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Exploring the impact of the COVID-19 environment on nursing delivery of family-centred care in a paediatric hospital

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Abstract

Aims and objectives: To understand how the pandemic environment impacted the delivery of FCC of children and families from a nursing perspective in a major tertiary paediatric hospital.

Background: Family-centred care (FCC) is a well-established framework to promote parental involvement in every aspect of a child's hospitalization, however, rules and restrictions in place during the COVID-19 pandemic affected the ways in which Family-centred Care could be delivered in practice.

Design: This is a qualitative exploratory descriptive study to elicit the perspective of paediatric nurses delivering care to children in a hospital during the COVID-19 pandemic in Victoria, Australia.

Methods: Nurses from all subspecialties in a tertiary paediatric hospital were invited to participate in virtual focus groups to discuss their experience of delivering FCC during the COVID-19 pandemic. Focus groups were recorded and transcribed, then analysed using Framework Analysis.

Results: Nineteen nurses participated across seven focus groups during June and July 2020. The four themes—Advocating with empathy, Enabling communication, Responding with flexibility, and Balancing competing considerations—and the eight subthemes that were generated, outline how nurses deliver FCC, and how these FCC actions were impacted by the COVID-19 environment and the related hospital restrictions.

Conclusion: This study documents the experiences, resilience and resourcefulness of paediatric nurses in Australia during the COVID-19 pandemic as well as moving Family-centred Care from a theoretical framework into a practical reality.

Impact: The findings from this study should inform consideration of the impacts of public health policies during infectious disease outbreaks moving forward. In addition by describing the core actions of Family-centred Care, this study has implications for educational interventions on how to translate FCC theory into practice.

No public or patient contribution as this study explored nursing perceptions only.

1 | INTRODUCTION

Family-centred care (FCC) is considered fundamental to the quality and safety of paediatric healthcare provision (Committee on Hospital Care, 2012). The theoretical origins are based on an understanding of child attachment and the importance of parental presence espoused by John Bowlby and James Robertson (Shields & Nixon, 1989; van der Horst & van der Veer, 2009). Child attachment theory was first applied to the paediatric hospital environment through the Platt report recommendations in Britain in 1959 (Ora, 1961), and by the 1970s the shift to welcome and expect parental participation in children's care in hospitals was evident across the world (Shields, 2011).

Whilst there are some variations in terminology and definitions of FCC in the literature (Al-Motlaq et al., 2019; Shields, 2011), paediatric centres in Australia typically apply the definition set out by the World Health Organization (WHO, 2016), and adopted by the internationally recognized Institute of Patient and Family-Centred Care (IPFCC). The IPFCC defines Patient and Family-Centred Care (PFCC) as "*the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.*" (IPFCC, n.d.). The four key aspects of PFCC cited are: (1) dignity and respect; (2) information sharing; (3) involving patient and family in decision making; (4) collaboration with the patient and family. These aspects link PFCC with improved quality and safety, health outcomes, and family and staff satisfaction. For the purposes of this study, we refer to this definition when discussing the concept of FCC, even whilst we deliberately choose to use the term FCC rather than PFCC. In our experience, FCC is the terminology commonly referred to by paediatric nurses.

Across 2020, the COVID-19 pandemic significantly impacted the provision of usual patient care, largely due to the implementation of visitor restrictions and extensive use of personal protective equipment (PPE) (Riddell et al., 2022). For nurses in paediatric centres, this was particularly challenging. The balance between providing the best care according to FCC values, whilst abiding by the hospital rules and restrictions put in place to optimize the safety of the community, was uncharted territory.

1.1 | Background

In Australia, the first year of the COVID-19 pandemic resulted in far fewer hospitalizations and deaths than in Europe and the USA, partly due to early strict lockdown and quarantine measures to slow the spread of COVID-19 (Kontis et al., 2020). In March 2020, the Australian government enforced social distancing and isolation measures with further restrictions following a second wave in the state of Victoria in June 2020 (Riddell et al., 2022). In line with this, hospitals in Victoria, including the study site, introduced a variety of new visitor policies. This included social distancing, restriction of visitors including siblings and extended family, and as the pandemic progressed, one parent only was allowed at the bedside, and masks became mandatory for parents and staff (Riddell et al., 2022).

