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# The influence of busyness on family centred Care: an ethnographY

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# THE INFLUENCE OF BUSYNESS ON FAMILY CENTRED CARE: AN ETHNOGRAPHY

**Short title** The burden of busyness on family centred Care


## Abstract

**Purpose:** Busyness as a construct within modern healthcare is complex and multidimensional. To date, no published studies have sought to explore the notion of busyness and its influence on a family centred model of care. This ethnographic study explored the influence of busyness on delivering family centred care and collaborative relationships.

**Design and Method:** An ethnography was the research design and the site was a metropolitan tertiary hospital inpatient pediatric unit in Sydney, Australia. Semi-structured interview and observation techniques were used for data collection. Ten pediatric nurses and ten parents were interviewed and 40 hours of non-participant observations undertaken. The Consolidated criteria for reporting qualitative studies was used to report the study.

**Results:** Three key themes were interpreted from the analysis: i) family centred care; ii) being present at the bedside; and, iii) the emotional cost of busyness.

**Conclusions:** The ethnography has given shape to social understandings of busyness and the complexities of pediatric nursing and family centred care. The culture of care changed in moments of busyness and transformed parent and nursing roles, expectations and collaborative care and generated internal emotional conflict.

**Practice implications**: Given the increasing work demands across health systems, new agile ways of working need to ensure maintenance of a family centred approach. Strategies need to be developed during periods of busyness to better support collaborative connections and the wellbeing of pediatric nurses and parents. At an organisational level, fostering a positive workplace culture that shares a vision for family centred care and collaboration are essential.

# THE INFLUENCE OF BUSYNESS ON FAMILY CENTRED CARE: AN ETHNOGRAPHY

Short title: The burden of busyness on family centred Care

## INTRODUCTION

The cultural landscape within hospital environments is influenced by time constraints and increased workload. Hence, busyness as a construct within modern healthcare 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. Exploration of the concept of nursing time was first undertaken by Jones (2010) in the USA conceptualised a framework, which incorporated dimensions of physical, psychological and sociological. 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 temporal space through nursing hours and nurse-patient ratios. Psychological nursing time is internalised and relates to how the participant (nurse) experiences nursing. This encompasses the shared intersubjective experiences that form a sense of time and drive patterns of behaviour. The sociological form of nursing time is experienced through the sequential ordering of events within the daily routines of practice. Hence, the concept of nursing time contributed to the construct of busyness within the nursing profession and nursing practice.

Perceptions of nursing time is by feelings of not having enough time. Indeed, a lack of time can have a detrimental effect on the individual themselves and nursing care

practices. However, the affect that busyness has on the delivery of family centred care is largely unknown.

## BACKGROUND

Family centred care fosters a partnership approach often involving the whole family in the healthcare decision-making about a child or young person's care (Shields, 2015) and places the family centrally, which promotes less distress and trauma for infants, children, young people and their family. The health 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 and pediatric consumers to lead the care (Irlam & Bruce, 2002).

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 a child's 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).

This ethnography explores the construct of busyness within the context of pediatric acute care and how this influences pediatric nursing practice, the delivery of family centred care and the care environment.

## THE STUDY

### AIMS

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

### RESEARCH QUESTION

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

### RESEARCH OBJECTIVES

The objectives of this 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

For the purpose of this study, busyness is defined as '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).

## METHODOLOGY AND METHODS

### DESIGN

Ethnography was the research methodology and method used for this study. Details of methods have previously been reported (Simpson-Collins et al., 2023). This study is reported in line with EQUATOR guidelines (Consolidated criteria for reporting qualitative studies – COREQ),

The theoretical framework adopted for this study was ethnography. 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.

## STUDY SETTINGS AND SAMPLING AND RECRUITMENT

The study site was an acute metropolitan tertiary hospital pediatric inpatient unit located in Sydney, Australia. The general pediatric inpatient unit (beds n=31) is divided into two clinical areas: pediatric unit which has 24 beds and the Child and Young People Short Stay Unit (NSW Ministry of Health, 2018).

