

1-17-2023

## Shifting Perspectives: A Qualitative Study to Understand Family Expectations at the Time of Their Child's Admission

RosaMarie Maiorella  
Avital Fischer  
Sumeet L. Banker

Follow this and additional works at: <https://aah.org/jpcrr>



Part of the [Critical Care Commons](#), [Health and Medical Administration Commons](#), [Health Services Research Commons](#), and the [Pediatrics Commons](#)

### Recommended Citation

Maiorella R, Fischer A, Banker SL. Shifting perspectives: a qualitative study to understand family expectations at the time of their child's admission. *J Patient Cent Res Rev*. 2023;10:13-20. doi: [10.17294/2330-0698.1947](https://doi.org/10.17294/2330-0698.1947)

Published quarterly by Midwest-based health system Advocate Aurora Health and indexed in PubMed Central, the Journal of Patient-Centered Research and Reviews (JPCRR) is an open access, peer-reviewed medical journal focused on disseminating scholarly works devoted to improving patient-centered care practices, health outcomes, and the patient experience.

# Shifting Perspectives: A Qualitative Study to Understand Family Expectations at the Time of Their Child's Admission

RosaMarie Maiorella, MD,<sup>1,2</sup> Avital Fischer, MD,<sup>3</sup> Sumeet L. Banker, MD, MPH<sup>4</sup>

<sup>1</sup>Division of Hospital Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, OH; <sup>2</sup>Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH; <sup>3</sup>Division of Pediatric Palliative Care, Maine Medical Center, Barbara Bush Children's Hospital, Portland, ME; <sup>4</sup>Department of Pediatrics, Columbia University Vagelos College of Physicians and Surgeons and New York-Presbyterian Morgan Stanley Children's Hospital, New York, NY

---

<b>Purpose</b>	Patient-centered approaches to health care acknowledge the important role that families have in patients' lives. Shared expectations between families and providers have the potential to improve patient and family experience, hospital care, and outcomes. We aimed to understand families' expectations for their child's admission from the vantage point of the start of a hospital stay.
<b>Methods</b>	This qualitative research studied families of hospitalized children at a large pediatric tertiary care center. Family members were approached if their child was admitted to the general pediatrics team, was under 18 years of age, had a length of stay less than 5 days, and had an English-speaking family member present. Semi-structured interviews were conducted by study personnel during the inpatient stay and audio-recorded. Written transcripts were independently coded by multiple investigators to generate codes, which were reconciled via triangulation. Codes were translated into broad themes to provide insight into the views of the study population. An accompanying survey included demographic questions.
<b>Results</b>	We conducted 20 interviews with 23 parents of hospitalized children. Participants were 83% female, 35% White, 22% Black, 35% Hispanic, and 70% publicly insured. Participant responses led to identification of 4 themes: 1) setting the stage; 2) building trust and credibility; 3) partnering with families; and 4) maintaining frequent and transparent communication.
<b>Conclusions</b>	Findings suggest that families' priorities and expectations at the start of their inpatient stay focus on issues of trust, partnership, and communication. These concepts may help providers strengthen communication and create more meaningful partnerships with families. ( <i>J Patient Cent Res Rev</i> . 2023;10:13-20.)
<b>Keywords</b>	pediatric hospital medicine; patient-centered care; family-centered care; hospital communication; parent expectations; qualitative research

---

Families have a critical role in the medical care of their children. Multiple medical societies, including the American Academy of Pediatrics, National Academy of Medicine, and Healthy People 2010, have adopted the concept of patient- and family-centered care (PFCC) as an important aspect of quality care.<sup>1</sup> Collaboration and effective communication among patients, families, and physicians is paramount.<sup>2</sup>

A large body of research has emerged on the outcomes of PFCC and, specifically, on family-centered rounds,<sup>3-6</sup> reporting the many benefits of PFCC and effective

communication with families of hospitalized patients. While prior studies have demonstrated the importance of communication with families during a child's hospitalization, particularly the transition from hospital-to-home,<sup>7,8</sup> few studies have focused on communication and expectation-setting at the start of the inpatient stay. Family perspectives about the role of health care professionals in different settings influenced their preadmission care and health care utilization.<sup>9</sup> Understanding family expectations has the potential to improve hospital communication and associated outcomes, such as length of stay and family satisfaction scores.

