Parents’ experience of family-centred care in the post anaesthetic care unit during non-clinical delays: A qualitative study

Abstract

The qualitative exploratory descriptive study explored parents’ experience of family-centred care during delayed transfer from a paediatric Post Anaesthetic Care Unit to inpatient ward. Data were collected in a tertiary children’s hospital in Melbourne, Australia, using in-depth, semi-structured interviews. Participants (n=15) were parents of children (n=10, aged 6 months to 16 years) delayed in a Stage 1 Post Anaesthetic Care Unit for longer than 30 minutes. Elements of the family-centred care framework guided thematic analysis, the core concepts of which are respect and dignity, information sharing, participation and collaboration. Respect and dignity was most often identified, expressed in three subthemes: 1) the caring behaviour of staff; 2) being present with their child; and 3) a journey shared with other families. Information sharing was also common, illustrated through 1) being told information; and 2) being heard. Participation, the third element of the framework, was infrequently identified by participants; however, parents of children under six years of age alluded to contributing to their child’s care. The final element, collaboration, was not identified in the study data. Only two of four elements of the family-centred care framework were common in parents’ experiences: respect and dignity, and information sharing. ‘Being with’ their child emerged as a central concern for parents’ perceptions of family-centred care.

Key words: Family Centered Care; Patient Centered Care; Post Anaesthesia Care Units; Recovery; Pediatric Care.
Introduction

Family-centred care (FCC) is operationalized in paediatric care through partnerships between children, parents, healthcare providers and hospitals (Institute for Patient and Family-Centered Care [IPFCC] 2020). Paediatric post-anaesthetic care units (PACUs) are a key transition point in the post-operative pathway. Increasingly, delay in transfer of care from PACU to inpatient wards occurs, which may be attributed to patient flow, administrative processes and/or the clinical needs of the child (Cobbe and Barford-Cubitt, 2018). While delays in transition of care are often used as performance and quality indicators of care delivery, little is known about how a prolonged stay in the PACU, for non-clinical reasons, impacts parents’ experience of FCC. This study used an existing FCC framework to explore parents’ experiences during non-clinical delays in a paediatric PACU.

Over 160,000 children undergo surgery in Australian hospitals annually (Australian Institute of Health and Welfare, 2019), representing a substantial number of parents who experience the perioperative journey with their child. Understanding parents’ experiences can inform strategies to enhance the quality of care for both children and their families.

Paediatrics is a unique speciality in nursing as it promotes parental involvement (Harrison, 2010). Parent involvement in care during the perioperative journey is a significant contrast to adult care, providing reassurance and comfort for the child (Bai, Swanson and Santacroce, 2018; Chorney and Kain, 2010), and influencing their health outcomes (Bai, Swanson and Santacroce, 2018; Tully et al. 2019). This research specifically examined FCC during the immediate postoperative phase which begins in the PACU.

Family-centred Care

While FCC is an evolving framework, its importance in underpinning quality paediatric healthcare is widely recognized (Al-Motlaq, et al., 2019; IPFCC, 2020; O’Connor,
Brenner and Coyne, 2019; Uniacke, Browne, and Shields, 2018). An International advocacy organisation, the Institute for Patient and Family-Centered Care (IPFCC) promotes FCC through collaborative, empowering relationships among patients, families, and healthcare professionals (IPFCC, 2020). The IPFCC framework was adopted for this study because it was internationally recognized and underpinned the FCC policies at the study hospital. The framework has four core principles: 1) respect and dignity; 2) information sharing; 3) participation; and 4) collaboration.

Respect and dignity are cornerstones of ethical practice and fundamental to nursing care (American Nurses Association, 2015; International Council of Nurses, 2012). Quality time spent with parents and understanding their values and beliefs typically demonstrate respect and dignity in paediatric healthcare, along with provision of care that is accessible, welcoming and responsive (Australian Commission on Safety and Quality in Health Care [ACSQHC] 2017).

Information sharing involves honestly and sensitively sharing unbiased information with families on an ongoing basis, in ways they find useful and supportive (IPFCC, 2020). The importance of two-way communication is emphasized in the quality and safety healthcare literature (ACSQHC, 2017; Vincent and Amalberti, 2015).