To date published reports of the impact of the COVID-19 pandemic on the delivery of FCC in hospitals have largely focused on harm caused by restrictions on family presence at the bedside in neonatal intensive care units (Mahoney et al., 2020; Muniraman et al., 2020; Scala et al., 2020; van Veenendaal et al., 2021). This includes the significant adverse effects on social and emotional development in infants, particularly those born preterm (Mahoney et al., 2020; Scala et al., 2020; van Veenendaal et al., 2021). There is little data from the paediatric nursing viewpoint. This sparse literature includes two reports from Italy, one written by a group of paediatric intensive care nurses (Tedesco et al., 2020) and an empirical study exploring nurse and caregiver experiences in a maternal and child health unit (Ferrari et al., 2021). Only one qualitative study by Shaw et al. (2021), which thematically analysed written reflections from 24 neonatal nurses across 11 countries on the experience of delivery care during the pandemic, included nursing voices from Australia. To our knowledge, there are no qualitative reports of paediatric nurse experience of the impact of COVID-19 policies on the delivery of FCC across a tertiary paediatric setting in Australia.

The aim of this study was to understand how the unique pandemic environment impacted the delivery of FCC in a paediatric healthcare setting from the nursing perspective, to inform current and future decisions about ways of delivering FCC. In addition, an examination of how FCC is operationalized in a paediatric hospital during the COVID-19 pandemic allows us to refine the core elements in FCC which are perceived by nurses to be essential and non-negotiable even in the most extraordinary circumstances. To achieve these outcomes, we explored how nurses at a major tertiary paediatric hospital in Victoria, Australia, provided FCC during the state's second wave of COVID-19 cases during June and July 2020.

2 | METHODS

2.1 | Study design and setting

This was an exploratory descriptive qualitative study, where the aim is both to explore and describe a phenomenon of which little is known. Hunter et al. (2019) outline how this approach can be used to illustrate the phenomena from the perspective of the participants (as in descriptive qualitative methodology) and understand this in the broader social context to generate new knowledge (as in

exploratory qualitative methodology). The unique COVID-19 pandemic environment ensured little research into the practice of FCC, and our aim was to describe this as well as further explore the potential application. Data collection was undertaken through virtual focus groups to take advantage of the discussion of shared experiences (Jayasekara, 2012; Kidd & Parshall, 2000). These were conducted via an online platform due to the study site's restrictions on gathering in person at the time.

This study was conducted at a tertiary paediatric hospital, in Melbourne, Victoria, Australia, over 2 months from 1 June to 31 July 2020. This is a 350-bed hospital providing all medical and surgical departments and includes specialist areas such as mental health, cardiac surgery, a state-wide trauma service and an emergency retrieval service. Approximately 2050 nursing staff are employed at the hospital.

2.2 | Participants

Accepting that there are inherent contradictions in determining sample size prior to undertaking a qualitative study of an under-researched phenomenon (Sim et al., 2018), this study was pragmatic in aiming to recruit a convenience sample of a minimum of 15 nurses from a variety of acute care wards in the hospital in six to eight focus groups.

Study advertisements were sent to nurses via email, posted on the hospital intranet and promoted in teams via nurse managers and educators. For all participants, consent was obtained through a we-blink in the invitation email which led to the participant information and consent form.

2.3 | Data collection

Nurses that consented were automatically directed to an online survey link to answer the demographic questions and invited to nominate a focus group time.

In recognition of the barriers to participating due to shift work, focus groups were offered on a range of days and times and went ahead with a minimum of two participants. Nurses were eligible if they were employed in inpatient wards at the hospital and provided clinical care to patients and families during the COVID-19 pandemic.

The focus groups were semi-structured, with a flexible interview guide organizing questions related to each of the existing FCC framework tenets (see Supplementary File 1). Discussion included nurses' experiences providing FCC to inpatients and families during the COVID-19 pandemic in general. Other questions explored the impact of involving families in decision-making, the quality of FCC provision, and what might have been approached differently to deliver FCC during this time.

Each focus group was up to 60 min in duration and was facilitated by two of four members (JO, BD, SK, MH) from the research team and audio recorded for transcription. The full team comprised of five PhD and two Masters prepared advanced practice nurses (JO, BD, SK, SR, FN) who work in the study site's Nursing Research Department. Their combined experience includes clinical expertise across a variety of specialities, as well as extensive qualitative research training and experience in facilitating focus groups. A sixth team member (MH) provided non-clinical project support assisting in data collection, notetaking, collating and analysing data and contributed to the group's reflexive practice.

The research team may have been known to some participants for their role in supporting nursing research. One member of the research team also worked clinical shifts (BD) but did not facilitate any focus groups with participants from her clinical area. The possibility that researchers were known was openly acknowledged to potential participants as the researcher's identities were transparent in recruitment advertisements.