Hospitalizations can be traumatic for families due to lack of familiarity about the hospital setting, workflows, and roles of care team members. The start of the inpatient stay represents an opportunity to set the stage with families and establish shared expectations for the hospital stay that

---

Corresponding author: RosaMarie Maiorella, Cincinnati Children's Hospital Medical Center, 3333 Burnet Ave., Cincinnati, OH 45229 (rosamarie.maiorella@cchmc.org)

may benefit patients and providers alike. The goal of this study was to achieve a better understanding of families' expectations for their child's hospitalization from their vantage point at the start of the inpatient stay.

## **METHODS**

We performed a study of families of children hospitalized at Columbia University affiliate NewYork-Presbyterian Morgan Stanley Children's Hospital (New York, NY), an urban-based 269-bed facility. Using a qualitative research approach, the study aimed to capture family priorities and expectations in their own words and free from the bias of medical providers. This study protocol was approved by Columbia's institutional review board.

### **Subject Eligibility and Protection**

Families of children admitted to the general pediatrics service between January and April 2019 were eligible for recruitment provided the patient was under the age of 18 years, had a length of stay less than 5 days at the time of recruitment, and had at least 1 family member present who spoke English fluently. Length of stay at the time of enrollment was limited to a maximum of 5 days to ensure inclusion of a broad spectrum of patient complexity while ensuring that the start of the inpatient stay was still fresh in participants' minds. Subjects were limited to those fluent in English since interviewers were all fluent in English. Given that interviews would be semi-structured, it was felt that this would lend itself to the most accurate results rather than relying on an interpreter. Additionally, patients must have been admitted either through the emergency room or as a direct admission. To help focus the interviews from the start of the inpatient stay, patients were excluded if transferred from another service or from the pediatric intensive care unit. Purposive sampling was used to identify subjects who met these criteria. No incentives were offered for participation.

It was stated during the consent process that the team member conducting the interview had no role in the patient's medical care and would not be communicating the results of the interview with the medical team. All participants were de-identified prior to analysis of interview transcript, no protected health information was collected, and all audiovisual recordings were stored on an encrypted laptop. Subjects included parents, legal guardians, or primary caretakers, henceforth referred to as "family (member)."

### **Semi-Structured Interview Guide**

Once subjects consented to participation, semi-structured interviews were conducted by study personnel during the inpatient stay. Literature review revealed 1 previous study<sup>9</sup> that provided a basis for the development of our

guide, though only 2 of the 7 published domains matched the goals of our study. Therefore, using a conceptual framework of family-centered care,<sup>2,10</sup> an open-ended, semi-structured interview guide was developed by the research team; this guide contained prompts and open-ended questions that were posed to all respondents, as well as optional probes that investigators could pose to subjects to explore individual responses with further depth. Question domains included: 1) the experience of the decision to admit; 2) communication of information regarding admission; 3) communication of illness-related details from the medical team; 4) orienting to team member roles; and 5) challenges associated with the admission process and opportunities for improvement.

The interview guide was reviewed by 1 faculty member with expertise in hospital medicine and 2 parent members of our institution's Family Advisory Council (FAC), all of whom helped establish content validity given their experience and expertise in family-centered care. Adjustments were made to the guide based on their feedback. Subsequently, the interview guide was piloted for comprehension and literacy by 3 additional members of the FAC and 3 family members of hospitalized children who would have met study inclusion. Interviews were audio-recorded and transcribed verbatim. A multiple-choice survey included demographic questions.

### **Qualitative Data Analysis**

Thematic analysis was performed using an inductive approach.<sup>11</sup> Written transcripts were independently analyzed by all investigators to generate codes. The team was comprised of 3 physicians with experience on the inpatient floor, including 1 with formal training in qualitative methods, who provided training to other members of the team. A preliminary codebook was designed using established guidelines.<sup>11</sup> As new data were collected, the codebook was revised in an iterative fashion and applied to the whole data set. To develop credibility and dependability, investigators met regularly to discuss coding decisions and resolve differences through consensus. These codes were grouped as common patterns emerged and translated into broad themes.

A total 20 interviews were conducted that corresponded to 20 patients; in 3 cases, 2 parents participated (in a joint interview). Through the process of conducting and coding these interviews, the research team determined that thematic saturation had been achieved and additional interviews were unlikely to reveal new themes. Member-checking was performed with key stakeholders in the FAC. To ensure confirmability, an audit trail was maintained by study personnel and a codebook is available upon request.

