




Parents' and nurses' perceptions and behaviours of family-centred care during periods of busyness

Melinda Simpson-Collins BN, Grad Cert Critical Care Nursing, MN Res, Clinical Nurse Specialist, Paediatric Acute Code Stroke (PACS) Coordinator and Registered Nurse¹ | Margaret Fry NP BSc(nursing), MED, PhD, FCEN, Professor Emergency and Critical Care^{2,3}  | Suzanne Sheppard-Law BN, MPH (research), PhD^{2,4}  | Claire Harris MSHM, BFin. Art, RN, Director Nursing and Midwifery Services^{2,5} 

¹Adolescent Unit, John Hunter Children's Hospital, New Lambton Heights, New South Wales, Australia

²Faculty of Health, School of Nursing & Midwifery, University of Technology Sydney, Ultimo, New South Wales, Australia

³Northern Sydney Local Health District, Royal North Shore Hospital, St Leonards, New South Wales, Australia

⁴Prince of Wales Hospital, South Eastern Sydney Local Health District, Randwick, New South Wales, Australia

⁵Nursing and Midwifery Services, Northern Sydney Local Health District, St Leonards, New South Wales, Australia

Correspondence

Margaret Fry, Nursing University of Technology Sydney, Faculty of Health, School of Nursing & Midwifery, Building 10, level 7 Broadway, NSW, Australia.
Email: margaret.fry@uts.edu.au

Abstract

Purpose: Busyness as a construct within modern healthcare is complex and multi-dimensional. To date, few studies have sought to explore how busyness influences family-centred care. This study explored the influence of busyness on the delivery of family-centred care for nurses and parents.

Design and Method: Ethnography was selected as the research design. The study site was a metropolitan tertiary hospital inpatient paediatric unit in Sydney, Australia. Semi-structured interview and non-participant observation techniques were used for data collection. Ten paediatric nurses and 10 parents were interviewed and 40h of non-participant observations were undertaken. The COREQ was used to report the study.

Results: The findings are presented as three key themes: (i) 'Supporting family-centred care' in which participants detail beliefs about the nurse-parent relationships and how despite busyness nurses sought out moments to engage with parents; (ii) 'Being present at the bedside' identified the challenges in optimising safety and how parents adapted their way of being and interacting on the unit; and (iii) 'The emotional cost of busyness' and how this influenced nurse-parent interactions, care delivery and family-centred care.

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

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

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collaborative connections and the well-being of paediatric nurses and parents. At an organisational level, fostering a positive workplace culture that shares a vision for family-centred care and collaboration is essential.

Patient or Public Contribution: Parents of sick children admitted to an acute paediatric inpatient ward were invited to be a participant in a single interview. Parents were aware of the study through ward advertisement and informal discussions with the researchers or senior clinical staff. Engagement with parents was important as healthcare delivery in paediatrics is focused on the delivery of family-centred care. To minimise the risk of child distress and separation anxiety, children were present during the parent interview. Whist children and young people voices were not silenced during the interview process, for this study the parent's voice remained the focus. While important, due to limited resources, parents were not involved in the design analysis or interpretation of the data or in the preparation of this manuscript.

Data sharing: The data that support the findings of this study are available from the corresponding author upon reasonable request.

KEYWORDS

busyness, ethnography, family centred care, paediatric nursing, parent, pediatric

1 | INTRODUCTION

The cultural landscape within hospital environments is influenced by time constraints and increased workload and can be subjective and/or objective depending on the environment and context. Hence, busyness as a construct within modern healthcare is complex and multidimensional. Exploration of nursing time was first conceptualised by Jones (2010) in the United States, whom defined nursing time into 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 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 interconnects to a construct of busyness within the nursing profession and nursing practice.

Perceptions of busyness within nursing time is a sense of not having enough time. Indeed, a lack of time can have a detrimental effect on the individual themselves and nursing care practices (Jones, 2010). However, the effect that busyness has on the delivery of family-centred care remains largely unknown.

1.1 | Background

The health professional's role within a family-centred care model is to be respectful and responsive to family's needs and values

Key points

- Periods of busyness during a shift challenged and compromised the delivery of family centred care.
- In moments of busyness communication patterns were altered with parents.
- Periods of busyness led to nurses' perception of stress and created a sense of emotional conflict in the delivery of care.
- Family centred care was shaped by busyness and care was perceived by parents differently.