2.4 | Ethical considerations

This study was approved by the study institution's Human Research and Ethics Committee (HREC 64552).

2.5 | Data analysis

Focus group data were analysed using the systematic method of Framework Analysis first developed by Ritchie and Spencer (1994) with steps followed as outlined by Furber (2010). Framework analysis allows for a comprehensive analysis of raw data into units of meaning by specifically targeting the focus of the research through the use of a 'framework'. This is useful where there is limited time, multiple researchers and a key pre-determined focus (Gale et al., 2013).

All researchers familiarized themselves with the transcripts, and each of these was then coded independently by two members of the research team. Codes were generated both inductively and deductively using the FCC framework, as defined by the IPFCC, which includes: dignity and respect, information sharing, participation and collaboration, as well as the category of "zero harm" as this is part of the study hospital's internal FCC policy. These codes were entered into a Microsoft Excel spreadsheet to enable the development of themes which could be mapped to the existing FCC tenets. To ensure the fit of this new framework, a process of indexing was undertaken to check initial codes and resulting themes with the raw data (Furber, 2010).

2.6 | Rigour

Trustworthiness of the data was achieved through dependability, credibility, and transferability (Lincoln & Guba, 1986) with adherence to the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007; see Supplementary File 2).

Researcher triangulation enhanced dependability, by ensuring in-depth discussion in the process of analysis, allowing for multiple perspectives in the confirmation of findings and also enhanced understanding through sharing reflections (Santos et al., 2020). Codes were cross-checked in several whole team meetings with rounds of indexing, mapping and discussions continuing until all researchers reached a consensus with the final themes and subthemes. Dependability was further maximized by a rigorous audit trail and memos of researcher reflections and discussions (Lincoln & Guba, 1986).

During the focus groups, member checking to ensure credibility, took place in real time (Kidd & Parshall, 2000); with the facilitator using phrases such as 'is what you are saying…' to check their understanding of participants' discussions. Rich descriptions and verbatim quotes from participants have been used to illustrate themes and subthemes, enhance credibility and provided the detail for readers to determine the transferability of the findings to their own context.

3 | RESULTS

Seven focus groups were conducted. A total of 19 nurses participated with two to four nurses in each focus group with the average duration of focus groups 44 min (range 27–58 min). Table 1 includes relevant demographic details of each focus group participant under their pseudonym. Of note 10 (58%) of participants were aged between 25 and 44 years and held Bachelor or Postgraduate degrees. Over half the participants had more than 10 years of nursing experience and 35% had worked over 10 years at the study hospital.

3.1 | Themes

Final themes and subthemes were mapped onto the original FCC tenets (see Table 2). Findings from this study provided a revised layered FCC framework which operationalizes the original high-level tenets of FCC. Thus, the resulting themes describe how nurses action FCC, and subthemes describe how these FCC actions were impacted by the pandemic environment and the related hospital restrictions.

3.2 | Theme 1: Advocating with empathy

The first theme *Advocating with empathy* describes the actualization of the FCC tenet of treating families with dignity and respect. This includes the nurses' role in appreciating family context and supporting and respecting each family's values. Specifically, in the pandemic environment, this was realized through *Appreciating family vulnerability* and *Negotiating rules*.

3.2.1 | Appreciating family vulnerability

All nurses that participated in focus groups expressed great empathy for families who had children in the hospital during the pandemic, recognizing the added stress the COVID-19 environment placed on already difficult situations. As Parker (FG6) voiced, '*It's a hard time to be a family in the hospital. It's always a hard time, it's very much harder now*'. Harriet (FG5) echoed '*being in hospital's a very tough time … being in hospital over this time is exceptionally tough*' (Harriet, FG5).

Isolation was the common word used to describe how nurses viewed the experience of hospitalization during the pandemic for families:

> The social isolation for families [is very hard]. They cannot have that best friend or sister come and sit with them during the day while mum's trying to breastfeed or you know, look after the other children and that sort of thing. There is children that are isolated from their siblings. Mums and dads have not been able to be there together.
>
> (Anvi, FG4)

Not only did nurses appreciate the impact of visitor restrictions but also the impact of directives to limit their own amount of time spent in patient rooms, which '*for the parent can feel really, really isolating - that we aren't going in there and not checking in as much*' (Heidi, FG6). In addition, nurses acknowledged the anxiety created by the existential threat where '*[Families] are also facing what the rest of us are facing, the isolation, the uncertainty*' (Anvi, FG4).