## RESULTS

In all, 23 family members were interviewed, including 19 mothers and 4 fathers. Most family members were non-Hispanic and had at least a high school degree or equivalent. The majority of patients received public health insurance and had never been admitted to the hospital before, though over one-third of family members reported having another child admitted to the hospital at least once. Interviews ranged in length from 10 to 30 minutes. Additional demographic information is displayed in Table 1.

Four major themes emerged regarding the expectations and communication between medical providers and family members: 1) setting the stage; 2) building trust and credibility; 3) partnering with families; and 4) maintaining frequent and transparent communication. Each theme is explored in detail in this section, with accompanying quotations shared within the narrative and in Table 2.

### Theme 1: Setting the Stage

It was important to families that providers understood their perspective at the start of their inpatient stay in order to provide context on how to approach them regarding the hospital stay. Two subthemes were related to this theme of setting the stage for the hospitalization: emotional response, and prior familiarity with the system and providers. Some family members worried that they did something wrong to lead to hospitalization or that they should have brought their child in sooner; one stated, *“As a first-time mom I don’t want to see [her admitted]. It makes me feel like I’ve done something wrong for her to be in the hospital.”* Others felt a sense of relief that their child would be admitted; one said, *“I felt relieved because honestly I wasn’t sure if he was okay to take back home.”*

Families’ previous experience with hospitalizations informed their familiarity with the schedule and different providers in an academic teaching hospital (rounds, meals, labs, vitals, etc). Some felt that they knew what to expect based on their child’s previous hospitalizations, and this also led to increased comfort in advocating for their child’s care within this system. One explained, *“I know lab tests take about two to three hours to get results. And if they don’t come to me, I go to them. I don’t just stay there waiting for them to come.”* Other families lacked familiarity with the composition of the medical team. *“I didn’t pay attention to that. I heard the word ‘senior,’ and I heard the word ‘supervisor.’ They all sounded like the same status.”*

### Theme 2: Building Trust and Credibility

Families noticed when providers took actions to establish trust and credibility from the start of their inpatient stay and continuing throughout the admission. This was

**Table 1.** Study Participant Demographics

<b>Parents (n=23)</b>	<b>n (%)</b>
<b>Relationship to patient</b>	
Mother	19 (83)
Father	4 (17)
<b>Other children’s admissions</b>	
N/A	8 (35)
Never	7 (30)
1 time	3 (13)
2 times	1 (4)
3 times	3 (13)
More than 3 times	1 (4)
<b>Race</b>	
White	8 (35)
Black or African American	5 (22)
Asian	2 (9)
Other	7 (30)
Declined to answer	1 (4)
<b>Ethnicity</b>	
Hispanic	8 (35)
Non-Hispanic	14 (61)
Declined to answer	1 (4)
<b>Highest level of school or highest degree</b>	
Did not start high school	0 (0)
Did not complete high school	1 (4)
High school degree or equivalent (eg, GED)	9 (39)
Associate’s degree, bachelor’s degree, graduate degree	13 (57)
<b>Patients (n=20)</b>	<b>n (%)</b>
<b>Admission source</b>	
Admission from emergency department	19 (95)
Direct admission	1 (5)
<b>Number of previous admissions</b>	
None	12 (60)
1	2 (10)
2	0 (0)
3	0 (0)
More than 3	6 (30)
<b>Outpatient specialists involved in child’s care</b>	
None	10 (50)
1	1 (5)
2	4 (20)
3	1 (5)
More than 3	4 (20)
<b>Primary health insurance</b>	
Public/Medicaid	14 (70)
Private	6 (30)
Self-pay/No insurance	0 (0)