Participation is encouraged in modern, paediatric healthcare. Parents are encouraged to participate in their child’s surgical journey at a level of their choosing, including enacting parental roles and participating in decision-making (Lee, Rosen, and Burrows, 2016).

Collaboration involves parents working together with health professionals and sharing responsibility for problem-solving and decision-making (IPFCC, 2020). Collaboration is an essential element of care for families but is commonly absent in paediatric critical care settings (Suleman, Evans and Manning, 2019).
The Post-Anaesthetic Care Unit

The surgical journey involves three phases: 1) pre-operative; 2) intra-operative; and 3) post-operative (Derieg, 2016). The post-operative phase includes the immediate care of the child during the high-risk period of anaesthesia emergence, delivered in the specialized setting of the PACU where it is increasingly common for parents to be at their child’s bedside (Chorney and Kain, 2010).

Non-clinical Delays

Delay in the PACU for non-clinical reasons, such as a lack of transport and unavailability of beds and nurses in receiving wards, is often viewed as a negative quality indicator (Cobbe and Barford-Cubitt, 2018). Despite organisation-wide efforts to improve flow through the PACU, non-clinical delays remain common (Cobbe and Barford-Cubitt, 2018).

A literature search revealed only two papers from one study investigating the impact on care of non-clinical delays in discharge from the PACU from the nurses’ perspective; families’ experiences were not captured (Lalani, Ali, Kanji, Jaffer and Ali, 2011; Lalani, Kanji and Ali, 2012). The impact of such delays on parent perceptions of FCC are an important quality indicator not yet reported in contemporary literature. This investigation of parents’ experience of non-clinical delay in the PACU, through the lens of an FCC framework, addresses this gap.

Aim

To explore parents’ experience of FCC during delayed transfer from a paediatric PACU to an inpatient ward, using the FCC framework.
Methods

Design and setting

This qualitative exploratory descriptive study was conducted at a tertiary, paediatric hospital in Melbourne, Australia. Approximately 10,000 children undergo surgery at the hospital each year. The perioperative department caters for 50 to 90 surgeries each weekday with approximately 20 to 30 of these requiring overnight admission post-procedure.

Study Population

The study population included parents of paediatric patients who received a general anaesthetic and were cared for in the PACU from May to October 2017. A purposeful sample was recruited to capture heterogeneity in the post-operative ward destination, surgical speciality and delay length. Inclusion criteria included English-speaking parents of paediatric patients who had elective surgery at the hospital, experienced a non-clinical delay in discharge from the PACU of 30 minutes or longer, and were present with their child during the entire PACU stay. Exclusion criteria included parents of patients who were not transferred to an inpatient ward (e.g. day surgery procedures), parents and/or children who appeared visibly distressed as judged by the nurse researcher, and parents of patients where the researcher was involved in care.

Procedure

Ethics approval was granted by the Human Research Ethics Committees at the study site under the negligible risk process (reference removed for blinding).

Eligible parents were approached by the researcher and provided with an explanation of the study and Participant Information Form. Consistent with qualitative description methods (Sandelowski, 2000, 2010), a sample of parents of 10 children was expected to be
sufficient to provide rich data, allowing the researcher to concentrate on the quality of the information collected.

Face-to-face interviews with consenting parents were conducted within 48 hours of their child’s discharge from the PACU to minimise recall bias. After obtaining verbal consent, all interviews took place either within patient rooms, or nearby interview rooms at the hospital.

Data were collected using a semi-structured interview guide (Table 1) that was informed by qualitative research texts, theory on FCC (IPFCC, 2020) and the researcher’s experience in paediatric PACU nursing (Speziali, Streubert and Carpenter, 2007; Tashakkori and Teddlie, 2003). The questions were purposefully broad to allow participants to focus on salient aspects of their PACU experience, and balanced with positive and negative tone to reduce risk of response bias. The interview guide provided flexibility for the interviewer to change order, reframe or ask probing questions using participant responses to minimise potential to influence participant responses. Field notes of descriptions and reflections about the interviews ensured context was preserved during data analysis.

The interviewing researcher was employed at the study site and, to reduce risk for perceptions of coercion or response bias, did not recruit family participants she had cared for. Reflexivity was managed using a reflective journal and feedback from research supervisors throughout data collection and analysis.