3.2.2 | Negotiating rules

The second subtheme of *Negotiating rules* illustrates the expanded role of the nurse in advocating for the family, in the presence of hospital restrictions put into place to safeguard the larger hospital community against the spread of COVID-19. Whilst nurses acknowledged the need for the rules, they also felt a responsibility to seek the exemptions available, particularly to the one-parent rule. These exemptions could be granted by nurse managers or the hospital executive, dependent on individual circumstances; and nurses were very aware that:

> Part of who gets some exemptions is probably about who's advocating for them … you know if there's people advocating to say, well actually this family needs more support, or they need the support of each other then you know, then there were exceptions.
>
> (Harriet, FG5)

Pseudonym	Age range in years	Highest level of education	Years nursing	Years nursing at study hospital
Focus group 1				
Jessie	35–44	Bachelor degree	>10	>10
Huong	35–44	Post-Graduate certificate/diploma	>10	>10
Focus group 2				
Eleanor	25–34	Master's Degree	5–10	5–10
Nancy	45–54	Master's Degree	>10	5–10
Casey	55+	Hospital certificate/diploma	>10	>10
Rachel	25–34	Master's Degree	5–10	5–10
Focus group 3				
Karen	35–44	Post-Graduate certificate/diploma	>10	>10
Ashley	35–44	Post-Graduate certificate/diploma	5–10	5–10
Ann	45–54	Post-Graduate certificate/diploma	>10	1–2
Focus group 4				
Anvi	35–44	Bachelor degree	>10	3–4
Susie	Not declared	Bachelor degree	1–2	1–2
Donna	25–34	Post-Graduate certificate/diploma	5–10	5–10
Nina	45–54	Post-Graduate certificate/diploma	>10	>10
Focus group 5				
Harriet	55+	Bachelor degree	>10	>10
Freya	Not declared	Bachelor degree	1–2	1–2
Focus group 6				
Heidi	25–34	Post-Graduate certificate/diploma	>10	5–10
Parker	25–34	Post-Graduate certificate/diploma	5–10	5–10
Focus group 7				
Laura	25–34	Bachelor degree	3–4	3–4
Katie	25–34	Master's Degree	5–10	3–4

Nurses typically viewed that part of their responsibility was to be this advocate, but did not always find this easy. Advocating to allow another family member to come into the hospital involved the willingness to weigh up each family's circumstance and their need for extra support, and then make a case for an exemption to be granted. As Maryam (FG7) explains:

> You [need to have], not a "rule-breaker" but a person that's willing, a nurse that has the time or initiative to stand up for the family and say look, this is a really tricky time … this mother already has anxiety issues … she is going to need support from her husband.
>
> (Maryam FG7)

TABLE 2 Themes and subthemes

Tenets of FCC framework	Themes—core ways nurses operationalize the FCC framework	Subthemes—Pandemic-specific ways nurses operationalize the FCC framework
Dignity and respect	Advocating with empathy	Appreciating family vulnerability
		Negotiating rules
Information sharing	Enabling communication	Using technology
		Considering the effect of PPE on caring for families
Participation and collaboration	Responding with flexibility	Minimizing the impact of restricted support
		Adapting to a changing environment
Zero harm	Balancing competing considerations	Weighing up risk
		Managing moral distress and regret

3.3 | Theme 2: Enabling communication

Information sharing is realized by nursing through *Enabling communication*. In the pandemic context, the social distancing rules and PPE requirements were significant barriers to the usual practices of communication. The subthemes of *Using technology* and *Considering the effect of PPE on caring for families* reflect the adaptations necessary to ensure adequate communication was achieved.

3.4 | Using technology

The need to communicate remotely with parents, family members and other health professionals triggered the adoption of technology, such as video-conferencing platforms. Whilst the setup of such technology was not initially straightforward, nurses appreciated its value. Technology was able to be used for scheduled consultations where '*if the other parent is at home, or the aunts and uncles are involved in the care of the young person, they can all join in the consult*' (Karen, FG3). In addition, where a family could not be present with their child they could have '*regular times where they would connect onto telehealth and we would be waiting for them and they would be able to interact with their child through telehealth and also talk to the nurses*' (Parker, FG6).