## SAMPLE

Purposive sampling was used to recruit; parents/carers and experienced pediatric nurses, knowledgeable and skilled in the care of pediatric patients, and engaged in the rituals of daily unit-based activities and parents present on the unit. A sample size of six to ten nurses was considered sufficient to achieve data saturation (Hammersley & Atkinson, 2019; Van Maanen, 2011) and, to make visible the cultural context of the setting (Musante (DeWalt) & DeWalt, 2010). Parents were considered key members of this social scene who engaged with clinicians for prolonged periods of time and had a unique perspective of this cultural setting. A sample size of six to ten parents were selected to make visible the cultural context of this healthcare setting. A sample size of six to ten was considered appropriate to enable data saturation to be reached. Recruitment was supported and facilitated by the senior managers and clinicians. Participants were aware of the purpose of the study, the researchers interests and nature of data collection.

## DATA COLLECTION

Non participant observation and semi structured interview techniques were selected for data collection (De Chesnay, 2015; Fetterman, 2010; Hammersley & Atkinson, 2019) to maximise insights into the world of pediatric nursing. The lead researcher (blind review), a paediatric nurse, conducted interviews and observations in collaboration with expert qualitative researchers (blind review). Ethnographic studies demonstrate that the length of time in the field varies significantly (Whittemore et al., 2001) and so non-participant observation (20-40 hours) of nurses over a six-month period (2019),was selected as this would enable sufficient exposure to the range of phenomena.

A sample size of six to ten participants was considered sufficient to achieve data saturation (Hammersley & Atkinson, 2019; Van Maanen, 2011). In 2019, observation periods were undertaken during morning and afternoon shifts over weekdays and weekends to maximise exposure to patterns and events. Night shift was excluded during observations to ensure exposure to repeated and recurrent activities during observation (Spradley, 1980).

Semi structured interviews, audio recorded, were conducted with nurses and parents of inpatient infants, children and young people to provide opportunity to better understand this social setting (Morris, 2015; Ranney et al., 2015). Interviews with pediatric nurses and parents were conducted after a period of observation (25 hours) to support relationship building and immersion within the field. Observation field notes informed the interview schedule for both the nurses (27 items) and parents (24 items). The interview duration ranged between 30 to 40 minutes with nurses interviewed, during business hours, in a private room near the clinical area.

Parent interviews were conducted at the bedside or in a private room on the Unit. Parent interviews were determined appropriate, by clinicians, if the child was clinically stable. For bedside interviews 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.

**DATA ANALYSIS**

An iterative-inductive process was undertaken to support data analysis (blind review), although transcripts were not returned to participants. The process involved moving forwards and backwards from the research question to the data, which enabled a process of data saturation, deep immersion and confirming and disconfirming questioning. Each

fieldnote and interview was reviewed multiple times once imported into the software program NVIVOv12™. All researchers were involved in data analysis, coding and interpretation.

To support analysis Brewer's (2000) ethnographic framework was used and guided by a doctoral trained expert ethnographer (blind review). 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. Through this systematic analytical process veracity, objectivity and perspicacity was strengthened (O'Reilly, 2012). Data coding

**ETHNOGRAPHY AS TEXT**

Realist tales were the narrative style selected to provide rich detail of this social scene (Brewer, 2000; Van Maanen, 2011). Realist tales enable the participant's voice to remain at the centre of narrative thereby connecting the reader with the scene. Verbatim quotes are provided with all participants identified; for example, Interview Nurse 5. In this way the veracity of interpretation can be judged. The many voices in this ethnography strengthen the understanding of this social scene.

## ETHICAL CONSIDERATIONS

Ethical approval was granted by the Local Health District Human Research Executive Committee (HREC) a reference number provided and ratified by an academic institution. Participants written consent was attained to be observed and/or to complete an in-depth interview.

## RIGOR AND REFLEXIVITY

The lead investigator was a Paediatric Clinical Nurse Consultant (CNC) who understood the language, nuances, and context of paediatric care. The lead researcher to strengthen the rigor of the study undertook pilot interviews (paediatric nurses and parents) and observations to minimise bias and become exposed to the cultural knowledge, processes, and expectations of everyday paediatric nursing. To strengthen rigor, the researchers (Blind review) established relationships with key gatekeepers who would assist to navigate this clinical setting. Deep immersion into the scene over a prolonged period of time supported the building of trust and rapport with the nurses and parents. Hence, data saturation was reached, and rich observation of natural behaviours and interactions achieved within a paediatric setting. When undertaking field notes, there was a section for personal memos that detailed reflective impressions, perceptions, patterns, concepts, analytic ideas and enabled the researcher towards a deeper understanding of the data. 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.

