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Inpatient Unit Leaders' Perspectives on Parent Engagement in Neonatal and Pediatric Intensive Care

Ashlee J. Vance, PhD, MA, RN, RNC-NIC, Sharron Docherty, PhD, PNP, RN, FAAN, Debra H. Brandon, PhD, RN, CNS, FAAN

Institute for Healthcare Policy and Innovation, University of Michigan, and Department of Systems, Populations, and Leadership, School of Nursing, University of Michigan School of Nursing, Ann Arbor (Dr Vance); and Department of Pediatrics, Duke University School of Nursing, and School of Medicine, Duke University, Durham, North Carolina (Drs Docherty and Brandon).

Abstract

Background: Hospital unit leaders help set the unit's priorities and are responsible for guiding the unit mission and philosophy of care; however, the perspective of leaders in facilitating parent engagement within intensive care units is limited.

Purpose: The purpose of this study was to explore how medical and nursing unit leaders facilitate parent engagement in intensive care settings.

Methods: Qualitative secondary analysis of 16 semistructured interviews of unit leadership (medical directors and nurse managers). Directed content analysis explored themes within the interviews using systematic strategies to ensure rigor.

Findings: Unit leadership described 3 main features of care delivery necessary for supporting parent engagement: (1) culture of care, (2) relationships in care, and (3) environment of care. Communication among providers and parents and timing of decision-making were key areas addressed, along with concerns about physical space limiting parent engagement. Unit leaders discussed how the 3 main features (unit culture, relationships, and physical space) of care delivery were interconnected to optimize parent engagement.

Implications for Practice: Overall, unit leaders recognized the importance of each feature of care delivery in facilitating engagement. Parent engagement is ultimately influenced by the optimization of delivering inclusive care: the physical space, the policies surrounding medical and nursing care, and the overall culture of the unit.

Correspondence: Ashlee J. Vance, PhD, MA, RN, RNC-NIC, 2800 Plymouth Rd, Bldg #14 Room G100-36, Ann Arbor, MI 48109 (ashleev@med.umich.edu).

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Implications for Research: Future research needs to explore best practices around relationship building and managing space limitations. Further clarification of the needs and expectations of both parents and providers surrounding parent engagement in intensive care settings is needed.

Keywords

healthcare providers; neonatal intensive care; parents; patient care; patient engagement; pediatric intensive care; qualitative research

Neonatal and pediatric intensive care units (NICU and PICU) are complex, high-tech, fast-paced, and emotionally charged spaces focused on providing life-sustaining treatments to infants and children with complex conditions. Care delivery in an intensive care unit is impacted by the physical layout of a unit, care practices and policies, and the people (eg, healthcare providers and parents) who interact together to manage care for a hospitalized infant. The healthcare team includes all providers engaged in an infant's medical treatment (eg, medical fellow, nurse practitioner, registered nurse, and/or social worker). The physical space of these units, the complexity and severity of the child's condition, and alteration to the parental role can leave parents feeling overwhelmed and stressed.^{1,2} Healthcare providers try to make hospital units less threatening, but the complex medical procedures and lack of physical space are difficult barriers to move beyond.³ Increasingly, children's hospitals strive to be more family-focused, inclusive, and collaborative, yet challenges in implementation remain.^{4,5} Healthcare providers are tasked with striking a balance between providing high-quality, safe care while involving parents in caregiving and decision-making as meaningful members of the healthcare team.

The unit leaders (medical directors [MDs] and nurse managers [NMs]) can support parent engagement by adopting policies and procedures encouraging involvement of parents in care planning and caregiving.⁶⁻⁸ Yet, despite the best efforts of healthcare teams, most intensive care settings struggle with effective provider-family communication,⁹ are often not family friendly,¹⁰ and in times of high workload, provider communication and attentiveness to parental involvement decreases.¹¹ Further organizational barriers like inadequate space for families, or policies limiting parent presence and participation in care, and ineffective provider-parent relationships limit parent engagement.

Parent engagement is a broad construct that includes a range of individualized parenting behaviors and interactions. In the context of healthcare ideal parent engagement includes involving parents in healthcare decision-making through frequent and clear provider communication, and encouragement of parental presence at the bedside. Family-centered care (FCC) models guide healthcare providers to invoke practices that encourage family engagement to help parents develop the necessary skills to provide competent care to their child during hospitalization and after discharge.^{1,12} When parents are encouraged to participate in care, their physiological well-being is improved,¹³ bonding with their infant is promoted,^{11,14} and a sense of control in an otherwise stressful and overwhelming environment is achieved. Accordingly, models of care that support parent engagement have become a priority within most pediatric intensive care settings.