**Table 2.** Qualitative Themes, Subthemes, and Quotations

Theme	Subtheme	Representative quotation
Setting the stage	Emotional response	<p><i>"I got nauseous to know that my daughter was going to be admitted ... it was more serious than we thought."</i></p> <p><i>"[The admission] kind of shook me ... it makes me feel ... like I wasn't taking care of her the way I was supposed to."</i></p>
	Prior familiarity with system and providers	<p><i>"I know that every once in a while they'll introduce themselves as either resident or attending, and I don't even know the distinction. But to me it's just like ... different doctor."</i></p> <p><i>"I gave birth to him in this hospital so I expected long hours, tedious, inconclusive results maybe, and maybe to lay down in an uncomfortable chair and spend the whole night watching over him. And that's probably what I expected."</i></p> <p><i>"She's been admitted multiple times ... I ask a lot of questions ... I want to know about the reasons why before she gets a medicine. ... And if I see something wrong, I will complain to the right people."</i></p>
Building trust and credibility	Providers showed comfort and attention to needs	<p><i>"The fact that when I got frustrated, they would be very comforting and very attentive not just to my daughter, but also to my feelings of the situation."</i></p> <p><i>"... [the attending physician] is the person, candidly, in whom I have the most faith and trust because of the dialogue that we've had with him, the open communication, the clarity ... and how thoughtful he has been."</i></p>
	Importance of providing a consistent and unified message	<p><i>"One doctor would tell me one thing and it's totally different from what this doctor would have already told me."</i></p> <p><i>"Between the ER and many consulting services and gen med and the nurses, the physicians updated me. And when I saw the nurse and thought I would tell her something, she already knew it."</i></p> <p><i>"Everyone came at a different time, but it looks like everyone was on the same page. And the primary team had called all the consults so everybody came this morning. So, looks like they're on top of it in a short amount of time."</i></p>
Partnering with families	Families feel validated for their concerns	<p><i>"I tend to have a lot of questions and [the attending] was very patient in answering all my questions ... he was not at all dismissive. In fact, he's taken all our concerns seriously."</i></p> <p><i>"I was relieved [to be admitted]. Just because I thought she was sick enough ... you know, as opposed to ... having to come back."</i></p> <p><i>"Especially in the ED, child life – they're absolutely wonderful. ... They stayed the entire time through what we were going through ... it is so helpful."</i></p>
	Families as participants in decision-making	<p><i>"They explain to me, and we make a decision together."</i></p> <p><i>"Sometimes if they get a test they won't even tell you why. But I'm the Mom who will ask what they're getting and why ... but they don't really like it if you're involved in that way."</i></p>
Maintaining frequent and transparent communication	Providers explained what was happening	<p><i>"They tell me the information and then explain it ... that helps having more layman's terms."</i></p> <p><i>"[Explain] more about what the tests mean. Because to say to a parent, oh, their CBC was high or low or their neutrophil count was off, I don't know what that means. I learned that from googling it and looking it up so now I know what it means. But to have someone explain that to me."</i></p>
	Timely communication	<p><i>"I understand certain things take time. But you can still try to communicate something. Give me something."</i></p> <p><i>"I think I was afraid there was more information that we weren't getting ... that there was something they were concerned about that they weren't expressing to us. But that was just parents' neurosis I suppose."</i></p> <p><i>"They kept coming back and giving me updates very, very often. So I really was very appreciative of that because I was in an unknown limbo when you're trying to understand what the status is and what's going to happen next ... even if it's the same result or the same feedback ... it almost makes me feel like you're not being forgotten."</i></p>

CBC, complete blood count; ED, emergency department; ER, emergency room.



important as they handed over control of their child to unfamiliar medical professionals. Two subthemes described here included: comfort and attention to the needs of child and family, and providing a consistent and unified message. Families felt that providers genuinely cared about them and their child, and this led to comfort with the team. As one family member expressed, *“When I got frustrated, they would be very comforting and very attentive not just to my daughter, but also to my feelings.”*

Families expressed trust and confidence when the broader team taking care of the patient, including nurses and physicians of different specialties, provided a unified message. *“They took time and explained it. One attending made sure she heard back from the consulting services before she had us come up to the floor. She wanted to make sure the plan was clear. So it wasn’t something I would have to worry about at 3 in the morning.”*

Conversely, when providers did not have a unified message or gave the parent different information, families expressed distrust in the team. As one family member explained: *“When he got sick from the medication I talked to his [specialist] so they made an adjustment. But the [general pediatrics] team didn’t seem to be concerned ... it’s very confusing. ... I have no confidence that I’m getting any of the right information.”*

### **Theme 3: Partnering With Families**

Families described feeling satisfied with their care when they felt included in decision-making and when their input and expertise as a caretaker was valued, both in the initial decision to admit to the hospital and as decisions were made throughout the hospitalization. Specifically, two subthemes emerged: families feel that their concerns are validated, and families serve as participants in decision-making. Families felt that providers understood and addressed caretaker priorities — whether that was the family member’s physical comfort or transportation needs or other nonclinical aspects of their child’s care, such as child life and schooling. For example, one family member was pleasantly surprised when their concern regarding missed school was addressed, stating *“I almost fell out of my chair the first time I heard someone walk in and be like, ‘oh, can we talk about schooling and what schooling she’s missing?’”*