## FINDINGS

In total, 12 nurses and 10 parents agreed to participate in the study. The nurses' interviewed (Table 1) and observed (Table 2) were experienced in pediatric nursing with an average of 10 and eight years respectively. Of the 10 parents that participated in the study 80% (n=8) were female with a median age of 43 years (IQR 27) (Table 3). Three key themes were interpreted from the analysis: i) family centred care; ii) being present at the bedside; and, iii) the emotional cost of busyness.

### *FAMILY CENTRED CARE*

For participating nurses, the culture of care was driven by a family centered care approach; meaning the care of and for the child and family was central. However, in the context of busyness, the desire to engage therapeutically with parents and the child was challenged. Instead, nurses were influenced by perceptions of busyness and reported that 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 moral distress. 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).*

Routinely for nurses, care practices were family centred and so in moments of busyness a sense of a lack of time emerged, which raised tensions for many nurse participants. However, during episodes of busyness nurses sought to find time to engage and support family members through different ways of working. For example, a few nurses spoke of

not taking breaks throughout their shift to support family centred care. Within this culture of care pediatric 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).*

Nurses spoke of choosing to work through their breaks or leave late to enable completion of care activities. Balancing care activities and being able to finish on time was important for many nurses. However, for many nurses, busyness created a sense of exhaustion.

*'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).*

The balance of work and personal life remained important in this culture of care, but completing care needs were given the priority. A family centred approach drove behaviour and actions to ensure care activities were complete over self-wellbeing. Despite busyness nurses were adept in seeking ways to engage with families and complete the care activities within a family centred approach.

***BEING PRESENT AT THE BEDSIDE***

Perceptions of busyness altered parents' decision-making to leave the beside of their child. Routinely the majority of parents reported how they would consult nursing staff on decisions that involved their child or young person and being at the bed side. This was difficult during times of busyness changing their options and choices. For some parents leaving their child unattended at the bedside was a considered decision. Parents would weigh the unit's busyness with the needs of the child, the timing of their presence at the bedside to support care activities and need to attend their own care. For parents' even

short episodes away from their child created a sense of tension and brought to the surface expectations of what it was to be a parent. For example,

*'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).*

During interviews, parents spoke of how busyness influenced their decision to stay or leave the unit. For some parents, there was significant concern that their absence would add to nurses 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).*

Given the perceived busyness of nurses, some parents were observed to ask the pediatric nurse whether it was alright for them leave;

*'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).*

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).*

As a result, busyness shifted expectations, altered behaviour and at times led to parental resistance to ask a nurse for help and/or support. 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 expectations of care of the child 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;

*'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. Pediatric 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).*

In moments of busyness the care and safety of their child became challenging for parents in this study. Busyness altered the care environment, the rules and rhythm of care whereby 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 new rhythm of care that busyness drove. Indeed, parents and nurses negotiated a relationship within this culture of care that defined and gave new meaning to care activities and behaviours.

***THE EMOTIONAL COST OF BUSYNESS***

The emotional cost of busyness was present and spoken of by many nurses. 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).*

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).*

During periods of busyness nurses' 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. Instead, during times of busyness the focus turned to the delivery of basic care activities, which were reluctantly given prioritisation over being with the family. However, all nurses were aware that this elicited an emotional cost and challenged their sense of what it is to be a pediatric nurse;

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

Busyness shifted nursing activities towards delivery of basic care instead of being present for the family. During these moments' busyness led to a clash of 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 their expected pediatric nursing care, created a sense of personal conflict for many nurses which was observable to many parents. For some parents, the change in nurses' behaviour during periods of busyness contributed to the breakdown in the parent-nurse relationship;

*'[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 family-nurse relationship was a shared experience. However, busyness impacted on the interactions between the nurse and parent and an emotional clashing of expectations could undermine 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; negative emotions, dissatisfaction and frustration would emerge. The feelings of frustration infused nurse-parent interactions. Yet when parents declined having a nurse undertake activities, an emotional cost for parent and nurse appeared to surface. 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 led to pediatric nurses and parents re-negotiating their relationships. Busyness brought to the surface an emotional cost to nurses and parents that influenced behaviour and jeopardised relationships in this setting. Busyness shifted how care was delivered by pediatric nurses and shaped how this care was received and perceived by families.