Given the important decision-making role nursing and medical leaders have in overseeing their units, their commitment to promoting parent engagement is invaluable. Understanding their perspective about care delivery in their units and describing engagement between providers and parents is necessary to improve care. Yet, the literature is limited in its scope to provide information about strategies unit leaders employed to facilitate parent-engaged environments. A deeper understanding of how unit leaders (MDs and NMs) lead and support care delivery that encourages parent engagement can create new system-level interventions and implementation of care models. Therefore, the purpose of this study was to explore unit leaders' (medical and nursing) perspectives in facilitating parent engagement in 2 intensive care settings.

METHODS

This qualitative descriptive secondary analysis was conducted with interview data collected from unit leaders (NMs and MDs) of intensive care units at one academic medical center in the Southeast United States. The original purpose of the interviews was to understand the context of caregiving for the primary study examining decision-making for infants with complex life-threatening conditions. The second and third authors of this article were investigators for the primary study and were involved in this secondary analysis. Institutional review board (IRB) approval was obtained for the primary study with the first author added to the IRB.

The primary study was a longitudinal mixed-methods multiple case study design examining the trajectory of parent and healthcare provider decision-making for infants with life-threatening conditions (1R01-NR010548). Thirty-three cases were studied; each case included the index infant, infant's parents, attending physician, and at least 2 additional healthcare providers (eg, medical fellow, nurse practitioner, bedside nurse, and/or social worker). Cases were recruited from 3 intensive care pediatric units from one hospital that provided care to children with life-threatening conditions (ie, pediatric cardiac intensive care unit [PCICU], neonatal intensive care unit [NICU], and bone marrow transplant unit [BMTU]). Unit leaders were recruited from each unit, not to comment or provide information about cases, rather to provide general information about the context of caregiving in which decision-making occurred. Data from the individual cases were not included in this analysis.

Participants and Setting

Data used for this secondary analysis included interviews from unit leaders ($n = 6$) of 2 units: NICU and PCICU. The BMTU unit data were excluded from this analysis because of important differences in patient population, length of stay, and care provider routines and schedules. Unit leaders (MDs and NMs) were included in each case study and interviewed annually to understand how care delivery influenced parent and provider decision-making and to provide a contextual basis of caregiving.

Data for this analysis included all interviews completed with MDs ($n = 2$) and NMs ($n = 4$) over the 3-year study period. In total, 6 MD interviews and 10 NM interviews were analyzed ($n = 16$). These interviews generated over 650 pages of text data reflecting descriptions of

care delivery over the study period. The semistructured interviews were 40 to 60 minutes in length, conducted in person, recorded, and transcribed: transcripts were verified by study staff.

Data Analysis

Interview questions in year 1 of the study were broad questions about the context of caregiving, unit philosophy or mission statement, unit practices, staffing, and resources. Questions included: “Describe your unit’s philosophy related to how you involve families in care?” “What unit policies, protocols guide staff working with families of infants?” “How does your unit communicate the plan of care?” In years 2 and 3, the questions focused on providing updated contextual information about care delivery, such as: “Over the past year have there been any changes?” “What is the decision-making process like between providers and families?” The full interview guide is available as Supplemental Table 1 (available at: <http://links.lww.com/ANC/A59>).

A text-based analysis program was used to view, store, code, and organize the interview data (ATTAS, ti version 4.2, Scientific Software Development, Berlin). Each interview was read carefully in its entirety before coding to gain an overall understanding of the data that focused on parent engagement in the intensive care environment. A multiphase deductive content analysis approach was used.¹⁵ This approach identifies concepts and/or categories from which to build a larger understanding or conceptual map of the concept of parent engagement.¹⁶ Using previous knowledge about FCC practices in addition to the authors’ clinical knowledge of hospital care, a general coding scheme was developed. Once all interviews were coded, broad context of care categories that provided an overall description of care delivery was identified. The use of the word providers throughout the results of this article includes nursing and/or medical staff (eg, medical doctor or resident, nurse practitioner, and bedside nurse) who may have interacted with a family during their child’s hospitalization.