Families valued inclusion in decision-making and working as a team for the good of the patient. For example, a family member explained the decision-making process when deciding when to transition a child from continuous positive airway pressure (CPAP) to room air: *“They asked ‘Do you agree that this child doesn’t need the machine?’ I said, yes, he doesn’t need it ... we all agreed together.”*

Some of the negative experiences shared by families related to their exclusion from the decision-making process. When asked what changes they would make to the medical team’s communication, one family member responded: *“That they listen to the parents.”*

### **Theme 4: Maintaining Frequent and Transparent Communication**

Families valued open, honest, and timely communication. Specific subthemes included: the importance of providers explaining what was happening, and timely communication. Some families felt well informed of plans for their child and expressed what a difference it made when providers were not rushed and explained what was happening for their child. *“So far I’ve met three different teams, everybody has come and explained everything. I never felt they were in a rush or anything, you see the chairs — they sit, they have the time ... they explained, they listened ... I noticed they are not in a rush.”*

Family members also commented on the importance of timely check-ins, even if there were no new updates. One stated, *“They have been very thorough in their explanations. ... We have someone coming in explaining everything, checking the status every 45 minutes to an hour.”* The transparency of communication also led families to trust that providers were not hiding anything from them. In fact, families interpreted it as a position of strength when the medical team admitted that there was something they did not know. As one family member explained: *“We actually appreciated that he was being honest. ... It seemed pretty obvious that there was no way he could know, so I think it’s an acknowledgment of strength to say ‘I don’t know.’”*

## **DISCUSSION**

Hospitalizations are stressful and intimidating experiences for children and families as they adjust to an unfamiliar environment while coping with a sick child and uncertain next steps. Our study found 4 overall themes: Families stressed the importance of providers understanding their experiences with their children’s illnesses, building trust and credibility through a holistic approach and unified message, accepting families’ expertise as primary caregivers by including them in decision-making, and maintaining a transparent and timely line of communication. This aligned with prior studies focusing on family-centered rounds and the hospital-to-home transition that have pointed to strong family communication and relationship-building with providers as drivers of successful experiences and good long-term outcomes.<sup>12,13</sup> While we expected responses to uniquely address expectations at the start of the inpatient stay, we found that responses applied to the hospitalization as a

whole. This suggests that families did not necessarily view the start of the inpatient stay as a distinct phase of care but rather a continuum of care, with common important themes applicable throughout the encounter. A better understanding of families' expectations will help guide future interventions to improve the transition into the hospital setting, set the tone for a strong relationship between providers and family, and potentially improve outcomes around patient and family satisfaction.

Interviewees highlighted the importance of provider understanding of the presence or absence of the family's prior experience with the medical system as well as in recognizing the emotional toll of parenting a sick child. An appreciation of these factors establishes a positive starting point and sets the stage for the remainder of the hospitalization. Families who had never experienced a hospitalization expressed confusion around the structure of the day, whereas families who had prior experience were more prepared. As supported in the literature, we found that some families expressed confusion about specific roles of members of the medical team.<sup>8</sup> However, this was not perceived to be as much of a negative as a lack of understanding of the day's schedule. More frustration emerged when families were unsure about when testing would be completed, when results would be conveyed, and when they would see their doctors. Therefore, while orienting families to the medical team is important and other work has led to improvements,<sup>14</sup> the families we studied suggested different priorities. Developing clear scripts for orienting families to the structure of a hospital stay, while also recognizing their struggles and troubles to get to this point, may help providers work with families to effectively set the stage for the hospital stay.

Establishing trust early is paramount to families who must cede care of their sick child to unfamiliar providers. Families emphasized the positive feelings they had toward providers whom they perceived genuinely cared about the well-being of their child. This perception emerged from providers who responded with kindness to both child and parents, and who appeared unrushed and attentive in their interactions. Interestingly, families were more impressed by seamless provider-to-provider communication and a single unified message over any single person's knowledge base. This is particularly salient as hospitalized pediatric patients become more complex, often requiring input from multiple subspecialists.<sup>15</sup> Though this can be challenging given the competing priorities that medical providers face in a fast-paced inpatient setting, making the deliberate effort to connect with families and practice closed-loop communication with all members of the medical team can improve the patient and family experience while also reducing

communication failures and poor outcomes.<sup>16-18</sup> These findings support ongoing efforts to include additional members of the medical team during rounds, as they play a significant role in reinforcing a unified message<sup>8,19</sup> and contributing positively to experience.<sup>20</sup>