<insert table 1>

Analysis

A seven-stage approach derived from qualitative exploratory descriptive research methods (Braun and Clarke, 2006; Gale, Heath, Cameron, Rashid and Redwood, 2013; Sandelowski, 2000) promoted rigour and transparency throughout the analysis. The stages of
analysis included: (1) verbatim transcription of audio-recorded interviews and de-
identification of data using pseudonyms (see Table 2); (2) familiarisation with the data
including reflective note taking; (3) inductive coding with a code applied to what was
interpreted as important by the primary researcher (Gale, et al., 2013); (4) further coding and
recoding by the research team, challenging assumptions and examining alternative
propositions, and development of a working analytical framework guided by the FCC
framework (Smith and Firth, 2011); (5) application of the analytical framework to all
transcripts, and development of a description for each code; (6) generation of subthemes from
the data under each of the four concepts of FCC, with supporting quotations identified; (7)
identifying connections between concepts and subthemes, and recording these in the results.

Rigour

Multiple mechanisms maximized the trustworthiness of the study. Use of the
qualitative data analysis process described by Braun and Clark (2006) ensured data were
analysed in a thorough and consistent way. Credibility of the findings was further enhanced
through researcher triangulation, while utilisation of the FCC theoretical framework provided
Purposive sampling was used to recruit parents of children of varying ages with varying
conditions, thus improving the transferability of findings (Guba, 1981). Transferability was
further enhanced by collection of “thick descriptive data” (Guba, 1981: p.86), enabling
comparison of the study context with other health settings and populations. Dependability of
the data was augmented through the creation of an audit trail that included documentation of
the data analysis process, and a research diary kept by the student researcher to record
insights about the data and decisions about recruitment and analysis.
Findings

Fifteen parents of 10 children participated in the study; participant characteristics are outlined in Table 2.

A summary of the thematic findings, including subthemes, is provided in Table 3.

Respect and dignity emerged as the dominant theme as it was the concept from the FCC framework most commonly identified by participants. A second dominant concept from the FCC framework commonly described by participants, was information sharing. Participation was infrequently identified by participants in this study; however, parents of children under six years of age most often alluded to contributing to their child’s care. The final concept within the FCC framework, collaboration, was not identified in the data.

Parents’ Experience of Respect and Dignity in the PACU

All participants described examples of care related to respect and dignity under three subthemes outlined below.

‘Caring’ behaviour of staff

Throughout the interviews it emerged that parents noticed and appreciated staff who demonstrated ‘caring’ behaviours towards them during their delay in the PACU, which were interpreted by parents as respect for their parental role. PACU staff were often described as friendly, kind, compassionate and thoughtful:

"...all the staff were friendly, kind, caring which was great. It makes it a lot easier" (Kate).

Many participants offered descriptions of behaviours by PACU nurses that helped them to feel relaxed, less vulnerable and welcomed:
"They made us feel well at ease, they put the curtain around us to make us feel comfortable, asked if we wanted any food, or to go out...it was really good" (Emma).

Many participants described PACU nurses’ ability to engage and interact with children specifically:

"All the nurses have been very nice to Josie and [provided] that cheerful, what she needs, sort of medicine..." (Eddie).

Caring was also experienced through meeting the emotional needs of the child and family by using humour to:

"lift [a] child’s spirits" (Susan).

Characteristics of caring staff were also described when participants explained it had taken an extended time to be transferred to the ward. Although parents were aware of the delay, caring behaviours from staff provided reassurance:

"I didn’t feel like we were being troublesome or anything. We didn’t feel like we have to get out of here – we were just like...we have to wait" (Kate).

Parents described caring gestures and behaviours by PACU nurses that put them at ease and helped them to feel valued during their stay, aligned with the principle of respect and dignity.

‘Being with’ their child

All parents reported ‘being with’ their child was their primary focus after their child’s procedure. During surgery a child is separated from parents for a period ranging from minutes to hours. Participants described feeling anxious while separated and relieved when reunited with their child:

"It’s just a relief...That they’re safe and well. Seeing you’re not allowed in the surgery room...As soon as you see them you’re like...they’re safe and well and it’s a big relief" (Kate).

Being with their child appeared to be more important than a seamless or timely transition to a ward as this mother described when asked about their delay:
"I just wanted to see my daughter" (Susan).