Rigor

Trustworthiness of the analysis process was developed through regular discussions with coauthors. Analytic memos were maintained throughout the coding process to track assumptions, insights, and potential biases to maintain reliability of the coding.¹⁷ Systematic documentation of decisions was made, and author discussions were kept as an audit trail of the coding process.¹⁸

RESULTS

Results from the interviews indicated there were 3 categories that influenced care delivery: (1) *culture of care*, (2) *relationships in care*, and (3) *environment of care* (Table 1). *Culture of care* includes ways in which care is planned and managed by unit practices (ie, unit philosophy, nursing care, guidelines, and policies). *Relationships in care* summarizes the interpersonal processes and communication used by providers to collaborate and engage with parents. *Environment of care* addresses the impact of unit characteristics, changes in

unit practices or physical layout, and the design of the unit. Figure 1 depicts how the 3 categories overlap with each other to facilitate parent engagement.

Culture of Care

Culture of care is the shared set of care practices and management that provides a guide to how parents can engage with providers and interact with the physical environment throughout hospitalization. Culture is impacted by specific care practices and unit policies that guide how care is managed, addresses how parents are encouraged to participate in care, and the timing of the encouragement. Unit leaders were specifically asked about FCC practices because there was a hospital-wide initiative during the study period to implement practices that were more “family centered.” Although the leaders discussed specific care practices and guidelines, they did not address the topic of culture overall. There were discussions about defining FCC and they articulated specific elements of the FCC philosophy but thought their units were not as family centered as they would like and there was a disconnect between where they wanted to be and what was occurring on the unit.

Our mission is to provide Family Centered care and include the families as much as possible in the care that’s provided to the babies; to be honest with you that’s very nurse-dependent. [NM 2]

[We] should be more family centered, you know this is the direction that everyone is going, and this is the right thing to do. [NM 3]

We attest to supporting family-centered care in that they communicate the medical plan and the nursing plan to parents; that they certainly do welcome parents at the bedside but with restrictions; I think probably if you look at the hospitals that truly support the great models of family-centered care, we’re not there. [NM 1]

Care Management

The manner in which care is delivered by providers is vital to establishing the culture within the unit. Nurse managers spoke of nursing practices that facilitated parent engagement like kangaroo care (skin-to-skin holding), parent participation in care tasks (eg, diaper changing, feeding, and soothing), and daily communication with parents. Table 2 provides some sample topics related to care practices. These topics were mentioned to describe care management. These care practices were also used as a tool to communicate expectations to parents about care delivery and times when they can be more involved. They included information about siblings, parental presence, visitors, medical rounds, and additional resources. These care practices were also the unit rules that set the expectations for parents during their child’s hospitalization.

I think a lot of families feel like that [as guests]. They want to know the rules, they want to know the guidelines, they want to know how to behave. [NM 2]

These expectations overlapped with creating and delivering the plan of care and helped facilitate how engaged a parent wanted to be with the plan of care.

Plan of Care

The predominant way unit leaders described managing care was “giving parents a plan.” Providers stated that a plan might get changed after more discussion if parents were not in agreement.

Give as much information as you can, give them a plan is very helpful for the family; allowing them to become more involved as the baby’s condition allows.
[MD 1]

The severity of an infant’s medical condition often limited parent contact but not necessarily presence at the bedside. Though providers tried to work with parents to create a plan, unit leaders stated that clinical expertise was the priority in formalizing the plan of care. Unit leaders acknowledged that some parents were okay with being given a plan and others wanted more involvement. A few leaders spoke of the need to provide a plan to parents early in hospitalization if the infant was unstable, and then find ways to allow parents to engage once the infant’s medical status started to improve. Therefore, timing was a critical factor in balancing parent engagement with the infant’s medical needs and acuity.

We try to be very inclusive of families from the very beginning, when the baby’s not so sick, if the baby’s extremely sick it’s very hard for families to interact with their baby. [NM 4]

Having a plan of care is vital to managing care in the hospital. It also cannot happen without communication to the parents and between the providers. Unit leaders often reported that plans were best communicated when there were established relationships with parents and good working rapport between providers. Unit leaders recognized the important advocacy role of nurses and how much desire for more family-engaged practices influenced change in practice.

