

# Family Participation during Intensive Care Unit Rounds: Attitudes and Experiences of Parents and Healthcare Providers in a Tertiary Pediatric Intensive Care Unit

Carolyn A. Stickney, MD<sup>1</sup>, Sonja I. Ziniel, PhD<sup>2,3</sup>, Molly S. Brett, BA<sup>1</sup>, and Robert D. Truog, MD<sup>1,4</sup>

**Objective** To compare the experiences and attitudes of healthcare providers and parents regarding parental participation in morning rounds, in particular to evaluate for differences in perception of parental comprehension of rounds content and parental comfort with attendance, and to identify subgroups of parents who are more likely to report comfort with attending rounds.

**Study design** Cross-sectional survey of 100 parents and 131 healthcare providers in a tertiary care pediatric medical/surgical intensive care unit. Descriptive statistics were used to analyze survey responses; univariate and multivariate analyses were performed to compare parent and healthcare provider responses.

**Results** Of parents, 92% reported a desire to attend rounds, and 54% of healthcare providers reported a preference for parental presence. There were significant discrepancies in perception of understanding between the 2 groups, with healthcare providers much less likely to perceive that parents understood both the format (30% vs 73%,  $P < .001$ ) and content (21% vs 84%,  $P < .001$ ) of rounds compared with parents. Analysis of parent surveys did not reveal characteristics correlated with increased comfort or desire to attend rounds.

**Conclusions** A majority of parents wish to participate in morning rounds, whereas healthcare provider opinions are mixed. Important discrepancies exist between parent and healthcare provider perceptions of parental comfort and comprehension on rounds, which may be important in facilitating parental presence. (*J Pediatr* 2014;164:402-6).

Communication with parents plays a vital role in the care of critically ill children in intensive care units (ICUs). Several national organizations have been strong proponents of family-centered rounds in pediatrics as a means of improving communication.<sup>1</sup> Although rounds have historically taken place at the patient bedside, in the latter portion of the twentieth century, many pressures, including those of time and confidentiality, prompted a movement away. A 1997 study showed that bedside rounds on an internal medicine service were at least as satisfactory to patients as conference room rounds.<sup>2</sup> Following a 2001 report by the Institute of Medicine that endorsed “patient-centered care,” the American Academy of Pediatrics and the Institute for Family-Centered Care issued a joint policy statement in 2003 that recommended that hospitals make attending rounds in patient rooms, with family present, standard practice.<sup>3</sup> Subsequently, a pilot study of parental participation in rounds on a ward in a large children’s hospital revealed that 85% of parents wished to participate in morning rounds.<sup>4</sup>

Differences exist, however, between rounds on the ward and rounds in a pediatric ICU. Care for children in an ICU is frequently much more complex, can require complicated medical technologies, and may involve care at the end of life. Consequently, the content of morning rounds is prone to be both more technical and sensitive in nature, which presents challenges to parental involvement. Acknowledging these challenges, the American College of Critical Care Medicine Task Force has nonetheless recommended that parents of children in the ICU be given the opportunity to participate in rounds.<sup>5</sup>

In light of these challenges, we hypothesized that several differences may exist between providers and parents of children in the ICU. The objective of this study was to describe and compare the current attitudes and perceptions of healthcare providers and parents regarding parental attendance of morning rounds and to explore predictors of parental attendance in our pediatric ICU.

## Methods

This cross-sectional survey study of parents and healthcare providers was conducted at a tertiary academic children’s hospital in a combined medical/surgical ICU that has approximately 2000 admissions per year. The ICU is a 29-bed closed

From the <sup>1</sup>Department of Medicine, Division of Medicine Critical Care and <sup>2</sup>Division of Adolescent Medicine and Program for Patient Safety and Quality, Boston Children’s Hospital; and <sup>3</sup>Department of Pediatrics and <sup>4</sup>Division of Medical Ethics, Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA

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ICU Intensive care unit

unit with 26 private rooms and 3 open rooms. All patients are cared for by either of 2 combined medical/surgical teams or a general surgical team. Rounds are conducted every morning at bedside and include the patient's physician team (pediatric ICU attending and fellow, pediatric residents, pediatric hospitalist physicians, and nurse practitioners), bedside nurse, and respiratory therapist. Immediate family members have access to the ICU on a 24-hours-a-day basis and are often, but not uniformly, invited to attend morning rounds at the discretion of the medical team.

