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Your Patient—My Child

Seven Priorities for Improving Pediatric Care From the Parent's Perspective

Penny J. Miceli, PhD; Paul Alexander Clark, MPA

Parents and professional caregivers, although united in their shared goal of returning a sick child to health, do not always view the caregiving situation from the same frame of reference. This article describes the perspectives of more than 50,000 parents whose child experienced a hospitalization. It outlines the greatest opportunities for improving the pediatric inpatient experience from the parent's perspective. In addition, practical tips and strategies for planning improvements in care from the patient/family perspective are offered. **Key words:** *children's hospitals, family-centered care, parent's perspective, parent satisfaction, pediatric care*

WHEN a child is ill and requires hospitalization, the foremost concern of parents and professional care providers alike is to provide the child with the care needed to return him or her to wellness. But what does it mean to care successfully for a child? What are the components of high-quality pediatric care? And *who*, ultimately, defines quality?[1,2]

Consider the perspective of clinical nursing staff. Their specialized training has prepared them to focus on the smallest or most remote details regarding their young patient's condition, to avoid missing a critical symptom, and to recognize warning signs when complications threaten. By necessity, these issues are a focal point for clinicians. The ability to focus in this way is essential to their role. These specialized abilities are important to successfully support their patient's physical recovery.

Now, consider the fundamentally different perspective of the parent. A parent possesses unmatched interest in *all* matters affecting the child (eg, physical, social, emotional, intellectual, spiritual, and developmental) and thus, views the situation through a much broader lens. Parents expect care providers to render proficient clinical care to ensure physical health for their child. However, physical well-being is only one aspect of a complex web of concerns constantly monitored by parents. The parental role promotes simultaneous focus on the child as a whole (physical, mental, social, and spiritual well-being) and the family unit. What might seem like a clear course of action to the clinician can require the parent to process the implications for the child and family on multiple levels.

Of these 2 perspectives, the lens of the clinician has historically been given the maximum consideration. Defining quality care has been a matter of clinical measures and statistics. Highly visible hospital "rankings" rely on mortality rates, available technology, and clinical reputation among physicians nationally—all markers of the technical aspects of care.[3] Although consumers often feel they received technically skilled care, they frequently come away from the experience feeling dissatisfied because many nontechnical aspects of care were overlooked.[4]

From Press Ganey Associates, Inc, South Bend, Ind.

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Corresponding author: Paul Alexander Clark, MPA, Press Ganey Associates, Inc, 404 Columbia Place, South Bend, IN 46601 (e-mail:pclark@pressganey.com).

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The parents' wide lens view of the caregiving landscape is gaining recognition as a movement toward family-centered care takes hold across the healthcare industry.[5] In pediatric care, the family-centered approach recognizes parents as the foremost experts on their child's overall well-being, supports parents in their role, and involves parents as partners in planning and delivery of care. Parents have knowledge important for understanding how best to care for the child *that only they can provide*. In the family-centered approach, parents become empowered and strengthened in their role.[5,6] Moreover, a recent joint policy statement of the American Academy of Pediatrics and the Institute for Family-Centered Medicine concluded that family-centered care "can improve patient and family outcomes, increase patient and family satisfaction, build on child and family strengths, increase professional satisfaction, decrease healthcare costs, and lead to more effective use of healthcare resources."[5(p692)]

Approaching pediatric care delivery from a family-centered framework presupposes a dialogue between professional caregivers and families. On one end of the spectrum, this dialogue can be as simple and focused as a one-on-one conversation between a parent and the child's care provider—or, on the other end of the spectrum, as broad as a formalized role for community parents on hospital planning committees and advisory boards.[6] Somewhere in between these two ends of the spectrum lie feedback mechanisms offered to individual families and children as part of normal hospital operations, such as consumer/patient satisfaction surveys. Such surveys are a key component of continuous quality improvement efforts because they provide for a form of dialogue between the facility and the population served on a broad scale.[1]

The remainder of this article describes the wisdom shared through surveys of more than 50,000 parents regarding how to improve the experience of pediatric inpatient care. The data are drawn from parent satisfaction surveys maintained in a large national database for the year 2002. This analysis focused on 3 questions:

Question 1: How satisfied are parents with the pediatric inpatient experience nationally?

Question 2: Does satisfaction differ depending on the degree of specialization (dedicated children's hospital versus a general acute care facility)?