Relationships in Care

Communication was the most frequently discussed topic and leaders described frequent interactions among providers and parents. Most interactions were positive, but many were described as challenging, making care delivery tense. All the unit leaders agreed that communication was essential for creating positive parent engagement and effectively managing care; yet communication could be the most frustrating aspect of their job, especially when there was a misalignment of values, a miscommunication, or disagreements among providers or parents. They discussed the need for frequent, regular communication with parents with the goal of developing a plan of care, or, “to get or stay on the same page.” Unit leaders spoke of their frustration with ineffective communication among providers when care plans changed or there were differing provider opinions about care strategies. Unit leaders recounted parents’ stories of ineffective communication that centered around parent frustration with providers when they perceived a lack of clear, consistent communication.

One of the major problems we have is miscommunication of the plan of the day ... when we talked to our parents and said what is it that you find most stressful here

and they said the most stressful time is when you guys are not on the same page.
[MD 2]

It was also noted that a source of frustration was the timing of communication. It was mentioned that it often occurs where parents and providers have different views of what information should be communicated and at what time (eg, a call in the middle of the night).

That's where we fall down sometimes because what we think is a critical piece of information and what they [parents] feel like is critical is not the same thing. [NM 4]

Unit leaders provided several independent reports of parents needing to be heard and when there was conflict, the resolution was to take time to listen to the parent.

I think it's comforting to a family to have open communication because that's what families are asking for is, "please just talk to me". [NM 2]

One leader talked about promoting the idea that the team could start asking parents how they want to be communicated with, such as the method and frequency of contact.

Updating families in the way that they want to be updated. What we have to always remember is that it's family first. [NM 3]

Nurse managers viewed attending physician and resident schedules as limiting the consistency of communication delivery, whereas nurse practitioners were perceived as having better communication among themselves and with parents.

Two strategies for improved communication were family conferences and medical rounds. Family conferences were discussed as an approach to managing care and increasing communication with parents. Family conferences were offered at the discretion of providers in both units; neither unit had a set policy for scheduling conferences and conferences were viewed as too time-consuming to be offered routinely and to every family.

It's very difficult for an attending to schedule a routine conference with every single family in the unit because of the time that entails. [MD 1]

Parents could request a conference if they needed information, if they knew to ask for one. One leader felt that weekly or biweekly updates via a conference might help families feel more comfortable. They also felt that most families preferred that the attending physician initiate the conference.

The unit leaders spoke of including families in medical rounds as a way to help parents with decision-making, increase communication, and improve parent engagement. Rounds often included 5 or more people in addition to the patient's nurse and families. Family presence was meant to increase parent engagement, but parents were inconsistently present and inconsistently encouraged by providers.

Some families will come and visit during rounds, but they're not really pulled into rounds very much by the providers. I think there's concern that it adds to the length of time it takes during rounds. [NM 2]

The duration of rounds and the number of people participating were mentioned as clear barriers for parent participation. Ideas about improving participation in rounds included having them present, but reserving questions until after rounds or to making an “appointment” with families to talk to them later.

Decision-making

Decision-making with families was talked about by unit leaders as a process connected to other activities like communication and developing a plan of care. Decisions were often made during medical rounds. However, when there was a disagreement or concern about decisions, a more in-depth family conference would be held for further discussion. Unit leaders described decision-making as a fluid and ongoing process that happened based on providers’ clinical expertise and was rooted in previously mentioned strategies such as family conferences and medical rounds. Decisions related to end of life and/or withdrawal of care were often the most difficult for unit leaders to clearly describe. The leaders acknowledged the tremendous empathy and ability of nurses from both units to help a family transition from being a family with a child to one without. Both units had established palliative care programs, which addressed improving quality of life for life-limiting disorders and minimizing suffering through prevention and treatment. These programs increased provider knowledge about palliative care and set guidelines for developing individualized palliative care plans. Yet, there was a delicate balance of who approached families with these conversations. In addition, there was often a lack of consensus among providers as to when palliative care should be introduced to families.

That really varies, and it’s one of the biggest stressors on the unit ... nurses seem to recognize the need for palliative care much sooner than physicians and parents do. But basically, it’s introduced slowly. [MD 1]

Environment of Care

Unit Design—Care delivery in an intensive care setting was impacted by the characteristics of the unit and physical space. The design of each unit was an important topic discussed by the unit leaders. They viewed the physical space as a limitation to parent engagement. Unit leaders described the limited space to work influencing the way they delivered care in that they could not support extended time at the bedside or allow parents to remain at the bedside throughout the night.