(Davidson et al., 2017). A dimension of family-centred care is to consult and provide communication that encompasses open and honest dialogue with the family enabling the parent/s and paediatric consumers to lead the care (Irlam & Bruce, 2002). 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 (O'Connor et al., 2019; Shields et al., 2012).

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 (Aarhun & Akerjordet, 2014; Shields et al., 2012; Van der Horst & Van der Veer, 2009). Health professionals who practice family-centred care align health and family needs with clinical decision-making while also considering the impact of a child's admission on all family members (Committee on hospital care and institute for patient- and family-centered care, 2012; Foster & Whitehead, 2017; Van der Horst & Van der Veer, 2009).

A family-centred care model perceives parents or carers as trusted, integral partners who are actively involved with the health-care team (Committee on hospital care and institute for patient- and family-centered care, 2012; Cox et al., 2017; Khan et al., 2018). 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; Van der Horst & Van der Veer, 2009). Further, having a parent or carer stay in hospital enhances the partnership in care between paediatric nurses and family (Cox et al., 2017; Khan et al., 2018). The presence of a parent or carer provides the optimal environment to build integral partnerships of care, form well-connected trusting relationships and is the primary source of support for the child, or young person (Committee on hospital care and institute for patient- and family-centered care, 2012; Shields & Nixon, 2004).

Parents and carers through a more integrated partnership with healthcare clinicians can better support shared decision-making, information sharing, negotiation of care and shared responsibilities (Committee on hospital care and institute for patient- and family-centered care, 2012; Coyne & Cowley, 2007). A family-centred care approach seeks to support the family's values and perspectives being heard and have their input form part of clinical decision-making (Davidson et al., 2017; O'Connor et al., 2019). This ethnography explores the construct of busyness within the context of paediatric acute care and how this influences a family-centred care approach for paediatric nurses and nursing practice.

2 | THE STUDY

2.1 | Aims

To explore a construct of busyness and its influence on family-centred care within a paediatric acute care setting.

2.2 | Research question

How does a construct of busyness within a paediatric acute care setting influence family-centred care?

2.3 | Research objectives

The objectives of this study were to identify how:

- (i) Attitudes, beliefs and values are socially constructed and influenced by a notion of busyness for paediatric nurses and parents;
- (ii) 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).

3 | METHODOLOGY AND METHODS

3.1 | Design

Ethnography was the research methodology and method used for this study. As part of a larger study the methods of this study have previously been reported (Simpson-Collins et al., 2023). This study is reported in line with EQUATOR guidelines; Guideline for reporting qualitative studies (File S1) (Tong et al., 2007).

3.2 | Theoretical framework

The theoretical framework adopted for this study was ethnography. Ethnography has evolved over time and is commonly used to explore healthcare 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 observations in the field and interviews. Ethnographic narrative, such as realist tales, provides an opportunity to present the voices of individuals within a social setting.

3.3 | Study settings and recruitment

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

3.4 | Sample and recruitment

Purposive sampling was used to recruit parents and experienced paediatric nurses, knowledgeable and skilled in the care of paediatric 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 and parents was considered sufficient to achieve data saturation (Hammersley & Atkinson, 2019; Van Maanen, 2011) and, to make visible the cultural context of the setting (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. Recruitment was supported and facilitated by the senior managers and clinicians. Participants were aware of the purpose of the study, the researcher's interests and nature of data collection.

3.5 | Data collection

Non-participant observation and semi structured interview techniques were selected for data collection (De Chesnay, 2015;

Fetterman, 2019; Hammersley & Atkinson, 2019) to maximise insights into the world of paediatric 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 h) over a six-month period (2019), was selected as this would enable sufficient exposure to the range of phenomena.

Observation periods were undertaken during 7am–3:30pm and 1:30pm–10pm 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). When undertaking observation, the researcher was never an active member of this scene and remained at a respectful distance (1m) during care activities and interactions from the key informant. The researcher removed themselves from the participant's space every 2h to reduce participant fatigue. 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 were trying to achieve; and feelings or emotions expressed.

Semi-structured interviews, audio recorded, were conducted with nurses and parents of inpatient infants, children and young people to provide opportunities to better understand this social setting (Morris, 2015; Ranney et al., 2015). Interviews with paediatric nurses and parents were conducted after a period of observation (25 h) 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 and 40 min 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.

3.6 | 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

NVIVO12™. All researchers were involved in data analysis, coding and interpretation.

To support analysis Brewer's (2005) 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 disconfirmatory data were explored. It was important to examine all data including disconfirmatory 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 disconfirmatory 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).