Question 3: What are the greatest opportunities for improving the experience from the family's perspective? The top 7 priorities are identified, along with "Solution Starters" for each. Solution Starters are practical tips and strategies for beginning to think about care delivery from the patient/family perspective, and making patient/family-centered quality improvements.

METHODS

This retrospective database study drew on survey responses collected between January 1, 2002, and December 31, 2002, from the Press Ganey Pediatric Inpatient National Database. The sample includes 50,446 surveys returned by parents of children treated at 1 of 65 US hospitals. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this investigation was conducted on a fully deidentified data set.

Patient profile

The average patient age was 5.7 years (range from <1 year to 21 years). The gender breakdown of the patients was 52.1% males and 42.6% female. The majority of respondents (70.3%) indicated that it was the child's first stay at the facility, while 24.4% indicated a repeat stay. The sample was about evenly split between parents indicating their child was admitted through the emergency department (43.6%) versus direct admission (43.4%). The average length of stay was 5.02 days, with the longest stay being 60 days.

Facility profile

Twenty-three of the 65 hospitals were dedicated children's hospitals (primary service

Table 1. Facility information

American Hospital Association region	Number of facilities	Number of returned surveys	% of total surveys returned
1 (Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut)	5	3,684	7.30
2 (New York, Pennsylvania, New Jersey)	13	6,062	12.02
3 (Virginia, West Virginia, Kentucky, North Carolina, Maryland, Delaware)	3	966	1.91
4 (Tennessee, Mississipi, Alabama, Georgia, South Carolina, Florida)	7	6,251	12.39
5 (Michigan, Ohio, Indiana, Illinois, Wisconsin)	13	11,731	23.25
6 (North Dakota, South Dakota, Nebraska, Kansas, Minnesota, Iowa, Missouri)	3	2,190	4.34
7 (Texas, Oklahoma, Arkansas, Louisiana)	6	5,313	10.53
8 (Montyana, Idaho, Wyoming, Utah, Colorado, Arizona, New Mexico)	2	3,058	6.06
9 (Washington, Oregon, California, Nevada)	13	11,191	22.18
Total	65	50,446	100

type "children's general"). The other 42 were general acute care facilities (primary service type "general medical/surgical"). The facilities were geographically diverse and all 9 American Hospital Association (AHA) regions were represented. The number of facilities and the number of returned surveys for each AHA region are mentioned in Table 1.

Instrument and procedure

Shortly after discharge, the parent received by mail the Press Ganey Pediatric Inpatient Survey© along with an appropriate cover letter and return envelope. Surveys were mailed to parents rather than being conducted over the phone or face to face to respect family privacy, allow parents time to carefully consider the questionnaire items before responding, and minimize the chance of acquiescence bias (ie, the hesitancy to criticize one's caregiver when anonymity is compromised).[7] The survey measures parent/patient satisfaction with the pediatric inpatient care experience, with the items on the instrument phrased in such a way as to be answered from the parent perspective (eg, "Courtesy of the person who admitted your child"). Thus, the term "parent satisfaction" will be used throughout the remainder of this article rather than "patient satisfaction." Nevertheless, depending on age, the child may also have an active role in determining survey responses.

The 46 survey items assess specific aspects of the care experience, which combine to provide a comprehensive measure of parent satisfaction. In accordance with a family-centered approach, an evaluative scale was chosen to allow families to express their unique appraisal of the care experience. Items are worded such that parents are asked to provide a numeric rating of a *concept* (eg, "Speed of admission process" and "Amount of attention paid to your and your child's special or personal needs"), rather than expressing agreement or disagreement with a statement, or being asked directly about their level of satisfaction.

Each item is rated on a Likert-type scale anchored from 1 (very poor) to 5 (very good). To aid interpretation, responses are linearly converted to a 100-point scale, where 0 indicates very poor; 25, poor; 50, fair; 75, good, and 100, very good, prior to analysis. The

items of the survey are arranged into 10 subscales, each representing a specific dimension of the care experience:

- Admissions
- Your child's room
- Meals
- Nursing care
- Tests and treatments
- Your child's physician
- Family and visitors
- Discharge
- Personal issues
- Overall assessment

Subscale scores are calculated by averaging across items within each subscale at the respondent level. A summary "Overall Satisfaction" score is calculated for each respondent by averaging across his or her subscale scores.