Encouraging and facilitating parents to be with their child emerged as a fundamental strategy to support respect and dignity for families in the PACU during a delay.

A ‘journey shared’ with other families

The final subtheme of respect and dignity emerged as a ‘journey shared’ between families. Participants often described their understanding of what other families were going through and a mutual respect for other parents. One mother described how seeing other families receiving care in the PACU was comforting:

"...I can see other staff attending other kids so it's reassuring me that my daughter is under the same care. It makes me feel better, seeing how other children are looked after by nursing staff..." (Susan).

Many parents felt empathy towards other families and were considerate of others in their responses:

"It’s sad. Because you know that they’ve just been through what he has been through. They’re here for a reason....and being a mother your heart melts" (Michelle).

"There were kids shouting because they were in pain, but we understand that they’ve gone through a procedure and are going through hard times, so it doesn’t annoy us or anything” (Rebecca).

Although their own child was ultimately their primary concern, participants were considerate of others during their time in the PACU, and a mutual respect developed between families.

"It’s all children and parents. We are all in the same boat" (Susan)

“‘We’ve all got sick kids" (David)

"Just when you hear the odd pain cry – you just want to run over and give them a hug. Cause I’m a parent" (Michelle)

"We understand that, it could have been us in the same spot. So yeah, it's understanding for us" (Emma)

Parents’ experiences of respect and dignity emerged through staff behaviours towards them, meeting their desire to accompany their child, and mutual respect between families.
Parents’ Experience of Information Sharing in the PACU

The second concept of the FCC framework frequently described by participants was information sharing. Participants provided many examples of ‘being told’ information, or ‘being heard’ when they requested information; these were often significant moments for them as described below.

‘Being told’

This subtheme emerged from examples of information sharing which made parents feel reassured. Participants described being told information about their child’s procedure, what was happening in the PACU and what they could expect to happen next. As one father described:

"The nurse that was there with us... didn’t leave his side and she was giving us regular updates. ‘Won’t be long now they’re just getting his room clean, we’ve got to get his paperwork in order’” (David).

Participants also expressed appreciation for nurses seeking further information from medical staff or receiving wards for them:

"The nurse was telling us what was going on. And when she didn’t know what was going on she’d say, ‘I’ll make a call’” (Michelle).

Most participants felt well informed about their delay and were aware that it could be some time before they were moved to the ward. It was also evident that when staff were unaware of how long the delay would be, efforts were made to keep families informed:

"They didn’t say it was going to be five hours, because they didn’t know that, they had to keep checking to see when his room would be available" (Nancy).

One mother described how being told the information about waiting times enabled her to plan her stay in the PACU, benefiting her and her family:

"It is always good to know how much waiting we have to do...[so] we can adjust our schedule. We want to avoid the traffic and we have to get a few things from home because Johnny vomited on me and I needed clothes. So...it was like,
‘Okay, you go now’...once we know that we are going to get the room at 1530 and we are just going to wait here for some time, we can plan” (Rebecca).

In contrast, three participants identified times they felt uninformed, which left them feeling anxious. Five parents explained they were unprepared for how their child would look and feel when they first saw them in the PACU. The words used to describe such feelings were ‘daunting’, ‘anxious’ and ‘difficult’. Two parents also explained that they were not told when their child’s surgery had gone longer than expected which made them feel nervous.

"...if an operation is extended then somebody [should] give us a call...[as] parents are expecting their child to be out of theatre...and that’s really difficult you know...when there is some complexity and that time has been extended” (Chelsea).

Participants frequently identified being told information about their child’s procedure, recovery and the process of being delayed in the PACU was important to them. Although there was frequently a degree of uncertainty around the delay participants appreciated being updated when information became available. The process of being told information often coincided with the subtheme of being heard.

‘Being heard’

Being a parent in the PACU was sometimes overwhelming and participants often wanted to ask questions. However, participants needed to feel comfortable in order to ask nurses questions they felt were “silly” or “too much”. In addition, participants indicated that sometimes when talking to medical staff, nurses ‘heard’ or interpreted what they were really asking, and were able to answer and help them accordingly. Some participants described times they felt heard by staff, and times their questions were being answered.

"They didn’t mind that I was asking questions. They were quite friendly in that way and trying to answer whatever they could” (Nancy).