Are we great at family-centered care? No. And I think it’s a lot of it is the physical limitations of the unit. [NM 1]

Unfortunately, our unit is not real family centered as far as our design, we don’t have a lot of space in our unit . Individual rooms for all our babies, that will totally change our philosophy of how we care. [NM 3]

At the time of the study, both the NICU and the PCICU were structured in a way in which infants’ bed spaces were side-by-side in multiple small rooms. The space did not allow for continuous parental presence because sleeping was nearly impossible and not encouraged. By year 3, the PCICU was renovated to single-patient rooms, which provided more private space for parents; however, the rooms held only reclining chairs for parents, if they chose to

stay overnight. The renovated rooms were small and described as cramped when lots of equipment was needed before or after cardiac surgery. PCICU leaders did not discuss how the move to the private rooms specifically impacted unit practices related to parent engagement.

Practice Changes—There were some key changes related to care delivery that leaders discussed as having an impact on parent engagement. The 2 main practice changes were implementation of children’s hospital-wide initiatives: (1) 24/7 visitation for parents and (2) family presence during medical rounds. The transition to “open” visitation (24/7) was a difficult practice change for nursing staff. Nurses expressed concern to leadership about accommodating the new practice because it meant parents would then be allowed to be present during shift report. Per the unit leaders, nurses were concerned about not having their own time during shift change and confidentiality while giving report. The leaders recognize that nursing concerns were likely expressions of feeling powerless in their role and the change in managing their own work routine. The NMs acknowledged there was tremendous demand for open visitation by providers and parents and once implemented the “awful things we thought were going to happen” did not happen. However, a core group of nurses remained unsettled by the new practice.

There’s remained a core group of staff who said you know what we shouldn’t be doing this ... and which continue to just not be happy with it. [NM 2]

Even with the resistance, the unit leaders were steadfast in setting a tone that valued parent engagement. Nurse managers talked about letting staff know that it was okay for families to be present on the unit at any time to help reinforce the idea that parents are partners in care, not visitors.

We want to develop a relationship with them so that its them working together with us, not us in isolation making mandatory decisions on their child’s life. [MD 2]

Ideal Environment—Unit leaders were asked about their “ideal model of care” and 2 ideas predominated: (1) physical space and design and (2) desire for more collaborative relationships. Leaders were displeased with lack of space. They spoke as if having a better physical space would provide a more supportive environment and become more family centered.

Unfortunately, our unit is not real family centered as far as our design, we don’t have a lot of space in our unit ... I think it improves your attitude towards what you do, your work, having the space and resources that you need to do a good job. [NM 1]

The leaders also conveyed a strong desire to improve positive interactions among providers and parents and to increase the emotional support for all who are connected with care delivery. They overwhelmingly emphasized a desire to increase communication, support, collaboration, and respect between the healthcare team and the families.

The ideal model of care would be one in which we all remember that the baby is the reason that we’re here, the baby and the family ... every day when we come to

work, the reason I'm here is to take the best care that I can of this baby and this family and bring them into the care. [NM 3]

These statements from leaders highlight the divide between ideals of value-driven care and the full expression of those values at the bedside. The overall sentiment from unit leaders was that the goal of providers is to partner with parents and involve them in care, yet it can be difficult to do in daily practice.

DISCUSSION

This study explored unit leaders' perspectives on how care was delivered in neonatal and pediatric intensive care settings to facilitate parent engagement. Parent engagement was influenced by the combination of unit culture, relationships, and environment. The culture provided a first impression of the unit and can set the tone for how welcomed they feel. Culture is a contributing factor to how parents experience care delivery in the hospital.¹⁹ The values held by healthcare providers impact the overall workflow and culture of the unit. Unit leaders directly and indirectly support parent engagement by adopting policies and procedures supporting the healthcare team's involvement of parents in care planning and caregiving, and by assuring parents that their presence and opinions are essential to achieving the best possible outcomes for their child and family.⁶⁻⁸ Expectations for parents are communicated through unit policies and practices; even if parents understand the expectations set by a unit, they need to be allowed to engage with healthcare providers in a manner that is satisfactory to them.