Psychometric testing of the survey, which was released in 1998, revealed the instrument to be valid and reliable, and to be a significant predictor of theoretically important outcomes such as the respondent's stated likelihood of recommending the hospital to others. Results of factor analysis of the instrument are presented in Table 2 and indicate a high degree of construct validity. Each item loaded most highly with its theoretically expected factor, and the factors identified mirror the subscales of the survey. In addition, Cronbach α (a measure of internal consistency or reliability) for the entire measure was .98 (with individual subscale alphas ranging from .65 to .95), confirming the instrument's high internal consistency and reliability. Moreover, multiple regression analyses showed that the survey items accounted for 78% of the variance in the families' stated likelihood to recommend the hospital to others ($F_{44,342} = 30.95$, $P < .01$; Adjusted $R^2 = 0.78$).

RESULTS AND IMPLICATIONS

Question 1: Average satisfaction level

The average parent overall satisfaction score (averaging across all questions and sections on the survey) was 83.8 on a 100-point scale (SD = 13.6). This translates into an average rating of the care experience situated between "good" and "very good" on the current scale. Although this is encouraging, there is room for improvement. As others have noted, "the only truly loyal customers are totally satisfied customers."[8(p91)] In the context of a healthcare satisfaction survey, any rating other than the highest possible, even if it is a generally positive rating such as "good," suggests that patients and their families may turn to other sources of care when the opportunity arises.[8]

In our experience analyzing patient satisfaction data, one thing that separates the highest-performing hospitals from others is that a greater proportion of respondents are willing to give them the highest rating possible (eg, 5 or "very good" on the current scale) as opposed to a rating of merely "good" (eg, 4 on the current scale). Thus, staff might do well to focus not just on meeting minimum family expectations but also on exceeding them by providing an exceptional experience worthy of the highest rating possible (eg, moving the 4s to 5s).[1]

Question 2: Satisfaction and specialization

Results regarding the difference in satisfaction levels shown at dedicated children's hospitals versus general acute care hospitals were mixed. As shown in Figure 1, parent satisfaction at the overall composite level (averaging across all questions and subscales on the survey) was significantly higher among those whose children were treated at a dedicated children's hospital. However, this did not hold true for every subscale of the survey. There was no statistically significant difference in satisfaction between those served by dedicated children's hospitals and those served by general acute care hospitals with regard to admission issues, nursing care, tests and treatments, physician care, or discharge issues. However, parents of children treated at dedicated children's hospitals were significantly more satisfied with their experience when it came to their child's room, meals,

Table 2. Primary factor loadings for survey items*

Question grouping	Loading on primary factor	Question grouping	Loading on primary factor
Admission		Family and visitors	
Speed of admission	0.866	Helpfulness of infornmation desk personnel	0.593
Courtesy of admission personnel	0.860	Accommodations/comfort for visitors	0.801
Room		Staff attitude toward family/visitors	0.623
Appearance of room	0.823	Comfort of overnight facilities	0.788
Room cleanliness	0.858	Facilities for family information provided	0.753
TV, call button, etc, working	0.698	Physician	
Courtesy of cleaning personnel	0.701	Time doctor spent with child	−0.853
Diet and meals		Doctor informed with clear language	−0.890
Special diet explanations	0.642	Doctor's concern for questions/worries	−0.914
Temperature of food	0.835	Doctor's friendliness/caring to child	−0.820
Quality of food	0.871	Trust in child's doctor	−0.867
Availability of food child likes	0.830	Discharge	
Nursing care		Felt ready for child discharge	0.714
Friendliness/courtesy of nurses	−0.865	Speed of discharge process	0.673
Nurses' promptness to call button	−0.781	Instructions for child home care	0.707
Nurses' attitude toward requests	−0.886	Personal issues	
Nurses' attention to special needs	−0.863	Staff concern for privacy	0.736
Nurses' inform using clear language	−0.835	Staff sensitivity to inconvenience	0.805
Skill of the nurses	−0.859	Staff address emotional/spirit needs	0.743
Tests and treatments		Response to concerns/complaints	0.787
Skill in blood draw	0.844	Staff include you treatment decisions	0.791
Skill of the intravenous starter	0.854	Respect for your knowledge of child	0.804
Concern for comfort during tests and treatment	0.776	Staff concern not to frighten child	0.796
Explained in language understood	0.598	How well child's pain was controlled	0.749
		Overall assessment	
		Overall cheerfulness of hospital	...
		How well staff worked together	...
		Overall rating of care provide	...
		Likelihood of recommending hospital	...