Nurses overwhelmingly perceived the use of technology for communication as a positive, and a change that would be valuable to keep post-COVID-19 times. For some nurses there was a degree of pride, and excitement at this adjustment:

> Telehealth has been an amazing discovery for I think a lot of us ... routine reviews are scheduled by telehealth and that makes a huge difference and a huge impact on families that live far from Melbourne ... it has shown that we can work differently.
>
> (Rachel, FG2)

3.4.1 | Considering the effect of PPE on caring for families

During the data collection period PPE directives such as wearing a surgical or an N95 mask, goggles, gown, and gloves varied across wards and departments, with emergency and critical care environments having stricter requirements. Nurses described a range of impacts of PPE on communication with children and families.

Huong (FG1) explains the practical effects of the mouth and face being covered: '*it's not 'til you get the ones that speak up and say "I can't hear you" that you've realised the whole day maybe no one has been able to hear you*'. Other practical issues raised by Karen (FG3) include the difficulty of identifying health professionals in PPE: '*[Families] don't know who anyone is. You can't distinguish who anybody is, at all. You wouldn't know who is walking into your room*', and the effect of the discomfort of PPE on the time nurses spend with families, where '*It is so hot, so you don't want to sit and talk and engage ... you want to get in there, do what you have to do and get out...*'.

Other nurses were acutely aware that having a nurse in PPE was very frightening for some children, making it very difficult to build rapport when '*a child is screaming because they don't want anything to do with this creature with a mask and goggles...*' (Laura, FG7).

Casey (FG2) goes further to suggest the impact of PPE is detrimental not only to verbal communication and the ability to build rapport, but for non-verbal aspects of communication, stating '*Full PPE is really hard because you can't even touch a patient without wearing gloves and that's inhumane. Like I would rather wash my hands a hundred times ... because it's human contact, it's gentle touch*'.

3.5 | Theme 3: Responding with flexibility

The two central tenets of the IPFCC framework, participation and collaboration are actioned in Theme 3 *Responding with flexibility*. This theme shifts the focus to the action of nurses in ensuring child and family participation and collaboration and allows

nurses to meet the family where they are in terms of input into their child's care. The subthemes of *Minimizing the impact of restricted support* and *Adapting to a changing environment* reflect the increased reliance on the nurse in the context of the absence of other supports in the pandemic.

3.5.1 | Minimizing the impact of restricted support

Nurses understood that their role in supporting families expanded in the pandemic environment. As one of the few health professionals continuing constant and frequent face-to-face care, and in the absence of family and visitors, nurses felt compelled to fill the gap practically and emotionally:

> I think we are trying to do what we can to make up for [restricted support] … we are trying to step in as that partner, for that parent that is there … to be that emotional and physical support.
>
> (Susie, FG4)

Thus nurses undertook tasks outside of their usual job description, particularly small tasks usually carried out by volunteers or family members. Whilst participants expressed their belief that picking up these tasks ensured the quality of FCC, by '*trying to do little errands to make sure that families and parents feel like they are well looked after*' (Donna, FG4), this work in addition to their usual tasks. Laura (FG7) describes:

> I would say that [the nursing role] has expanded a lot … we now have to take the meals to the families, we make them cups of tea, if they want a coffee from [the shop] upstairs we will run up and grab it for them, if they have something brought in we go and wait outside Emergency in the cold [for it to be dropped off]….

Focus group participants expressed an increased appreciation of the value of being present in a time where much of the care had moved to a distanced or virtual model. The positives of this included an increased ability to develop a therapeutic relationship with the family, as Ashley (FG3) explains: '*when there is one parent at the bedside and one nurse you form a relationship quite quickly, so they often have a debrief with us*'.

3.5.2 | Adapting to a changing environment

The need for nurses to fill the gap of reduced services and hands-on care from other friends, family and professionals during the pandemic demanded increased flexibility and the ability to adapt to frequently changing requirements. Participants generally perceived developing this skill as a positive where '*being flexible and responding to change has probably been good*' (Harriet, FG5); and justifiably felt proud of themselves and their colleagues in terms of their ability to do this:

> From the get-go everyone's been like "Ok this is what we are doing and how we are doing it" … no-one has questioned it, they are all just "yep, no worries", like when the plan of care has needed to be changed because of COVID everyone has just gone "yep cool no worries let's do it that way then."
>
> (Jessie, FG1)

However, Nina (FG4) was more cautious, acknowledging the effort to adapt, but suggesting that despite this, circumstances prevented the provision of the usual FCC:

> I feel like as nurses we kind of have been able to adapt to the changes … I would not say that we have perfectly adapted to it. I could just say that we are doing the best that we can in this current situation.