"It's hard because some of the questions you feel like asking seem pretty trivial I suppose, but they still answer everything” (Dean).
‘Being told’ and ‘being heard’ were two central subthemes to information sharing in relation to FCC in the PACU during non-clinical delay.

Parents’ Experience of Participation in the PACU

The final concept of the FCC framework that emerged in the study data related to participation. Of the 15 parents interviewed, only three described ways in which they were able to participate in their child’s care. The children of these three families were aged six years and under. The ways in which participation was described involved parenting roles such as feeding and cuddling:

"It didn’t really matter because I still had to feed him anyway. I wanted cuddles. So, I just sat there with him. I was just going with the flow" (Michelle).

Another mother described she felt able to participate in her child’s care when she desired, even if it was not essential:

"They don't make you feel like an outer. You're involved the whole way. They talk you through it. It's good. If you can't do it, the nurse will do it" (Emma).

Finally, Rebecca expressed that she wanted to be able to play her child music:

"[I wanted to play] some calming music or something like that. Even if they are in pain sometimes they hear the music they may like, it’s like a mental trigger, they may calm down" (Rebecca).

While all 15 participants were invited to be with their child during their recovery from anaesthesia, only three mentioned specific examples of participation.

Discussion

This study has uncovered detail of family experiences during delayed transfer from a paediatric PACU to an inpatient ward that are important in the delivery of FCC. Parents’ experience of non-clinical delay appeared to be consistent with three components of the FCC framework: respect and dignity, information sharing and participation. However, descriptions of participation were infrequent, limited to the experience of parents who
accompanied younger children. Examples of *Collaboration* were not provided or discussed by parents, suggesting a possible gap in the delivery or perception of FCC. The findings also suggest that the quality of FCC may mitigate parental concerns related to the delay in transfer from the PACU to the ward.

*Respect and Dignity*

The findings suggest care that fostered *respect and dignity* was critical to parents. Participants felt relaxed, welcomed and had reduced feelings of vulnerability when compassion, kindness and caring gestures and words were used by staff. A study on the benefits and challenges of FCC in a paediatric ICU similarly identified parents’ gratitude for kind and thoughtful actions extended to them by nurses (Coats et al., 2018). Further, parents were appreciative when nurses exhibited humour when caring for their child. Humour has been identified as promoting child healing and reducing parent stress in a paediatric hospital environment (Majzun, 2011).

Consistent with previous research (Nadeau et al., 2016), all parents described feelings of relief associated with ‘being with’ their child after an anxious separation during surgery. While parents’ desire to ‘be with’ their child has previously been linked to parent *participation* (Lee, Li and Yates, 2015; Nadeau, et al., 2016), the findings reported here challenge this assumption. Instead, being with their child emerged in parents’ descriptions as an expression of *respect and dignity*, due to its alignment with honouring patient and family perspectives and choices within FCC (Institute for Patient- and Family-Centered Care, 2020).

Further, parents typically described ‘being with’ their child as a passive activity, rather than involvement in aspects of care delivery such as decision-making or practical care that align with previous descriptions of participation (Lee, Li and Yates, 2015; Nadeau, et al., 2016). Parental presence in the PACU is often used as a proxy for parental participation.
in nursing literature (Lee, Li and Yates, 2015; Nadeau, et al., 2016). However, these studies did not consider parents ‘being with’ their child from the perspective of providing respect and dignity within FCC.

The subtheme ‘a shared journey’ within the FCC concept of respect and dignity challenges the assumption that the dignity and respect afforded to patients and their families in healthcare settings comes only from healthcare professionals. Our findings suggest respect and dignity may have a much broader application, extending between individuals and families; hence we offer a more holistic conceptualisation than previously reported.

In this study, parents described feelings of empathy, respect and understanding towards others in the PACU. As a consequence of spending an extended period of time in a space that lacked privacy, almost all families talked about shared understanding and mutual respect for each other’s surgical journeys. Research in other care contexts has similarly highlighted the significant benefit of meeting parents of other children with similar conditions and the valuable peer support this provides (Baumbusch, Mayer and Sloan-Yip, 2019; Blinded for review). This finding provides a perspective not previously reported in the paediatric FCC literature and warrants further exploration.