Surveys were developed on the basis of the study objectives and after a review of current literature. Parent and healthcare provider surveys were developed in parallel to allow for the direct comparison of their perceptions of several dimensions of rounds. Parent surveys were reviewed by members of a family faculty group; healthcare provider surveys were similarly reviewed by members of their target audience. The Institutional Review Board of Boston Children's Hospital approved this study; consent from both parents and healthcare providers was implied by completion of the survey.

Parents and legal guardians of children admitted to the ICU under the care of a medical/surgical team for 2 successive mornings were eligible for recruitment, which occurred during the day shift on weekdays. The duration of admission was selected to increase the probability that parents would have had opportunity to attend morning rounds at least once. Parents of children admitted to the general surgical service were excluded as the format and content of rounds for these patients differs significantly. Parents were deemed ineligible if they were not fluent in English, or if their level of emotional distress was too great to participate as judged by their child's care team. Daytime nursing staff, nurse practitioners, pediatric hospitalists, ICU fellows, and attending physicians were eligible to participate in the healthcare provider survey, as were all resident physicians rotating in the ICU in the year preceding the survey period.

Parent recruitment took place from February through May 2011, until a predetermined target of 100 parents was reached. Parents were approached at bedside and were provided with a mobile computer to complete the survey online at that time. Parents who preferred not to use the web-based format completed an identical paper survey, which was transcribed into the database. The survey collected parental demographic information as well as information about the child's baseline health status as perceived by the parents. Likert-scale questions assessed attitudes and perceptions regarding parental attendance of rounds as well as their personal experience if parents indicated they had attended rounds in the ICU previously. Data regarding the child's age and hospital admissions during the preceding year were abstracted from chart review.

Healthcare provider participation in the online survey was solicited by e-mail; healthcare providers who had not completed the survey received reminder e-mails at 1-week intervals for the 1-month survey period. The survey collected demographic data, and Likert-scale questions were used to assess beliefs regarding parental attendance of rounds. Both

surveys were administered with REDCap software hosted at Boston Children's Hospital.<sup>6</sup>

## Data Analyses

Descriptive statistics were used to analyze survey responses of parents and healthcare providers. Direct comparison of parental and healthcare provider responses was performed with Fisher exact test, as were secondary analyses to assess the potential significance of other demographic and historical characteristics. Exploratory multivariate logistic regression analyses were performed to determine predictors of parental attendance and for providers' belief that parents should be invited to rounds. Content variables were explored only in a multivariate context if the Fisher exact test was statistically significant. Demographic variables were included as controls independent of their significance in bivariate analyses. All statistical analyses were performed with Stata/IC 12 software (Stata Statistical Software: Release 12, 2011; StataCorp, College Station, Texas).

## Results

During the recruitment period, 167 patients met eligibility criteria; 65 patients' families were not present at bedside, 3 declined to participate, and the remaining 99 patients had at least 1 parent participate (97% participation), for a total of 100 responses (Figure 1; available at [www.jpeds.com](http://www.jpeds.com)). Parent demographics are presented in Table I. From

**Table I. Demographics of parent participants**

Relationship to child, n (%)	
Mother	70 (70)
Father	28 (28)
Other	2 (2)
Highest level of education, n (%)	
High school/equivalent	20 (20)
Some college	26 (26)
4 y college	27 (27)
>4 y college	27 (27)
Ethnic background, n (%)	
White	80 (80)
Black	11 (11)
Asian	5 (5)
Native American	1 (1)
Other	3 (3)
Child's usual state of health, n (%)	
No health problems	22 (22)
Only minor health problems	12 (12)
Health problems that require visits to physicians but rare hospitalization	14 (14)
Health problems that occasionally require hospitalization	23 (23)
Health problems that require hospitalization more than once a year	15 (15)
Fairly constant and life-threatening health problems	14 (14)
Attended ICU rounds, n (%)	74 (74)
Patient age	
Range	10 d-25 y
Median (IQR)	5.8 y (2.3-13.6 y)
Median length of ICU stay* (IQR)	2.3 d (1.7-3.5 d)
Median length of hospital stay* (IQR)	2.7 d (2-5.7 d)

\*Length of stay at time of survey.

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