*The factor analysis used principal components extraction with oblimin rotation; questions from the overall assessment subscale of the survey were omitted from the factor analysis because of their (predicted) high intercorrelation with other items; items with loadings over 0.40 were retained; and question wordings are abbreviated because of space constraints.

treatment of family and visitors, various personal issues, and their overall assessment of their experience.

If hospitals specializing solely in the treatment of children provide a more satisfying experience with some elements of care, then the question becomes, "What are they doing differently?" Or more pointedly, "What can general acute care facilities learn from them and implement on their own?" Some ideas such as child-focused architectural changes may be feasible only in an environment focused on this narrow patient base. But, a large number of family-centered modifications can be made regardless of facility type. For example, individual room or unit décor can be made more cheerful and child-friendly. Visitation policies can be made more family-friendly.[9,10] All facilities can have special meal choices available that are appealing to children, or flexible options for meal times.[11] Providing for the unique emotional and spiritual needs of families may require staff education and resources,[12] but neither this nor any of these other obstacles are insurmountable in a general acute care setting. Rather, it

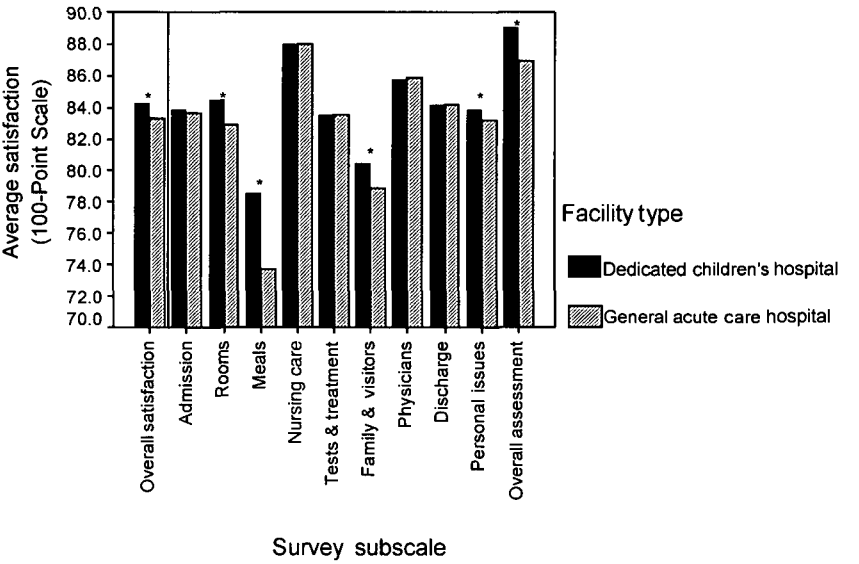

Figure 1. Survey overall satisfaction score and subscale scores by facility type ($P < .01$).

is an issue of understanding the needs of the population, and having the willingness to act accordingly.

Question 3: Top priorities for improvement and Solution Starters

By focusing on the issues that are most important to parents (ie, that are highly correlated with their overall satisfaction) *and* with which parents are currently most dissatisfied, healthcare organizations can make the most effective use of quality improvement resources. Therefore, a priority index incorporating these 2 facets of the parent perspective was created for the national data set using the 3-step process outlined below. For clarity, an example is provided throughout using the item "Staff sensitivity to the inconvenience that a child's health problems and hospitalization can cause" (Priority 1, below).

Step 1: Each of the 46 items on the survey was rank ordered from highest to lowest in terms of its current mean score nationally. The item that showed the highest mean score was assigned a rank of 1, whereas the item with the lowest mean score was assigned a rank of 46. "Staff sensitivity to the inconvenience..." showed a mean score of 82.8 nationally, earning it a rank of 32 out of 46. *In other words, only 14 other items on the survey were rated lower than this item by families.*

Step 2: Each of the 46 items on the survey was rank ordered from lowest to highest in terms of the correlation it showed with the overall satisfaction composite score. The item that showed the lowest correlation was assigned a rank of 1, whereas the item with the highest correlation was assigned a rank of 46. "Staff sensitivity to the inconvenience..." showed a correlation of .77 with overall satisfaction nationally, earning it a rank of 44 out of 46. *In other words, only 2 other items on the survey showed a stronger correlation with overall satisfaction than this item.*

Step 3: The ranks from steps 1 and 2 were added, yielding a combined ranking. The mean rank (step 1) and correlation rank (step 2) for "Staff sensitivity to the inconvenience..." were added (32 + 44) for a combined priority ranking of 76. This combined rank was the highest achived by any item on the survey, and thus, this item should be given high priority in improvement planning, as it is both relatively low scoring *and* highly important to families.