3.7 | Ethnography as text

Realist tales were the narrative style selected to provide rich detail of this social scene (Brewer, 2005; 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.

3.8 | 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 obtained to be observed and/or to complete an in-depth interview.

3.9 | Rigour 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 rigour 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 rigour, 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.

4 | FINDINGS

In total, 10 nurses participated in either an interview and/or were observed during the study. Of the 10 nurses' interviewed (Table 1) seven also agreed to be observed (Table 2).

The 10 nurses were experienced in paediatric care with an average of 10 and 8 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) supporting family-centred care; (ii) being present at the bedside; and (iii) the emotional cost of busyness.

4.1 | Supporting 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 to their practice. However, in the context of the environment when busyness was perceived, the desire to engage with parents and the child was challenged and shifted the nature of interactions, communication and trust.

Because there's just not the time to explain it and show them.

(Interview Nurse 1)

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 was perceived as time pressures, which heightened tension 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 perceived by nurses to be family-centred and so in moments of busyness a sense of time pressure emerged. Time pressure was perceived to increase workload and change communication and interaction behaviours. For many nurse participant's time pressures increased a sense of stress. However, during episodes of busyness nurses sought to find moments to engage, communicate and support family members through different ways of working. For example, a few nurses spoke of not taking breaks throughout their shift to support

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) | |

family-centred care. Within this culture of care paediatric nurses were willing to care for others at the expense of their health and well being.

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, when the environment was perceived as busy nurses' reported increased care giving demands that impacted personal wellbeing.

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

4.2 | Being present at the bedside

Perceptions of busyness altered parents' decision-making to leave the bedside 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 bedside. 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 5 min, it's really quick, 1-2 min 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 the 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 and also raised in interview that it was important to ask the paediatric nurse whether it was alright for them to 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. 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)

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. Indeed, parents and nurses negotiated a relationship within this culture of care that defined and gave new meaning to care activities and behaviours.

4.3 | The emotional cost of busyness

The emotional cost of busyness was present and spoken of by many nurses and parents. 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 paediatric nurse;

That's what annoys me, is that you only have time to do the basics.

(Interview Nurse 6)

Busyness reduced the nurse's capacity to be 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 paediatric 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 surfaced during 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 6h... it is difficult because if they say can you come back in 30min he has just gone to sleep now, then you have to stick to that 30min whether you've got time or not.

(Field note Observation 5, Nurse 2)

Busyness led to paediatric 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 paediatric nurses and shaped how this care was received and perceived by families.

5 | DISCUSSION

5.1 | 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 paediatric 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 paediatric nurses and fathers were under-represented in this study and therefore, sex-specific differences were not explored. While we acknowledge the importance of children and young people's voice, this ethnography explored the dynamic interaction between parents and nurses in the context of busyness. Children and Young people's voices were not explored, which may have led to a different interpretation. Lastly, due to resources, parents and nurses did not co-design this research, which may have resulted in different findings.

5.2 | Recommendations for further research

This study has highlighted how busyness influenced interactions and behaviour between paediatric nurses and parents and challenged communication processes. Further research is recommended to explore the complexities of busyness and enhance the space required to support family-centred care.

Research is needed to determine the influence of role negotiation, active parental participation including expectations and ways of working that better support and define family-centred care during periods of busyness (O'Connor et al., 2019). Future research also needs to explore child-centred care, the care perspectives of children and young people and their notion of busyness on care practices. Children and young peoples' voices are important and future research should explore strategies that could improve their involvement in co-designing family-centred care (O'Connor et al., 2019).

5.3 | 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 (Committee on hospital care and institute for patient- and family-centered care, 2012; Foster & Whitehead, 2017). 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 paediatric 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 well-being of parents was compromised by the requirement to adhere to social rules, sleep deprivation and hypervigilant advocacy. Parental needs and well-being 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 well-being.

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).

6 | CONCLUSION

Busyness was a temporal construct that influenced paediatric nurse and parent behaviour, family-centred care delivery and a sense of safety and well-being. Fostering a positive workplace culture in the

presence of busyness was challenging and 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 family-centred connections during periods of busyness to optimise partnerships in well-being between paediatric nurses and parents.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Margaret Fry  <https://orcid.org/0000-0003-1265-7096>

Suzanne Sheppard-Law  <https://orcid.org/0000-0002-9971-9343>

TWITTER

Claire Harris  MargFry

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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