Unit leaders described how care was delivered and the practices meant to help support parent engagement, but the providers ultimately remained in charge, or leading. Medical directors believed giving parents a plan was beneficial because it helped parents know what to expect in the unfamiliar intensive care settings, but it still gave the impression of a power imbalance. Although healthcare providers have clinical expertise to save lives, this should not diminish the importance of the parents' expertise.²⁰ As one provider described: *there will be times when the provider needs to lead and other times when the parent leads*. Providers and parents are not expected to have equal roles or expertise, but mutual respect is necessary by acknowledging both roles are valuable and the timing of who is leading when is important.

Provider values, attitudes, and expectations of parents (even if unspoken) impact interactions and the formation of *relationships* with parents. The culture of the unit impacts the type of relationships that are formed between providers and parents and how much parental involvement is encouraged.^{21,22} Parent engagement means that parents and providers to work together to decide and implement care goals and have space to work through care plan disagreements. In order to establish parent engagement, there must be communication. When communication is frequent, transparent, and respectful, using language parents can understand, provider roles shift from "doing" roles to supporting and facilitating roles.^{23,24} Parents place their full trust in healthcare providers to save their child, and in return they want to be heard when they speak. Parents have asked for providers to help them (parents) build capacity but not simply "do" for them; parents want to know they are an important

member of the healthcare team.³ A unit-wide commitment in creating relationships among providers and families is fundamental to parent engagement. These relationships facilitate a partnership wherein parents add value to the care plan and are not viewed as “visitors.”⁶ In this study, unit leaders valued parent engagement. Yet, they remarked how inconsistent engagement was encouraged in their units. Neither unit had a standardized practice for integrating parents in the care of their infant. There were unit policies related to visitation, but there was no mention of specific practices that outlined when and how parents were encouraged to participate in the care of their infant. Parents may need some guidance in understanding the care environment, making parent engagement an active process. Certain parents may be more self-directed than others, but every family should feel as though there was active engagement during their infant’s hospitalization. Variation in type and amount of participation must be welcomed as differences in family values, obligations, and general coping resources make for a range of parent engagement desires and needs.¹⁹ Communication from providers is at the core of how care is managed. Open and transparent communication is vital for helping parents acclimate to the hospital environment and ensures parents are involved in their child’s care.

The hospital environment itself can be unfamiliar and threatening to parents. The physical limitations of the unit can be significant barriers in unit practices and can inhibit parent engagement.²⁵ When single-family rooms or private rooms are available, it substantially influences the frequency and duration of time that parents can be present at the bedside.^{26–28} However, unit design alone cannot improve care delivery; that requires a change in unit culture through provider–provider and provider–parent relationships.²⁹ Caring for families is not just providing access to child. Unit design is a serious issue for many older hospitals. However, providers must be careful to not rush to the conclusion that a singleroom design inherently equals a more family-centered unit. If the space is accommodating, respectful, and friendly, it can lessen the overall stress and fearfulness of having a child in the hospital.¹ Parents often report different expectations and needs related to unit design compared to healthcare providers. Parents desire individualized care and privacy, whereas staff prioritize ease of workflow and efficiency in the design of the unit.³⁰ The struggle is learning how to balance differing needs and cocreate care delivery that prioritize both provider and parent needs. If there is a unit-wide commitment to caring about all relationships, this creates a culture that makes the physical space into a welcoming and supportive environment, regardless of layout. The 3 categories of our study suggest that culture and relationships contribute more to parent engagement than the physical environment; yet it is still important to think about how the physical environment facilitates parent engagement. Our findings suggest that parent engagement is best facilitated when all 3 categories—relationships, culture, and physical space—are in harmony.

Limitations

Several limitations exist within the present study. The sample of unit leaders was all from the same children’s hospital; thus, working under similar policies and hospital-wide practices. Policies or system-wide concerns may not be the same at other institutions of similar size that care for infants and children with complex conditions. One topic not addressed by unit leaders is the potential difference in parent-infant relationship between parents who have

established relationships with their infants and those who have yet to take their child home. This relationship difference may impact the level of parent engagement and should be explored in future work. Other limitations are lack of perspective from bedside providers and the age of the data. The MDs were routinely on service and NMs had daily interaction with nurses, providers, and parents. As to the age of the data and potential relevance, the larger implications related to care delivery, awareness of unit practices, and longitudinal perspective of persistent challenges and changes remain relevant. The greater implication is the usefulness of gathering data from unit leaders who are positioned to make changes within their unit. These unit leaders were acutely aware of unit operations providing rich detail about the context of caregiving. The authors also have general knowledge about the units from which the data were collected, and the practices discussed in this article are still in place.