It should be noted that the top 7 priorities did not differ with regard to facility type—the opportunities for improvement are the same.

Although parent satisfaction regarding some issues was higher if the child was treated in a dedicated children's hospital (as suggested by Fig 1), families of children treated at both dedicated children's hospitals and general acute care facilities expressed dissatisfaction with the same issues. The top priority items are listed below, along with bulleted Solution Starters for beginning family-centered improvement efforts. The national average for the item and the correlation the item shows with overall parent satisfaction appear in parentheses.

Priority 1: Improve staff sensitivity to the inconvenience that a child's health problems and hospitalization can cause (national average = 82.8, correlation = .77)

Strategies for improving staff sensitivity to the inconveniences faced by families include the following:

- Understand the logistical difficulties parents face in balancing multiple roles (parent, spouse, worker, extended family member), and the disruption a hospitalization causes in fulfillment of these roles.[1]
- Evaluate how your facility supports parents in their parenting role. How flexible are your organization's policies and procedures? Can you tailor services to the unique needs of the child or parent? Honestly evaluate how family-centered your care is.[5,13]
- Evaluate how your facility supports parents in their various other roles. Is telephone access in and out of the room reliable? Do parents have access to e-mail and Internet? Do you provide data ports and adequate outlets/power supply for business laptops?
- Provide space for families to be together as a family unit (including siblings), allowing them to function in as normal a way as possible. For example, family lounges or small kitchenettes that have a residential feel and are convenient to the unit can provide families with a more home-like atmosphere, supporting their efforts to engage in normal family activities (eg, talking around the kitchen table, playing a game with siblings, preparing child snacks).[14]

Priority 2: Improve the degree to which the hospital staff address emotional and spiritual needs (national average = 80.0, correlation = .72)

Strategies for addressing the emotional and spiritual needs of families experiencing a child's hospitalization include the following:

- Understand the emotional turmoil parents face. They themselves may be frightened regarding the situation, yet shoulder the responsibility of comforting and supporting their sick child. Parents need emotional and spiritual support too to fulfill this important role.
- Respond to expressed worries with information and reassurance.[15]
- Provide comprehensive information regarding parent-to-parent support groups, and support parents' efforts to network with families facing the same medical condition.[5,16]
- Elicit emotional and spiritual needs in a standardized fashion (such as taking a spiritual history); orchestrate resources and services to meet whatever needs are presented.[17]
- Actively collaborate with pastoral care professionals/chaplains; learn from each other and work as a team toward meeting parents' emotional and spiritual needs.[12]

Priority 3: Improve staff response to concerns/complaints made during the child's stay (national average = 81.4, correlation = .77)

Strategies for improving your staff's response when parents express concerns or complaints include the following:

- Acknowledge that family-centered care can occur only if staff are willing to hear and respond to the parents' concerns. Convey to parents that their input is sought and respected. Build relationships based on open communication, involvement, and responsiveness.[18,19]
- Passionately thank parents for bringing the concern/complaint to your attention. Train all front-line staff in service

recovery, communication skills, and emotions management. A simple, sincere apology such as "I'm sorry that this has happened" can go a long way.[20,21]

- Develop a system for tracking complaints over time to look for quality-improvement opportunities.[22]

Priority 4: Improve staff efforts to include parents in decisions about the child's treatment (national average = 84.1, correlation = .75)

Strategies for including parents in decisions about the child's treatment include the following:

- Ask parents their thoughts about the situation, illness, treatment, etc.
- Invite parents to participate. Ask for their observations about their child's behavior, condition, response to treatment, and pain. Convey to them that although you hold medical expertise that can help, the parents are the expert when it comes to their child. For you to do your job most effectively, you need their input and collaboration.[23]
- Prepare elective surgery patients and parents for what surgery is like as far upstream as possible; send information, provide education, send videos, and provide a hot line they can contact should they have any questions.[24]
- Create a parent resource room/library where parents can go to gain greater understanding of the issues facing their child and family. Alternatively, bring the information to the parents via personalized information packets, book carts, or smaller libraries convenient to the unit and equipped with information relevant to those served by the unit.[14] A well-informed parent can more effectively participate in decision making.
- Offer parents choice, control, and personalization in as many facets of the care experience as possible. Actively solicit parent and child preferences.[1,5]
- Include families during rounds so that they feel fully informed and involved in the evolving treatment plan. A full member of the care team would not be expected to wait in the hall during rounds.[5,9,10]

Priority 5: Improve the accommodations and comfort for visitors (national average = 80.3, correlation = .66)

Strategies for improving the comfort and accommodations for those visiting pediatric patients include the following:

- Recognize that, for better or worse, the hospital is serving as the child's temporary "home." As Griffin notes, "although families may be visitors to the hospital, they are not visitors to their children."[9(p137)] They are the one true constant in the child's life, and they do not want to feel like "visitors." Try to accommodate as much as you can in the way of normal parent/child activities.[1] Is there a comfortable place for them to snuggle up and read? Play games? Watch favorite videos?
- Recognize that parents expect to be able to spend the night with their child in relative comfort. Sleeper-chairs/sofas, blankets, pillows, and showering/cleaning facilities are highly valued by family members and are increasingly considered a minimum standard. Provide a place where visitors and family members can meet privately to converse among themselves. Make it a comfortable, welcoming space—renaming a meeting room will not suffice.[14]
- Consider offering pagers to families to reduce the anxiety they feel about leaving the child's bedside for fear that something might happen in their absence.[25]

Priority 6: Improve information provided about available facilities for close family members (eg, places to sleep, eat, shower, talk). (national average = 76.1, correlation = .64)

Strategies for assisting families who might need special facilities to take care of their day-to-day needs include the following:

- Recognize that parent-child separations are stressful for both parties, and not conducive to healing.[26] Families value the

availability of accommodations nearby should they need to temporarily relocate to be closer to their child. Inquire about the family's issues in regards to proximity to the hospital. Some hospitals purchase or rent nearby facilities for families of patients to use during the course of the hospitalization, if onsite accommodations are lacking.[27]

- Make sure staff at all such facilities understand the range of services parents need and the importance of flexibility in providing those services to parents under stress. Our experience conducting parent interviews suggests that it can be very disheartening to parents to be told that helpful amenities are available, only to learn of excessive restrictions on when and how they can be accessed.
- Create a family concierge position whose purpose, like a hotel concierge, is to proactively meet all family members' needs throughout their stay.[1,27]

Priority 7: Improve staff concern to make the child's stay as restful as possible (national average = 83.8, correlation = .72)

Strategies for making a child's hospital stay restful include the following:

- Remember that many things affect whether or not the child's time in the hospital is, on balance, restful. Is the physical space comfortable and conducive to rest?[14] Is it quiet?[28] Is the décor cheerful, or is the space scary to a child? Have as many elements been scaled to child size as possible? Do patient rooms and parent lounges have a view of the outdoors?[14]
- For a sick child, a parent's presence is likely a soothing, calming force. Your efforts to include parents, especially during tests and treatments, will therefore promote a return to rest among young patients.[5,29]
- Evaluate how your facility handles the timing of interventions/treatments. Is a child's sleep disrupted unnecessarily?[30] Could you wait until after the child is put under anesthesia before the parents leave?[31]
- Coordinate care between specialists as much as possible. For example, if blood must be drawn for multiple tests, try to draw it all at once if possible. As one child testifies, "I didn't like it when people said it's no big deal to get your blood taken. It's a big deal to me. It is a big deal because you're taking something that's supposed to be in my body. It might not be a big deal to you because it's not happening to you."[30(p7)] Consider clustering unpleasant procedures wherever appropriate.[32]
- Respect the child's body as his or her own—ask permission before touching. Explain what you are doing and why. If the plan you have communicated to the child must be altered, explain this to the child. Failing to do so may increase anxiety in the child, who may feel that he or she must be hypervigilant of the unexpected or that you are not to be trusted.[33]
- Are activities available to help the child take his or her mind off the hospitalization (eg, cable television, videos, games, toys)?

