: [redacted]
Email: [redacted]

APPENDIX 7: PARTICIPANT INFORMATION SHEET AND CONSENT FORM (PISCF) FOR FAMILY FACE TO FACE INTERVIEWS

[redacted] **Hospital**

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Face to Face Family Interviews

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

Invitation

You are invited to participate in a research study that will be exploring what busyness is and how this affects the relationship between nurses and families within the paediatric inpatient unit.

The study is being conducted by Melinda Simpson-Collins Master of Nursing (Research) student at the University of Technology Sydney. The study will be overseen by University of Technology Sydney research supervisors:

Primary Supervisor

Professor Margaret Fry

Director Research and Practice Development Northern Sydney Local Health District

[redacted]

Co- Supervisor

Dr Suzanne Sheppard-Law (formerly Polis)

Senior Research Fellow

University of Technology Sydney

[redacted]

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. ‘What is the purpose of this study?’

The purpose of this study is to explore how parents or carers perceive busyness within the paediatric inpatient unit and how this effects their relationship with the nurses that care for them.

2. ‘Why have I been invited to participate in this study?’

You are eligible to participate in this study because you are a parent or carer of a infant, child or adolescent admitted to the paediatric unit for at least twelve hours.

3. ‘What if I don’t want to take part in this study, or if I want to withdraw later?’

Participation in this project is voluntary and if you decide not to take part or decide to withdraw at any time, this will not affect your relationship or your child’s relationship with the investigators or the care received at [redacted] Hospital.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. If you elect to withdraw your consent prior to the analysis and theming of your interview, your interview can be removed and destroyed. Following analysis and theming we will not be able to remove your interview data because the data will be de-identified.

4. ‘What does this study involve?’

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. Face to face family interviews will be conducted over a period of six months. Interview duration will be thirty to forty minutes. Only one interview per participant is required. The interviews will be held at the bedside with your infant, child or adolescent or in a private room away from the clinical area at a time convenient for your family between 9am to 4:30pm on weekdays. The interview questions will be about your perceptions of busyness within the paediatric unit environment and how this makes you feel about: building therapeutic relationships with healthcare professionals, time spent with nurses, receiving safe and quality care, family involvement in the care of your child or adolescent and support received during times of stress. Family interviews will be undertaken when the infant, child or adolescent is considered medically stable and after twelve hours into their admission. The interview time will work in collaboration with the healthcare teams to ensure that there are no interruptions to maintain privacy. Questions will be open ended and you will be supported to describe your experiences freely. The interview will be audio recorded for transcription. Interviews will be transcribed word by

word by the researcher. All personal details such as names will be removed and replaced with pseudonym names.

5. ‘How is this study being paid for?’

The study is not receiving funding or sponsorship from any entity.

6. ‘Are there risks to me in taking part in this study?’

This study is minimal risk, if you become distressed during the face to face interview, then the interview will immediately cease. You will have access to the paediatric social worker that provides support to families that are admitted to the paediatric unit. The paediatric social worker is aware of this study and has agreed to be contacted if required to help you manage your distress if you consent to speaking with them. In addition, the Nurse Unit Manager and the clinical nurse caring for your family can be notified with your consent to help support you. If you feel distressed after the interview, the Nurse Unit Manager or clinical nurse caring for your family can support you and contact the paediatric social worker if the researcher is not present on site.

7. ‘What happens if I suffer injury or complications as a result of the study?’

If you suffer any injuries or complications as a result of this study, you should contact the researcher as soon as possible, who will assist you in arranging appropriate medical treatment.

8. ‘Will I benefit from the study?’

There are no known benefits for you in participating in the study and it may not directly benefit you. Study findings will generate new knowledge in relation to ‘busyness’ and how this impacts the therapeutic relationship between nurses and families in paediatric inpatient units. There is limited research available that specifically looks at the impact of ‘busyness’ from the nurse’s perspective, the child, adolescent and parent/carer perspective. A better understanding of these phenomena could lead to innovative strategies and resources being implemented to enable: effective therapeutic relationships, better holistic care, a greater culture of compassionate care while reducing stress, moral distress, and compassion fatigue.

9. ‘Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything and there is no payment for participation.

10. ‘How will my confidentiality be protected?’

No identifiable information will be collected about you in connection with this study. All study data will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researchers named above and the Human Research Ethics Committee (HREC) for monitoring purposes, will have access to your details and results that will be held securely within [redacted] Local Health District. All research data will be stored in Mrs Melinda Simpson-Collins office at [redacted] Hospital, [redacted] Local Health District. The research data includes: all paper data (consent forms, field and interview notes) and electronic data. The paper data will be stored in a locked filing cabinet and all electronic data will be stored on a password protected computer. The data will only be accessible by the research team. All research data will be retained for a minimum of five years post study completion or last publication.

11. ‘What happens with the results?’

If you give us your permission by signing the consent document, we plan to discuss/publish the results in the researcher’s Master of Nursing (Research) thesis for the University of Technology Sydney and national/international journals. In addition, the results will be presented at conferences or other professional forums. In any publication, information will be provided in such a way that you cannot be identified. Personal information will not be identifiable.