## DISCUSSION

### STRENGTHS AND LIMITATIONS OF THE WORK

The strengths of this ethnography include the methodological approach, which enabled the exploration of social interactions, social processes, perceptions and cultural norms embedded within care practices. Ethnography enabled the gathering of rich data from the differing viewpoints and deep immersion into the scene over a prolonged period of time. Data saturation was reached, and rich observation of natural behaviours and interactions achieved within a pediatric setting.

There are a number of limitations, which should be considered for this study. Sampling bias may be present given the small sample size and single site. Male pediatric nurses and fathers were under-represented in this study and therefore, sex-specific differences were not explored. Some voices were silent in this setting, which may have led to a different interpretation.

### RECOMMENDATIONS FOR FURTHER RESEARCH

The ethnography highlighted how the construct of busyness influenced therapeutic relationships between paediatric nurses and parents and challenged communication processes. Further research is recommended to explore a communication framework that

supports and/or improves authentic engagement between paediatric nurses and parents. The framework needs to address the complexities of busyness and enhance the space required to build therapeutic relationships.

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.

## IMPLICATIONS FOR POLICY AND PRACTICE

Implications for policy and practice include 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. Policy needs to facilitate resources to reduce the fluctuations of busyness such as: reliable volunteers that could assist and emotionally support families during hospitalisation. Policy should be developed that provides 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. Policies need to enhance parent orientation to the ward, shared expectations of care and role responsibilities to better support the therapeutic relationship.

The study identified that busyness affected family centred care and how nurses struggled to balance the needs of all ward patients. The inability to being present at the bedside or position the family at the centre of care elicited emotional conflict between a nurse's

workload, the delivery of care and finishing on time. Within the literature, perceptions of busyness shift the centre of care away from patients and families towards a nurse-centred care focus. Hence this reduced a nurse's capacity to establish well-connected relationships with families (Livesley & Long, 2013; Simpson-Collins et al., 2023). Routinely the presence of a parent or carer at the bedside provided opportunity for nurses to build partnerships of care and form therapeutic relationships (Shields & Nixon, 2004). However, busyness reduced within practice any sense of time for active engagement at the bedside. Workload elicited time constraints and gave shape to a sense of busyness thus changing the rhythm of work (busyness). For nurses and parents' busyness defined a temporal perception of time loss and compromised a family centred care approach (Alomari et al., 2018; Vinckx et al., 2018).

Within practice periods of busyness led to nurses recognition of parental support which assisted to reduce the nurse's workload. The finding that parents actively support busy nurses while needing to balance their own expectations and advocacy roles is supported in the literature (Beach, 2001; Blower & Morgan, 2000; Darbyshire, 1994). Parents put their child's or young person's needs before their own (Hallström et al., 2002) adding to the complexity of hospitalisation. Additionally, busyness led to parents experiencing a reluctance to leave the ward preferring to remain close to their child; to be a safety net and indeed that they provided the best security for their child. Similarly, recent studies undertaken in pediatric 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).

Experiences of parental stress during the hospitalisation of a child, is well recognised (Aarthun & Akerjordet, 2014; Hallström et al., 2002). Importantly, parental involvement in care and perceived responsibility of care was found to be one of the biggest stressors

for parents (Power & Franck, 2008). 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. During periods of busyness in the hospital setting strategies to reduce parental burden need to be considered (Rosenberg et al., 2016; Shala et al., 2019). Further research is needed to explore parents needs and wellbeing.

The ethnography identified that busyness affected the emotions of nurses. 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. Busyness can elicit a stress response from nurses (Govasli & Solvoll, 2020). This finding is supported by other authors who identified that busyness (increased nursing workload, experiences of feeling rushed, exhaustion and emotional conflict) led to perceptions of stress (Berger et al., 2015). The emotional impact of not being able to provide expected nursing care, created a sense of personal conflict for many nurses that surfaced within their behaviour, interactions and care delivery. Researchers have identified that the capacity for moral agency when perceptions of busyness emerge can result in distress and ethical insensitivity (Govasli & Solvoll, 2020; Haahr et al., 2019; Storaker et al., 2016). These dimensions can elicit ethical challenges, which may inhibit a nurse's ability to provide person or family centred care (Haahr et al., 2019; Storaker et al., 2016).