Partnering with families is a core element of PFCC,<sup>4</sup> and this process should begin at the start of the inpatient stay. Families were comforted by an appreciation of their concerns as providers sought to form a care alliance. Families emphasized how much they valued the inclusion of team members such as child life specialists and hospital teachers. Providers should recognize the important role of nonmedical activities in the healing process for children as well as the expertise offered by professionals in these fields.<sup>21,22</sup> Studies indicate that child comfort is a key factor in families' willingness to recommend a hospital.<sup>20</sup> As has been highlighted in other studies, families feel more positive and trusting toward a team that values the parents' own expertise in their child.<sup>13</sup> Therapeutic partnerships should be tailored to each family based on established principles and best practices, including but not limited to understanding family and patient's emotional needs, showing respect for parents alternative values and beliefs, and being accessible to parents as questions arise.<sup>23</sup>

Accurate and effective communication is vital in providing high-quality care during child hospitalization and influences family experience.<sup>20,24</sup> Families acknowledged that diagnostic study results take time and that providers may not have all the answers — they valued transparency and frequent updates rather than a single, later point of communication with “all the answers” provided. Families expressed frustration when they felt that they waited excessively for results or when they perceived that information may have been withheld. Additionally, it was the perception of an unrushed provider that led families to further build trust in their medical team. This perspective could guide providers to set expectations regarding check-ins with families during start of the inpatient stay, even if diagnostic studies are not yet completed. Providers may also choose to utilize alternate forms of information-sharing, such as patient portals in which patients and families may be able to conveniently access results when appropriate.<sup>25</sup> A multifaceted approach to timely communication with families can minimize stress and uncertainty, thereby improving the patient and family experience.

### Limitations

This study has several limitations. First, our sample was limited to a single academic institution and thus may limit transferability of findings. However, our interview questions were not institution-specific and instead probed

general feelings toward admission and communication. Second, our sample excluded families with limited English proficiency, thereby excluding important perspectives related to cultural differences and language barriers. Despite this limitation, the sample was racially and ethnically diverse. Third, we included families up to 5 days after admission, which may lead to recall bias regarding their feelings from the start of the inpatient stay. Lastly, we acknowledge that the interviewer's hospital affiliation may have biased participants to be more positive than they might otherwise have been, though we attempted to mitigate this by making clear that interviewers had no role in the patient's medical team.

## CONCLUSIONS

This study is one of the first to focus on communication from the start of a pediatric inpatient hospital stay. The complementary themes identified may help provide a framework for setting expectations and bilateral communication with families at the time of admission. Future directions should include testing these themes on a broader population and exploring their application toward education of providers and development of family-focused orientation materials. It will be important to keep these themes in mind as providers continue to advance patient- and family-centered care.

### Patient-Friendly Recap

- When patients and providers share the same expectations regarding care, health outcomes and patient experiences may improve.
- Authors interviewed parents within the first 5 days of their child's hospital stay to learn what expectations they had upon arriving at the hospital and whether those had been met.
- Analysis of family responses highlighted the importance of setting the stage for pediatric hospital stays, building trust and credibility, treating parents as partners in their child's care, and maintaining frequent communication.
- Reconciling a shared set of priorities for pediatric hospitalizations can help providers deliver better patient- and family-centered care.

### Author Contributions

Study design: all authors. Data acquisition or analysis: all authors. Manuscript drafting: Maiorella. Critical revision: Fischer, Banker.

### Conflicts of Interest

None.