12. ‘What should I do if I want to discuss this study further before I decide?’

When you have read this information, the researcher Melinda Simpson-Collins will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her at [redacted] The researcher’s primary supervisor can also be contacted on [redacted]

13. ‘Who should I contact if I have concerns about the conduct of this study?’

This study has been approved by the [redacted] Local Health District HREC. Any person with concerns or complaints about the conduct of this study should contact the Research Office who is nominated to receive complaints from research participants. You should contact them on [redacted] or email: [redacted] and quote HREC reference number: LNR/17/HAWKE/443. **Thank you for taking the time to consider this study. If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.**

[redacted] Hospital

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Face to Face Family Interviews

STUDY TITLE: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

I,.....of.....

agree to participate as a subject in the study described in the Participant Information Sheet set out above

I acknowledge that I have read the Participant Information Sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

I understand that I can withdraw from the study at any time without prejudice to my relationship to the investigators or the care I receive at [redacted] Hospital. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I understand that if I have any questions relating to my participation in this research, I may contact Melinda Simpson-Collins at [redacted] or Margaret Fry at [redacted] who will be happy to answer them.

I acknowledge receipt of a copy of this Consent Form and the Participant Information Sheet. Complaints may be directed to the Research Office on [redacted], [redacted] Hospital, [redacted] Phone [redacted] | email [redacted]

Signature of participant	Please PRINT name	Date
Signature of witness	Please PRINT name	Date
Signature of investigator	Please PRINT name	Date

[redacted] **Hospital**

Face to Face Family Interviews

STUDY TITLE

Study Title: Nurses and families' perspectives on 'busyness' in a paediatric inpatient unit: an ethnography

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise the care I receive at [redacted] Hospital

Signature Date

Please PRINT Name

The section for Revocation of Consent should be forwarded to:

Melinda Simpson-Collins
Research Student University of Technology Sydney
[redacted]
[redacted]
[redacted]
[redacted]
Phone[redacted]
Email: [redacted]

APPENDIX 5: ETHICAL AND SCIENTIFIC APPROVAL

Research Office
Kolling Building, Level 13
Royal North Shore Hospital
St Leonards NSW 2065
Tel (02) 9926 4590 Fax (02) 9926 6179

Health
Northern Sydney
Local Health District

6 July 2018

Mrs Melinda Simpson-Collins
Paediatrics Unit, Level 6
Mona Vale Hospital
Mona Vale NSW 2103

Dear Melinda

NSLHD reference: RESP/17/321
Title: Nurses and Families perspectives on 'busyness' in a paediatric inpatient unit: an ethnography
HREC reference: LNR/17/HAWKE/443
SSA reference: LNRSSA/17/HAWKE/444

Thank you for submitting an application for authorisation of this project. I am pleased to advise that the delegate of the Chief Executive for Northern Sydney Local Health District on 06 July 2018 has granted authorisation for the above project to commence at **Royal North Shore Hospital**.

The version of the SSA reviewed by NSLHD RGO was: **AU/7/830235**

Ethical approval for this study was granted by the **Northern Sydney Local Health District HREC** at a meeting of the Executive Committee **held** on **14 February 2018.**

The documents authorised for use at this site are:

Document	Version	Date
Protocol	2.0	04 February 2018
RNSH Participant Information Sheet and Consent Form – Observational Study for Nurses	2.0	04 February 2018
RNSH Participant Information Sheet and Consent Form – Face to Face Nursing Interviews	2.0	04 February 2018
RNSH Participant Information Sheet and Consent Form – face to Face Family Interviews	2.0	04 February 2018
Interview Guide – Paediatric Nursing Interviews	2.0	04 February 2018
Interview Guide – Family Interviews	2.0	04 February 2018
Poster – Nurses	2.0	04 February 2018
Poster – Family	2.0	04 February 2018

The NSLHD RGO Notes:

- The NSLHD logo must be applied to all Participant- related documentation prior to use

Site authorisation will cease on the date of HREC expiry **14 February 2023**

You are reminded that, in order to comply with the Guidelines for Good Clinical Research Practice (GCRP) in Australia, and in accordance with additional requirements of NSLHD, the Chief Investigator is responsible for ensuring the following:

1. The HREC is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.
2. The HREC is notified of all Serious Adverse Events (SAEs) or Serious Unexpected Suspected Adverse Reactions (SUSARs) in accordance with the Serious Adverse Event Reporting Guidelines.

3. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and are submitted to the lead HREC for review, are copied to the Research Governance Officer.
4. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the Research Governance Officer.
5. The Institutional annual report for all Human Research is due to the NSLHD Research Office on the 30 August. In addition, annual report acknowledgment from the Lead HREC should be submitted to the Research Governance Officer.

Standard forms and additional guidance documents are available on the Research Office Website:
http://www.nslhd.health.nsw.gov.au/AboutUs/Research/Office

Yours sincerely

Production Note:
Signature removed
prior to publication.

Jodi Humphries
Research Manager
Research Office
Northern Sydney Local Health District

cc. Margaret Fry

RESD/18/3035