## CONCLUSION

Busyness was a temporal construct that influenced pediatric nurse and parent behaviour, the therapeutic relationship and a sense of safety and wellbeing. Fostering a positive workplace culture in the presence of busyness was challenging and compromised a family centred care model. Busyness altered communication patterns within partnerships

and raised perceptions of time constraints. Given increasing work demands across health systems new agile ways of working need to ensure maintenance of a person/family centred approach. Future research needs to explore strategies that support collaborative connections during periods of busyness to optimse the wellbeing of pediatric nurses and parents.

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## TABLE 1: PAEDIATRIC NURSE OBSERVATION CHARACTERISTICS

| Demographics | 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) |

## TABLE 2: PAEDIATRIC NURSE INTERVIEW CHARACTERISTICS

| Demographics | N | (%) | Median (Interquartile range) |
|---|---|---|---|
| **Gender** | | | |
| Female | 9 | (90) | |
| Male | 1 | (10) | |
| **Age (years)** | | | 34 (23) |
| **Years in Nursing** | | | 11 (22) |
| **Years in Paediatric Nursing** | | | 8 (22) |
| **Years in Study Setting** | | | 5 (18) |
| **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) | |

## TABLE 3: PARENT PARTICIPANT CHARACTERISTICS

| Demographics | 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) | |

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist reported

| No | Item | Guide questions/description |
|---|---|---|
| | Domain 1: Research team and reflexivity | |
| | Personal Characteristics | |
| 1. | Interviewer/facilitator | Which author/s conducted the interview or focus group? *reported* |
| 2. | Credentials | What were the researcher's credentials? *reported. PhD,* |
| 3. | Occupation | What was their occupation at the time of the study? *reported* |
| 4. | Gender | Was the researcher male or female? Authors female |
| 5. | Experience and training | What experience or training did the researcher have? *reported* |
| 6. | Relationship established | Was a relationship established prior to study commencement? *reported* |
| 7. | Participant knowledge of the interviewer | What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research* *reported* |
| 8. | Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? *reported* |
| | Domain 2: study design | |
| | Theoretical framework | |
| 9. | Methodological orientation and Theory | What methodological orientation was stated to underpin the study? *ethnography* |
| | Participant selection | |

| | |
|---|---|
| 10. Sampling | How were participants selected? *purposive,* |
| 11. Method of approach | How were participants approached?. *face-to-face,* |
| 12. Sample size | How many participants were in the study? reported |
| 13. Non-participation | How many people refused to participate or dropped out? Reasons? Setting reported |
| 14. Setting of data collection | Where was the data collected? hospital |
| 15. Presence of non-participants *reported* | Was anyone else present besides the participants and researchers? |
| 16. Description of sample | What are the important characteristics of the sample? *reported* |
| Data collection | |
| 17. Interview guide pilot tested? *reported* | Were questions, prompts, guides provided by the authors? Was it |
| 18. Repeat interviews | Were repeat interviews carried out? None |
| 19. Audio/visual recording Audio recording - *reported* | Did the research use audio or visual recording to collect the data? |
| 20. Field notes group? *reported* | Were field notes made during and/or after the interview or focus |
| 21. Duration | What was the duration of the interviews or focus group? *reported* |
| 22. Data saturation | Was data saturation discussed? Yes |
| 23. Transcripts returned correction? No *reported* | Were transcripts returned to participants for comment and/or |
| Domain 3: analysis and findingszData analysis | |
| 24. Number of data coders | How many data coders coded the data? |
| 25. Description of the coding tree | Did authors provide a description of the coding tree? No |
| 26. Derivation of themes Derived from data *reported* | Were themes identified in advance or derived from the data? |
| 27. Software reported | What software, if applicable, was used to manage the data? |
| 28. Participant checking feedback on the findings? Reported no | Did participants provide |
| 29. Quotations presented | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? *participant number reported* |
| 30. Data and findings consistent findings? yes | Was there consistency between the data presented and the |
| 31. Clarity of major themes | Were major themes clearly presented in the findings? Yes |
| 32. Clarity of minor themes themes? No | Is there a description of diverse cases or discussion of minor |