The sentiment of '*doing the best that we can*' reflects both an understanding of the constraints in delivering the best care in a pandemic, and a reflective sadness about this, which illustrates the demands on nurses to balance different considerations.

3.6 | Theme 4: Balancing competing considerations

Theme 4 arises from the tenet of '*zero harm*', which is not in the IPFCC description of FCC delivery, but is in the study site hospital policy on FCC. Focus group participants believed that actual 'zero harm' was not achievable, and even less so during a pandemic. Instead, they viewed their role in preventing harm as *Balancing competing considerations*. In the context of the pandemic, this was reflected through *Weighing up risk* and *Managing moral distress and regret*.

3.6.1 | Weighing up risk

Weighing up risk during the pandemic in the hospital environment reflected what was happening also in the community, where the needs of the individual shifted to be secondary to the safety of the community. As Harriet (FG5) states: '*It's very real anxiety about COVID and trying to limit the infection rates in hospital and externally it is very real, so I think people are weighing up the balance of that*'.

This shift prompted nurses to change their type and frequency of interactions with families, even whilst they felt this was not optimal:

> I certainly rethink do I actually have to go in the room. You know [as] a shift leader, I personally visualize every child and meet every family, or that would be my aim. I am certainly not doing that during Covid if unnecessary.
>
> (Karen, FG3)

In some cases sadness was expressed at the outcome of weighing up risk:

> You talk about first baths and that sort of thing, you do not get that back as a parent, and that's really sad to know that mum or dad are missing out on that really important first. But obviously we need to try and optimize everybody's position in the pandemic.
>
> (Anvi, FG4)

3.6.2 | Managing moral distress and regret

Whilst participants intellectually rationalized the shift in hospital regulations to prioritize the safety of the community over the needs of families, there was no doubt it was emotionally difficult. In some cases, there was a level of moral distress expressed, over decisions or situations enforced by the rules in place. For example, Laura (FG7) reflected:

> You take home the experience of the family as well, at least I do, I think about being shut in a room with a 6 week old baby completely having their agency and autonomy taken away from them.

And Nancy (FG2) describes how such imposed rules which are not family-focused, leave her feeling *'really helpless, being a nurse in the clinical environment … I've often felt like what can we do about [lack of support for families], other than providing some explanation and saying that things will be better'*.

In other cases, nurses describe decisions about care that raise genuine ethical dilemmas. This is especially poignant in palliative care:

> We've got children who are not technically dying this minute, but they are very fragile … at what point do you call? What's a good time for siblings to come in and see that child who they may not see awake again? You know it's really hard to call … the unit managers and execs are obviously looking after the whole ward and the whole hospital and trying to keep everyone safe … [but] it makes such a difference in long term bereavement when there is contact with the unwell child … it's just hard because you know it could be different.
>
> (Nina, FG4)

4 | DISCUSSION

4.1 | Operationalizing FCC policy

In addition to exploring the nursing delivery of FCC in a pandemic, our study was able to more broadly describe how paediatric nurses operationalize the FCC policy everyday. The value of this knowledge is the translation of the theoretical framework into clinical practice. These fundamental actions to achieve FCC as perceived by paediatric nurses are labelled in our four themes: advocating with empathy, enabling communication, responding with flexibility and balancing competing considerations. The move from the nouns listed in the framework to verbs of the themes emphasizes the action that is needed to maximize FCC outcomes.

The challenges of applying FCC in practice have been recognized in the literature (Coyne et al., 2011; Cruickshank et al., 2005; Dennis et al., 2017). Whilst a recent study has described nursing FCC actions as perceived by parents in a paediatric post-anaesthetic care unit (Taranto et al., 2021), what has not been explicitly reported is a description from paediatric nurses of the ways they achieve the core tenets of FCC, as enshrined in policy. Other studies exploring nurses' perceptions of the delivery of FCC consistently lists reported elements as nouns and thus desired outcomes, not actions (Coyne et al., 2011). This is true even in literature where the aim is to bridge the discord between models of FCC and the operationalization of FCC (Dennis et al., 2017).

The value in describing how to 'do' FCC is twofold. First, it enhances the understanding of the nuances of the nursing role and second, it serves as a resource for those wishing to practically apply FCC. This is valuable as methods of practical application are not intuitively understood through existing FCC policy and framework documents. Although the primary aim of this study was to explain differences in the delivery of FCC during a pandemic, in doing so, we have gained a valuable description of key FCC practices by nurses which could apply outside a pandemic. The subthemes illustrate the flexibility of the FCC delivery during COVID-19 which increases confidence in the ability of the FCC as a model, to be adapted to a range of environments and contexts. This has previously been a critique of the FCC framework (Dennis et al., 2017).