CONCLUSION

More information is needed to further our understanding of how parents and providers negotiate expectations related to communication, care delivery, and decision-making. A multisite study examining similarities and differences in care delivery across settings would also provide valuable information about parent engagement strategies. Future research would benefit from a comprehensive, conceptual definition of parent engagement, along with the development of a reliable and valid measure of parent engagement in intensive care settings. Differentiating parent engagement as a distinct concept from parent involvement, parent participation, or parental presence would clarify and synthesize current results in the literature. Lastly, observational research of parent-provider interactions and unit culture would help us understand the subtlety that exists in the relational aspects of care. Observations would elucidate whether there is an agreement between what people say they do and what they actually do.

This study offers a valuable perspective on the caregiving environment from the perspectives of unit leaders. Unit leaders set unit priorities, influence unit culture, and set core values.²⁴ Parents expect individualized and family-driven care and should be able to decide the level of involvement they are capable of and want to have.³¹ Finding ways to help healthcare providers incorporate relational aspects of care and create clear expectations for providers and parents can have a positive overall impact on care delivery,^{32,33} whether the focus is on parent engagement or FCC practices, these policies ultimately strengthen parental identity and confidence.³⁴ Even with family-first, supportive practices, units must remain committed to finding strategies that create true partnership and foster engagement between providers and families.

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What This Study Adds

- Exploration of unit leader perspectives related to parent engagement within intensive care.
- Identified 3 main features of the care environment that are interconnected to facilitate management of care between providers and parents.
- Suggestions for future research and refinement of expectations about parent engagement.

Summary of Recommendations for Practice and Research

What we know:

- Helping parents engage during their infant's hospitalization will increase parental bonding and build parental capacity.
- Together unit culture, relationships, and the environment provide the means for parents and providers to co-manage and deliver care to hospitalized infants and children.

What needs to be studied:

- Further refinement of parent engagement as a concept would help clarify expectations for both providers and parents.
- Additional studies that include multiple sites focused on communication and engagement would help identify best practices for parent engagement.

What can we do today that would guide caregivers in the practice setting considering use of this evidence for guiding practice:

- Encourage providers to value and support parent engagement and family-first care practices.
- Provide opportunities for parents and providers to communicate with frequency and openness related to all aspects of care.

FIGURE 1.
Synthesis of findings for parent engagement.

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TABLE 1.

Care Environment Categories

Categories	Definition	Subcategories	Representative Quote
Culture of care	Refers to the set of shared goals and practices to formulate a plan and manage care of hospitalized infants	a. Care management b. Plan of care	You want people to be part of the process, you know if we sit there and make decisions alone, we'll frequently miss the opportunity to get good information from the family. Let them know what's going on with their baby, to give them as much information as you can, to give them a plan. Most of the time it's deciding what the options are and telling them [parents] where do you think you should go.
Relationships in care	Refers to the interpersonal skills necessary for positive interactions between parents and providers to effectively manage care	c. Routine updates d. Decision-making	Part of our usual conversation with them when we touch base is to talk about what their baby weighs and what they're eating now, and what their oxygen level is and any plans for the next twenty-four hours. We want to develop a relationship with them so that, it's them working with us, not us in isolation making mandatory decisions on their child's life.
Location of care	Refers to the impact unit characteristics, changes, and physical layout has on managing care	e. Unit design and practice changes f. Ideal environment	Creating a safe environment ... create an environment that was more family friendly. We've changed a lot of stuff--We've done way more in terms of involved care and a lot more families on rounds. An environment where people feel collaborative, they feel supported, they feel important. We all remember that baby is the reason that we're here, the baby and family

TABLE 2.

Care Delivery Practices

Patient assignments
Bereavement program
Care guidelines
<u>Committees</u>
Family conferences
Family presence in rounds
<u>Family visitation</u>
Handoff communication
Infection control
Kangaroo care
Medical rounds
Nursing report
Palliative care program
Quality of life program
Unit guidelines
Sibling visits/sibling cart