**Information Sharing**

Parents commonly reported their need for information, and this emerged through two subthemes; being told about their child’s care and being heard. Despite being a key theme discussed by all participants, previous studies have not examined information sharing in the context of paediatric postoperative care in the PACU. Instead, previous research has examined information sharing in broad paediatric pre-operative care settings (Bogusaite, Razlevice, Lukosiene and Macas, 2018; Sjöberg, Svedberg, Nygren and Carlsson, 2017).
Specifically, aspects of information sharing that were valued by parents involved ‘being told’ information about the procedures that were done, the process of care delivery, and about their delay. This information reassured parents, helped them feel informed, and reduced their anxiety. ‘Being heard’ was also important. This involved feeling comfortable asking “silly” questions of nurses, staff answering questions where possible, and actively seeking information when answers were not known or immediately available.

**Participation**

The findings of this study suggest family presence in the PACU was often a passive activity, hence may differ to family perceptions of participation elsewhere in the hospital (Uniacke et al 2018). All 15 participants were present in the PACU with their child for the duration of their stay. While being present may be considered a form of participation, only three participants provided explicit examples of active participation in their child’s care during their experience of delay in the PACU.

This finding was surprising, as reference to parental participation in the PACU is evident in much of the literature (Lee, et al., 2015; Nadeau, et al., 2016; Sjöberg, et al., 2017). The point of differentiation for the three parents that described participation was they all had children that were aged six years or under and described aspects of participation that were typical of their parental role, including feeding, cuddling and playing music with their child. Participation in non-physical care, such as decision-making, was not described. Interestingly, previous research suggests that perceptions regarding participation may differ between parents and nurses (Tourigny, Chapados and Pineault, 2005). Further exploration is needed to determine parent perceptions and preferences around participation in the PACU environment.
Collaboration

Data analysis did not provide any findings to demonstrate family collaboration in the paediatric PACU, despite the IPFCC advocating collaboration as a key concept of FCC (IPFCC, 2020). This may be because the IPFCC links collaboration to involvement in policy and program development and implementation, along with facility design and professional education; topics that were not raised by participants in this study. This finding raises a question about how collaboration is operationalized in direct care settings such as the PACU. Similar to previous research in the perioperative setting (Sjöberg, et al., 2017), the vulnerability of parents, and the short and transient nature of PACU care, may assist to explain why collaboration with families was not evident.

Parental collaboration and participation in PACU care were identified as possible gaps in delivery of FCC during delay. These concepts are worthy of further investigation both in relation to their importance in the PACU setting and how they can be enacted. Further research is needed to understand the shared journey of parents with other parents in the PACU, as this emerged as a potential source of support for families in this clinical setting.

Limitations

The small sample size from one hospital was a key limitation. While data saturation was achieved in some concepts, we did not set out to achieve theoretical saturation, but rather to provide sufficient examples of the pre-determined themes or codes in the data until new data become redundant (Saunders, et al., 2018). It is possible the research questions may have limited collection of data concerning the presence or absence of collaboration, potentially explaining the lack of collaboration identified in this study. The collection of additional data may contribute new information, and offer new insights to study findings where saturation
was not achieved, particularly in relation to participation and collaboration aspects of FCC in the PACU.

**Implications for practice**

Currently in Australia, there is limited evidence available to inform policy about the ideal timeframe for a paediatric patient to be transferred from the PACU to an inpatient ward. This has led to variability in practice driven by organisational priorities rather than principles of paediatric care quality. The findings of this study provide important insights about parent perceptions of FCC in the PACU during non-clinical delay.

This study highlighted respect and dignity and information sharing as dimensions of FCC commonly identified by parents in the PACU. Conversely, limited data about family experiences in relation to the participation and collaboration may indicate either gaps in current care or may imply these are not significant elements of FCC for parents in this care setting. This information may support further research as well as education and training for nurses to ensure the needs of families are met during delays in the PACU.

**Conclusion**

This study found that parents commence on an emotional journey when their child undergo surgery. The dominant theme described by participants was how respect and dignity were experienced during a non-clinical delay, most evident through participant’s descriptions of being with their child after surgery, the caring nature of staff, and through sharing the experience with other families. Similar to previous research, parents also frequently described the act of information sharing, a second concept of the FCC model. Participation and collaboration were rarely discussed by participants and provide the basis for further research on this topic. This research contributes to the limited literature about the impact of non-clinical delay on families in the PACU.
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Conflicts of interest

The authors declare there are no conflicts of interest.
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Blinded for review


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Table 1: Semi-structured interview guide

Demographic Questions

What sex is your child?