4.2 | Adapting to provide FCC in a pandemic

Subthemes in this study illustrate the ways nurses have had to adapt core actions to deliver FCC in the pandemic and mirror the few other paediatric studies in this setting. This includes themes of isolation and uncertainty, the difficulties of separation, family and visitor restrictions, the impact of PPE on communication and expression of empathy, and the need for nurses to be creative, flexible, and resilient (Ferrari et al., 2021; Shaw et al., 2021; Tedesco et al., 2020). These similarities, despite the vastly greater numbers with COVID-19 in US and European countries largely represented in previous studies, reflect that the impact of COVID-19 on FCC practices is attributable to the infection control and public health policies as much as the pandemic itself. This is important as it emphasizes the need for public health policymakers and politicians to consider the potential effects of public health policies that are implemented to protect the community.

Other international research also echoes many of the impacts on healthcare delivery during COVID-19 highlighted in this study.

For example, the stress and distress caused by one-parent policies have been described in a tertiary paediatric hospital in Canada (Diskin et al., 2021), and in paediatric intensive care units throughout Europe, North and South America, Africa and Oceania (Camporesi et al., 2021).

One aspect of the nurses' experience of providing FCC during the COVID-19 pandemic that has not previously been described is the expanded role of the nurse as an advocate for families. Whilst advocacy is a well-recognized aspect of nursing (Heck et al., 2022), this is not explicitly reflected in the IPFCC framework, nor the study site FCC policy. The frameworks focus on working with the family in partnership and implicit in this is 'enabling' families, stemming from a historical context where the ideal of FCC shifted the control of health care decisions from professionals to families (Dennis et al., 2017). However, by not making advocacy explicit, the imperative for this key action in realizing FCC in situations where families are not in a position to negotiate care or take an active role in decision making is compromised. Importantly, our study highlights the key role of advocacy in delivering FCC and demonstrates how this role has expanded as a direct result of the pandemic. For example, the isolation of families, with one primary caregiver only by the bedside prompted a need for nurses to step up their role in speaking up for families. The fundamental role of advocacy in providing FCC raises the question of whether it should be explicit in the FCC model.

4.3 | Positive outcomes of adjusting delivery of FCC

Despite the challenges of delivering FCC in a pandemic, there were several positives that nurses identified. The position nurses found themselves in as the primary support for the one parent at the bedside, whilst intense, allowed for the opportunity for an accelerated therapeutic relationship. This could lead to the identification of important factors impacting the child and family's health. This has not previously been reported.

Pride in the nursing and broader healthcare team in adapting to change quickly, rising to challenges posed, and willingness to explore different ways of delivering care is consistent with other qualitative studies of nursing experiences during the pandemic (Shaw et al., 2021). Another positive outcome of the pandemic confirmed in our study is the realization of the potential of technology to communicate with families, which was recognized as having ongoing benefits post-pandemic in terms of respecting family's travel time, the possibility of inclusion of immediate and extended family members in updates and equity of access. The positives for families in maintaining the use of telemedicine post-pandemic have been previously recognized in a range of paediatric healthcare areas such as asthma management (Davies et al., 2021), neuromuscular disorders (Carroll et al., 2022) and behavioural and mental health issues (Hiscock et al., 2021).

The current study suggests that paediatric nurses found ways to deliver FCC to meet the needs of families, even when the situational context was not ideal. So whilst the INCFCC recently released a position statement suggesting that the restrictions placed on hospitals due to the pandemic, particularly in the paediatric context, have jeopardized the core components of FCC (Al-Motlaq et al., 2021), and previous literature has argued that true FCC can only be achieved if organizational and environmental barriers are mitigated (Coyne et al., 2011), these assertions were challenged in our context.

The resourcefulness and resilience of nurses during the pandemic mirror international narratives (Shaw et al., 2021). What might have been underestimated is the profound value paediatric nurses place on promoting and delivering FCC. When, despite their best efforts, nurses are unable to realize their FCC goal, even whilst it can be rationalized in the context of prioritizing community safety, it is often at a personal emotional cost.