DISCUSSION

The present study suggests that, at the most global level, overall satisfaction with the pediatric care experience from the parent's perspective is good to very good, but differs based on facility type (dedicated children's hospital or general acute care facility). Some argue that increased specialization promotes more efficiency and cost-effectiveness through economies of scale.[34] For example, dedicated children's hospitals are often able to accomplish lengths of stays equal to or shorter than those for similar pediatric patients receiving treatment in general acute care hospitals.[35] The data reported here suggest that greater specialization might also translate into higher parent satisfaction, at least with some aspects of pediatric care (eg, room, meals, personal issues, and family/visitors).

It is interesting to note, however, that no difference in parent satisfaction was observed between specialized and general facilities within the realm of nursing care, physician care, or tests and treatments. Rather, the differences seemed to lie in many of the personal issues facing the families and many of the elements of care that speak to "family-centeredness." In addition, the items on the survey that presented the greatest opportunity for improvement were the same regardless of facility type. Dedicated children's hospitals may have more experience focusing their quality efforts in these areas because of their specialization, but they share the essential struggles experienced by pediatric programs everywhere.

STRENGTHS AND LIMITATIONS

A major strength of the present study is that the sample was not limited to observations drawn from a single facility. With the input of more than 50,000 parents experiencing pediatric inpatient care at over 65 hospitals from all nine AHA regions, this work represents the most comprehensive study of its kind. The study is limited, however, in that the hospitals represented were not randomly selected, and thus self-selection bias may be present. The facilities in this study have made a commitment to measuring satisfaction with care, and to do so with an instrument specifically designed to assess pediatric care issues. Results, therefore, may not be representative of parent views of pediatric care in the US hospitals that do not do such surveying.

CONCLUSIONS

Demographic and technological shifts, including a growing pediatric population, the survival of more high-risk neonates, and advances in pediatric treatment options, converge to make pediatric clinicians busier than ever.[36] As pediatric caregivers face this changing care landscape, it becomes increasingly important to thoughtfully consider the quality of care from the family's perspective. As difficult as the perpetually changing, complex, and busy clinical environment may be for clinicians, it is exponentially more difficult and daunting for families. Parent satisfaction surveys can be a vital source of information about how best to improve the experience from the family's perspective.

REFERENCES

1. Press I. *Patient Satisfaction: Defining, Measuring and Improving the Experience of Care.* Chicago: Health Administration Press; 2002.
2. Donabedian A. The quality of care: how can it be assessed? *JAMA.* 1988;260:1743-1748.
3. America's best hospitals 2003: US News and World Report [Web page]. Available at: http://www.usnews.com/usnews/nycu/health/hosptl/tophosp.htm. Accessed November 13, 2003.
4. Kenagy JW, Berwick DM, Shore ME. Service quality in health care. *JAMA.* 1999;281:661-665.
5. American Academy of Pediatrics/Institute for Family-Centered Medicine. Policy statement: family-centered care and the pediatrician's role. *Pediatrics.* 2003;112(3, pt 1):691-697.
6. CCMC. Family centered care: fact sheets [Web page]. Available at http://www.ccmc.org/fccfacts/htm. Accessed October 2, 2003.
7. Hall ME. Patient satisfaction or acquiescence? Comparing mail and telephone survey results. *J Health Care Mark.* 1995;15(1):54-61.
8. Jones TO, Sasser Jr W.E. Why satisfied customers defect. *Harv Bus Rev.* November/December 1995;73:88-99.
9. Griffin T. Facing challenges to family-centered care, I: conflicts over visitation. *Pediatr Nurs.* 2003;29(2):135-137.
10. Moore KA, Coker K, DuBuisson AB, Swett B, Edwards WH. Implementing potentially better practices for improving family-centered care in neonatal intensive care units: successes and challenges. *Pediatrics.* 2003;111(4, pt 2):e450-e460.
11. Williams R, Virtue K, Adkins A. Room service improves patient food intake and satisfaction with hospital food. *J Pediatr Oncol Nurs.* 1998;15(3):183-189.
12. Feudtner C, Haney J, Dimmers MA. Spiritual care needs of hospitalized children and their families: a national survey of pastoral care providers' perceptions. *Pediatrics.* 2003;111(1):e67-e72.
13. Eckle N, MacLean SL. Assessment of family-centered care policies and practices for pediatric patients in