## References

1. Kuo DZ, Houtrow AJ, Arango P, Kuhlthau KA, Simmons JM, Neff JM. Family-centered care: current applications and future directions in pediatric health care. *Matern Child Health J.* 2012;16: 297-305. [CrossRef](#)
2. Committee on Hospital Care, American Academy of Pediatrics. Family-centered care and the pediatrician's role. *Pediatrics.* 2003;112:691-7.
3. Muething SE, Kotagal UR, Schoettker PJ, Gonzalez del Rey J, DeWitt TG. Family-centered bedside rounds: a new approach to patient care and teaching. *Pediatrics.* 2007;119:829-32. [CrossRef](#)
4. Sisterhen LL, Blaszak RT, Woods MB, Smith CE. Defining family-centered rounds. *Teach Learn Med.* 2007;19:319-22. [CrossRef](#)
5. Shields L, Pratt J, Hunter J. Family centred care: a review of qualitative studies. *J Clin Nurs.* 2006;15:1317-23. [CrossRef](#)
6. Mittal VS, Sigrest T, Ottolini MC, et al. Family-centered rounds on pediatric wards: a PRIS network survey of US and Canadian hospitalists. *Pediatrics.* 2010;126:37-42. [CrossRef](#)
7. Solan LG, Beck AF, Brunswick SA, et al. The family perspective on hospital to home transitions: a qualitative study. *Pediatrics.* 2015;136:e1539-49. [CrossRef](#)
8. Solan LG, Beck AF, Shardo SA, et al. Caregiver perspectives on communication during hospitalization at an academic pediatric institution: a qualitative study. *J Hosp Med.* 2018;13:304-11. [CrossRef](#)
9. Leyenaar JK, Rizzo PA, O'Brien ER, Lindenauer PL. Paediatric hospital admission processes and outcomes: a qualitative study of parents' experiences and priorities. *BMJ Qual Saf.* 2018;27:790-8. [CrossRef](#)
10. Institute for Patient- and Family-Centered Care. What is patient- and family-centered care? Accessed June 5, 2022. <https://www.ipfcc.org/about/pfcc.html>
11. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval.* 2006;27:237-46. [CrossRef](#)
12. Cox ED, Jacobsohn GC, Rajamanickam VP, et al. A family-centered rounds checklist, family engagement, and patient safety: a randomized trial. *Pediatrics.* 2017;139(5):e20161688. [CrossRef](#)
13. Rea KE, Rao P, Hill E, Saylor KM, Cousino MK. Families' experiences with pediatric family-centered rounds: a systematic review. *Pediatrics.* 2018;141(3):e20171883. [CrossRef](#)
14. Unaka NI, White CM, Sucharew HJ, Yau C, Clark SL, Brady PW. Effect of a face sheet tool on medical team provider identification and family satisfaction. *J Hosp Med.* 2014;9:186-8. [CrossRef](#)
15. Cohen E, Kuo DZ, Agrawal R, et al. Children with medical complexity: an emerging population for clinical and research initiatives. *Pediatrics.* 2011;127:529-38. [CrossRef](#)
16. Melnyk BM. Intervention studies involving parents of hospitalized young children: an analysis of the past and future recommendations. *J Pediatr Nurs.* 2000;15:4-13.
17. Smith L, Daughtrey H. Weaving the seamless web of care: an analysis of parents' perceptions of their needs following discharge of their child from hospital. *J Adv Nurs.* 2000;31:812-20. [CrossRef](#)
18. Snowdon AW, Kane DJ. Parental needs following the discharge of a hospitalized child. *Pediatr Nurs.* 1995;21:425-8.
19. Rosen P, Stenger E, Bochkoris M, Hannon MJ, Kwok CK. Family-centered multidisciplinary rounds enhance the team approach in pediatrics. *Pediatrics.* 2009;123:e603-8. [CrossRef](#)



20. Feng JY, Toomey SL, Elliot, MN, Zaslavsky AM, Onorato SE, Schuster MA. Factors associated with family experience in pediatric inpatient care. *Pediatrics*. 2020;145(3):e20191264. [CrossRef](#)
21. Lowenstein DB, Cervenka MC, Mitchell L, Stewart N, Kossoff EH, Kelley SA. Child life services in an epilepsy monitoring unit. *Clin Pediatr (Phila)*. 2018;57:1269-74. [CrossRef](#)
22. Committee on Hospital Care and Child Life Council. Child life services. *Pediatrics*. 2014;133:e1471-8. [CrossRef](#)
23. Rapp RC, Pascoe J. Clarifying parents' and pediatricians' views of partnership. *J Am Board Fam Med*. 2016;29:563-71. [CrossRef](#)
24. Khan A, Furtak SL, Melvin P, Rogers JE, Schuster MA, Landrigan CP. Parent-provider miscommunications in hospitalized children. *Hosp Peds*. 2017;7:505-15. [CrossRef](#)
25. Dendere R, Slade C, Burton-Jones A, Sullivan C, Staib A, Janda M. Patient portals facilitating engagement with inpatient electronic medical records: a systematic review. *J Med Internet Res*. 2019;21(4):e12779. [CrossRef](#)

© 2023 Advocate Aurora Health, Inc.