What age is your child?

How many times has your child previously experienced care in the post anaesthetic care unit (PACU)?

How many of those instances were at ‘the study site’?

What procedure did your child have done this time?

What ward did your child go to following their stay in the PACU?

How long were you delayed in the PACU?

General Questions

Can you tell me about your experience in the PACU?

Can you give me an example of what was positive about your experience?

Can you give me an example of what could have been done better during your experience?

Can you tell me how that made you feel?

What advice would you give other parents visiting the PACU?

How was information communicated to you during your experience?

Can you tell me about the PACU environment?
## Table 2. Participant characteristics and pseudonyms

<table>
<thead>
<tr>
<th>Parent/s*</th>
<th>Child*</th>
<th>Child age</th>
<th>Child sex</th>
<th>Number of times the child has had a GA</th>
<th>Surgical procedure speciality</th>
<th>Post-operative Ward</th>
<th>Delay in PACU</th>
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</thead>
<tbody>
<tr>
<td>Emma and Dean</td>
<td>Jesse</td>
<td>6 years</td>
<td>Male</td>
<td>4</td>
<td>Cardiac</td>
<td>Cardiac / Surgical</td>
<td>84 mins</td>
</tr>
<tr>
<td>Susan</td>
<td>Joey</td>
<td>14 years</td>
<td>Female</td>
<td>4</td>
<td>General Surgery</td>
<td>Adolescent / Surgical</td>
<td>77 mins</td>
</tr>
<tr>
<td>Michelle and Chris</td>
<td>Jason</td>
<td>7 months</td>
<td>Male</td>
<td>1</td>
<td>Cardiac</td>
<td>Cardiac / Surgical</td>
<td>80 mins</td>
</tr>
<tr>
<td>Rebecca and Tony</td>
<td>Johnny</td>
<td>3.5 years</td>
<td>Male</td>
<td>3</td>
<td>Cardiac and General Surgery</td>
<td>Cardiac / Surgical</td>
<td>53 mins</td>
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<tr>
<td>David</td>
<td>Jack</td>
<td>10.5 years</td>
<td>Male</td>
<td>2</td>
<td>Orthopaedic</td>
<td>Short-stay Surgical</td>
<td>97 mins</td>
</tr>
<tr>
<td>Kate</td>
<td>Jim</td>
<td>12 years</td>
<td>Male</td>
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<td>Orthopaedic</td>
<td>Long-stay surgical</td>
<td>135 mins</td>
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<td>Chelsea</td>
<td>Joanne</td>
<td>16 years</td>
<td>Female</td>
<td>5</td>
<td>General Surgery</td>
<td>Long-stay surgical</td>
<td>188 mins</td>
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<td>Nancy and Eddie</td>
<td>Josie</td>
<td>10 years</td>
<td>Female</td>
<td>2</td>
<td>General Surgery</td>
<td>Long-stay surgical</td>
<td>260 mins</td>
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<tr>
<td>Tim</td>
<td>Joshua</td>
<td>6 years</td>
<td>Male</td>
<td>4</td>
<td>Orthopaedic Surgery</td>
<td>Long-stay surgical</td>
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<td>Jacqui and Paul</td>
<td>Jeremy</td>
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<td>Male</td>
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<td>General Surgery</td>
<td>Neonatal Ward</td>
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</tr>
</tbody>
</table>

Note: * Pseudonyms
Table 3: Themes and subthemes derived from participant experiences of delay in PACU

<table>
<thead>
<tr>
<th>Family-centred care framework concepts</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect and dignity</td>
<td>Caring behaviour of staff</td>
</tr>
<tr>
<td></td>
<td>Being present with their child in the PACU</td>
</tr>
<tr>
<td></td>
<td>A journey shared with other families</td>
</tr>
<tr>
<td>Information sharing</td>
<td>Being told</td>
</tr>
<tr>
<td></td>
<td>Being heard</td>
</tr>
<tr>
<td>Participation</td>
<td>Contributing to care</td>
</tr>
</tbody>
</table>
Author/s:
Taranto, J;Thornton, R;Lima, S;Redley, B

Title:
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