nine US emergency departments. *J Emerg Nurs*. 2001;27:238-245.
14. Frampton SB, Gilpin L, Charmel PA. *Putting Patients First: Designing and Practicing Patient-Centered Care*. San Francisco: Jossey-Bass; 2003.
15. Himes MK, Munyer K, Henly SJ. Parental presence during pediatric anesthetic inductions. *AANA J*. 2003;71:293-298.
16. Ainbinder JG, Blanchard LW, Singer GH, et al. A qualitative study of Parent to Parent support for parents of children with special needs. Consortium to evaluate Parent to Parent. *J Pediatr Psychol*. 1998;23(2):99-109.
17. Clark PA, Drain M, Malone MP. Addressing patients' emotional and spiritual needs. *Jt Comm J Qual Saf*. 2003;29:659-670.
18. Holm KE, Patterson JM, Gurney JG. Parental involvement and family-centered care in the diagnostic and treatment phases of childhood cancer: results from a qualitative study. *J Pediatr Oncol Nurs*. 2003;20:301-313.
19. Barbarin OA, Chesler MA. Relationships with the medical staff and aspects of satisfaction with care expressed by parents of children with cancer. *J Community Health*. 1984;9:302-313.
20. Malone M, Gwozdz J. Best practices: after the "Oops," Part 1: satisfaction monitor [serial online]. January/February 2002. Available at: http://www.pressganey.com/products_services/readings_findings/satmon/article.php?article_id=42. Accessed September 29, 2003.
21. Pichert JW, Miller CS, Hollo AH, Gauld-Jaeger J, Federspiel CF, Hickson GB. What health professionals can do to identify and resolve patient dissatisfaction. *Jt Comm J Qual Improv*. 1998;24:303-312.
22. Allen LW, Creer E, Leggitt M. Developing a patient complaint tracking system to improve performance. *Jt Comm J Qual Improv*. 2000;26:217-226.
23. Balling K, McCubbin M. Hospitalized children with chronic illness: parental caregiving needs and valuing parental expertise. *J Pediatr Nurs*. 2001;16:110-119.
24. Ellerton ML, Merriam C. Preparing children and families psychologically for day surgery: an evaluation. *J Adv Nurs*. 1994;19:1057-1062.
25. Ashenberg MD, Lambert SA, Maier NP, McAliley LG. Easing the wait: development of a pager program for families. *Pediatr Nurs*. 1996;22:103-107.
26. Voepel-Lewis T, Tait AR, Malviya S. Separation and induction behaviors in children: are parents good predictors? *J Perianesth Nurs*. 2000;15(1):6-11.
27. HIN. Broadway tickets, hotel rooms keep patients and families satisfied. Hospital and health system management: story of the week: Healthcare Intelligence Network (HIN), 2001. Available at: http://www.hin.com/sw/hospitalHSmanagement.html. Accessed September 17, 2001.
28. Cmiel CA, Karr DM, Gasser DM, Oliphant LM, Neveau AJ. CE credit noise control: a nursing team's approach to sleep promotion. *Am J Nurs*. 2004;104(2):40-48.
29. Stephens BK, Barkey ME, Hall HR. Techniques to comfort children during stressful procedures. *Adv Mind Body Med*. 1999;15(1):49-60.
30. McIntyre MO. Promise you'll tell if it will hurt: a 7-year-old patient offers some rules for the grown-ups who work in hospitals. *The Washington Post*. September 10, 2002;HE07.
31. Cameron JA, Bond MJ, Pointer SC. Reducing the anxiety of children undergoing surgery: parental presence during anaesthetic induction. *J Paediatr Child Health*. 1996;32(1):51-56.
32. Byers JF. Components of developmental care and the evidence for their use in the NICU. *MCN Am J Matern Child Nurs*. 2003;28:174-180; quiz 181-182.
33. Lipp MR. *Respectful Treatment: The Human Side of Medical Care*. New York: Harper & Row; 1986.
34. Herzlinger R. *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry*. Reading, Mass: Addison-Wesley; 1997.
35. NACHRI. All children need hospitals focused solely on their unique needs: National Association of Children's Hospitals and Related Institutions (NACHRI). Available at: http://www.childrenshospitals.net/nachri/abouth/ACReport.pdf. Accessed September 26, 2003.
36. McClimon PJ, Hansen TN. Why are children's hospitals so busy? *J Pediatr*. 2003;142(3):219-220.