4.4 | Moral distress and regret

An important finding from this study is the recognition of the psychological impact of nursing during the pandemic, even in the context of low case numbers and few hospitalizations. In particular, there are new ethical tensions which arise when the balance between community safety and individual care shifts, and is especially marked when it comes to the delivery of FCC. Nurses expressed moral distress, defined as "*the distress felt at being unable to do what is right, or being forced to do what is wrong*" (Guillemin & Gillam, 2015, p 729), and moral regret, which is the feeling that what one is doing wrong, although in the context it is ethically justified. Distinguishing between these can be helpful in understanding if there has been an ethical wrong, or if the situation is the best possible option in the circumstances (Guillemin & Gillam, 2015).

Morley et al. (2020) outline several types of moral distress, including "moral constraint" which arises from the inability to carry out what an individual perceives as the right thing to do due to a type of constraint outside the individual's control. This is illustrated by participants in this study through examples such as the inability to facilitate family, community and hospital support due to restrictions, and being unable to use touch and face-to-face interactions to deliver care whilst wearing PPE.

Acknowledgement of moral distress and regret amongst nurses, related to the constraints of delivering care in a pandemic is vitally important to mitigate potential negative consequences. Unresolved or repeated incidents of moral distress can lead to moral injury, which is psychological trauma resulting from a profound compromise of moral values (Rosen et al., 2022). Whilst moral distress can prompt emotions of frustration, unease and anger, moral injury can trigger a crisis in identity (Rosen et al., 2022; Rushton et al., 2022) The consequences of moral injury are long-term and often irreversible, including poor mental health, burnout and workforce attrition, as well as damage to morale in the workplace (Morley et al., 2020; Rosen et al., 2022). Building moral resilience through interventions such as facilitated ethical reflection is vital to combating moral distress and mitigating the effect

of moral injury (Rosen et al., 2022). Such interventions should be built into the COVID-19 recovery process of the nursing workforce and supported by the organizational culture (Delany et al., 2021; Rushton et al., 2022).

4.5 | Limitations

There are some considerations when interpreting the findings of this study. First, participant experience must be considered with reference to context. At the time of data collection, there were relatively low Covid-19 case numbers in Australia, with very few paediatric patients hospitalized. In places with a significant COVID-19 disease, it would be expected the balance of considerations in attempting to maintain FCC, and the nature of any moral distress could be different. Although, as discussed, international literature suggests many of the same issues for nurses in other settings, the significance of context nevertheless may limit transferability.

The number of participants in each focus group was smaller than anticipated, with the study recruiting just over the minimum number of participants intended overall. However the target number of focus groups was met, albeit with fewer participants in each, and the richness of discussion enabled meaningful reoccurring themes to be created. Thus the overall findings were not deemed to be compromised by the small participant group. Furthermore, it is acknowledged that the nurses do not work in isolation and that other health professionals contributed and added value to the delivery of FCC. Their perspectives were not captured as part of this study and their experiences may be quite different.

5 | CONCLUSION

This study used an exploratory descriptive qualitative design to highlight how the recent pandemic environment impacted the delivery of FCC in a tertiary paediatric hospital from the perspective of nurses. Through virtual focus groups, nurse participants described their efforts to deliver FCC during the initial COVID-19 wave in 2020 in Victoria, Australia. The findings inform us of the consequences of the pandemic in the delivery of paediatric care even in places where case numbers are low. This is important for future health policy planning which must consider potential harms from restrictions, as much as from the disease that prompts such restrictions. Whilst the challenges in the paediatric hospital setting are clearly illustrated in this study, so are the resilience and resourcefulness of nurses, and the value they place on FCC. This should indeed be celebrated. Future research to support these findings should consider the perspectives of paediatric patients and their families in the delivery of FCC in the hospital during the COVID-19 pandemic.

The findings of this study provide a framework on which to build FCC clinical practice and research beyond the pandemic context by articulating FCC action items that move the conversation about FCC from a theoretical one, to a practical reality. Using framework analysis allowed for reconsideration of the accepted key tenets of FCC, and translated the high-level abstract FCC tenets into clinically practical and informative information about 'doing' FCC. These FCC actions will be instrumental in the development of educationcal interventions aimed to support nurses new to paediatrics or who wish to advance their competency in delivering FCC. Embedding the identified FCC actions into education programs and nursing clinical guidelines aimed at supporting nursing competency in the delivery of FCC may well prove more functional and more easily applicable to practice than those focusing on the theory of FCC alone. These findings also open the door to a reconsideration of the FCC model to reflect practice, in particular by acknowledging the central role of advocacy and the impact of perceived inability to deliver FCC on nursing moral distress and moral injury.

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