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Family involvement in PICU Rounds: Reality or Rhetoric?

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Key-words: Family-centered care; critically ill; child; medical rounds; parent.

In pediatrics, the family are the centre of the child's life, and crucial to their psychosocial wellbeing and their recovery from illness. Despite the impetus to improve family centered care in pediatric and neonatal intensive care units, practices are not consistent worldwide. In most North American, Antipodean and Northern European PICUs family visitation is not restricted. However, in some countries restrictions still apply to family access, preventing the delivery of family centered care (1, 2). Even if families are present in the PICU, their involvement in medical rounds is often restricted or not encouraged. Yet, between 85 – 100% of family members in intensive care settings would choose to be present for rounds, if given the choice (1). More specifically, a recent study in PICU found family members believed that their presence during rounds would improve the care of their child; 100% of parents who were present during a round and 87% of parents who were absent during a round (3).

There is increasing evidence that family-centered rounds (FCR) increases families' feelings of inclusion and respect, satisfaction with care and promotes a better understanding of their child's care, without significantly prolonging round duration or impairing teaching opportunities (4-6). However, healthcare providers continue to have mixed views about parental participation. Concerns are expressed by healthcare staff about patient confidentiality, mostly in non-single patient room accommodation, increasing the duration of rounds and limiting teaching and patient discussions (1, 7, 8). However, the concerns staff express about confidentiality, are not shared by parents (7, 9, 10) . In fact, one study found parents felt confidentiality and intimacy were

respected better during the bedside rounds, compared to the conference room (5). In addition, we know language barriers impact negatively on healthcare (11), and parents who do not speak the local language inevitably receive suboptimal information and feel least included (12). In an era of global movement and immigration, this remains unacceptable.

In this issue of *Pediatric Critical care Medicine*, Levin et al (13) reports the results of their study of family participation in PICU ward rounds in a large North American PICU. Their objective was to identify areas for improvement from both parental and healthcare professional perspectives. They used both direct observations of rounds and surveys of staff and English-speaking families. The ethnic profile of their family sample was diverse: 43% African American, 29% Caucasian, 22% Hispanic and 5% other, and of these, 9% of these were not English speaking and thus could not participate in the survey. Indeed the non-English speaking families they observed were less likely to be present for the ward round. Not including these families, is a serious flaw in this study, but one they acknowledge.

In this prospective, mixed methods, cross sectional study, they observed 232 family-centered rounds, involving 176 children, over a 10 week period and parents, nurses and physicians were asked to complete a survey after the round. They found that FCR did increase round duration (average of 10.5 minutes per child compared to 8.9 minutes without parental presence); even though the average families talk time during the round was only 25 seconds. It is surprising that round duration was increased given the very short talk time

of parents, which the authors suggest relates to changes in healthcare providers behaviour. It may also be due to healthcare providers and parents having differing priorities or competing demands. In rounds without parents, healthcare providers do not have to explain terms and some assumptions can be made about common understandings. Increased round duration may also be due to social exchanges with families; however, 50% of parents in this study felt there was insufficient courteousness shown to them, suggesting this was not the case.

Across the three surveys (nurses, physicians and parents) in the study of Levin and colleagues (13), there was a predominantly positive response about the effects of FCR. However, the PICU fellows did not agree that parents contributed useful information during the round and both physicians and nurses' believed that parental presence hindered patient discussions. A poor nurse response rate of 25% in this study, limits the ability to draw strong conclusions about the nurses' views, which is a limitation. This unit had practiced this process of FCR for seven years, which may also have impacted upon staff's views, compared to units where involving parents in rounds is new.

Of the 232 FCR observations, there was a parent present at only 52% of these rounds. In the 48% of FCR where a parent was not present, 28% were non-English speaking. A further limitation is that only 12 surveys were completed by parents who chose not to attend the FCR, thus it is not possible to generate reasons for this from these small numbers. Unsurprisingly,

parent's reasons for FCR attendance were to be informed, to participate in their child's care, and as part of their parental role. However, of note, one third of families did not understand statements made within the round or providers roles. Despite collecting data on parental education level, this variable did not appear to be related to round understanding or provider roles. Interestingly, feedback from the 54 parents about FCR improvements suggested healthcare team needed to be more considerate and courteous.

Opening up clinical rounds for parents and inviting them to stay during the clinical presentation and discussion of health professionals is a sensitive issue. It is not something that can be organised overnight but rather carefully designed providing parents with understandable information how to participate in the care of their critically ill child. At the same time, there is mounting evidence to make clinicians rethink the way medical rounds are conducted. Established and experienced PICU nurses and physicians may need to reconsider their views and behaviors towards families in the PICU. To change to a system where parents are welcomed and empowered to share their expertise, even during a medical and/or a nursing round can be challenging but rewarding. Relatively few, but increasing numbers of studies are available on parental presence during round practices. We hope that the PICU community will continue working on developing and testing effective interventions to improve family-centered care practices. Indeed, a number of nurse experts have classified this area among one of the top research priorities within PICU (14, 15).

Levin and colleagues (13) remind us about the complexity of empowering parents to join medical and nursing rounds. But the primary change remains with us, as healthcare professionals, to become open-minded and create an empathetic environment for parents, even during rounds. After all, family centered care should not just be rhetoric, but rather deliver the reality of today's families' expectations.

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