ORIGINAL RESEARCH PAPER
Volume - 12 | Issue - 04 | April - 2023 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

PARENTAL EXPECTATIONS FROM HEALTH CARE PROVIDERS OF PEDIATRIC WARDS IN TERTIARY CARE HOSPITAL ON THE BASIS OF FAMILY CENTERED APPROACH

Occupational Therapy

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ABSTRACT

Background & Objective - Implementation of Family centered (FCC) approach is required for better outcome of child health during hospitalization. For implementation of Family centered approach evaluation of parental expectations & present practice perspectives is required. The oobjective of the study was to assess parental expectations & need of Family-centered approach. **Methodology-** Mixed method approach was used with the parents of child admitted in pediatric wards between ages 3-12 years. 200 participants for quantitative (MPOC-56) & 85 for qualitative study (in – depth interview) were recruited from the paediatric wards of tertiary care hospital **Results-** It was found that parents experience higher satisfaction in Respectful & supportive care and comparatively less satisfied about providing specific information about their child during hospitalization. In- depth interview revealed themes like Family expectations, Expectations from staff, live through, Perception, Knowledge about intervention, Awareness about child health obtained. Both subpart of study shows similar findings on the basis of FCC principles that Respect and dignity is highly followed in this tertiary care hospital as well as information sharing is lacking subsequently in current practice. **Conclusion-** For the family-centered approach to be successful, health-care faculty must be properly educated, and management reforms must be implemented.

KEYWORDS

Family centered approach, Parental expectations.

INTRODUCTION-

Parents play important role in the development of child. So, it is necessary to aware parents about every change in child's health condition. Doctors and staff may not be able to explain properly child's health condition to parents due to heavy work load and time constrains. Because of various factors like parent child separation, family needs are not taken into consideration; inadequate information about treatment, lack of communication parents are not satisfied with health care services which leads to issues like conflicts and/or vandalism. So, it is necessary in India to implement family centered care approach for the better outcome of child health.

Family centered practice is based upon the belief that the best way to meet a person's need is within their families. Family centered care is an approach that recognizes the importance of the family as care client, assuring its participation in the planning action to be taken.

Family centered care in paediatrics is based on the understanding that the family is the child's primary source of strength and support that the child's and family's perspectives and information are important in clinical decision making. Family centered care is needed in all parts of paediatric care like Neonatal Intensive Care Unit, Paediatric Intensive Care Unit, general wards, etc. For better outcome in child health effective communication between Multidisciplinary team is required.

While working with paediatric population, occupational therapist should understand each family system, style, culture, values, beliefs, economic status, etc because each family is unique for better outcome of their child health. To implement to the family centered practice, the important aspect is to know the expectation of the families receiving the services. Considering all these we wanted to evaluate family centeredness in the institute where family centered care is not formally executed.

AIM-

To evaluate parental expectations from health care providers of paediatric wards in tertiary care hospital on the basis of Family - centred approach.

OBJECTIVE-

Primary objectives:

- To assess parental expectations.
- Evaluate the need of Family-centered approach in pediatric department of tertiary care hospital.
- Secondary objectives:
- To assess the current situation of tertiary care hospital on the basis of Family-centered approach.
- To promote Family-centered approach for the better improvement of child's health.

METHODOLOGY-

Study Design-

In this Mixed Method study design, Qualitative and Quantitative data was given equal importance. Qualitative study was selected to know parental expectations from health care providers in a better manner. Quantitative data gives current situation about family centered care in tertiary care hospital.

Theoretical Framework-

Considering the complexity of issues during the treatment of children in hospital which required involvement of family members. In this context the family centered care is highly recommended. The qualitative and quantitative data of this survey and in dept interview will help to understand the intricacies of their matter. Considering at this mixed methodology was analysed.

Study Setting-

Pediatric wards of tertiary care hospital

Participants:

Study Population-

parents of child admitted in pediatric wards between 3- 12 years.

Sample size- As per statistical calculation 398.

200 participants for quantitative study and 85 participants for qualitative data till data saturation were enrolled in the study. Further data collection was hampered due to COVID-19 pandemic.

Inclusion Criteria-

- Parents of child admitted in pediatric wards between age 3-12 years
- Parents willing to fill the consent form.

Exclusion Criteria-

1. Parents of children on intensive care support in PICU [Pediatric intensive care unit]
2. Parents of children having visual or auditory impairment.
3. Parents of expired children.
4. Parents of children consulting on OPD basis in tertiary care hospital.

Study Tool-

Measure of process of care -56 (MPOC-56)

Measure of process of care -56 (MPOC-56) scale is relevant and useful for measuring parents' perceptions of care giving, regardless of the child's diagnosis or the specific services received. Scale and its 5 components reflect what parents view as important health care provider behaviours. It basically provides parents perception. Measure of process of care -56 (MPOC-56) itself as tapping aspects of family centered service which were interrelated. [10]

Parents of children admitted in tertiary care hospital having stable conditions were directly approached face to face and their demographic data was collected. In the paediatric wards multidisciplinary team collectively were involved in the care of child. Which includes Occupational therapist also. After brief introduction about goal of interview and co-investigator later in same tertiary care setting interview was conducted in separate room to maintain the privacy of parent. Later MPOC-56 scale was given to the parent to fill as per understanding language Hindi, English and Marathi.

Concurrent-

Quantitative data was collected using standardized test Measure of process of scale -56. This scale gives reflexion about current situation of family centered care in tertiary care hospital. Depend on that need later implementation of family centered care will be planned.

Qualitative data was collected using in depth interview gives details about parental expectations from health care worker. Which is important for planning of intervention and doing changes in any health care systems.

The approval of the Institute's Ethics Committee (Institutional Review Board) was taken prior to the commencement of the study. The methodology has been elaborated as under.

1) Research Team And Reflexivity-

1. Personal Characteristics-

A male therapist, masters in occupational therapy as the principal investigator and a female therapist pursuing masters in occupational therapy as a co-investigator were the authors of the study. Co-investigator lives in hostel. The co-investigator conducted the interviews with the study participants. The co-investigator did not have any experience/did not undergo any training to conduct the qualitative research whereas the principal investigators being a trained therapist and having experience in conducting qualitative studies rightly guided this study.

2. Relationship With Participant-

Parents participated in the study were strangers to co-investigator. So, establishing the relationship was important, prior to the commencement of the study. The participants were clearly made aware about the personal goals and the reasons for doing the research. The interviewer had justified herself in front of the participants regarding her personal assumptions as well as the literature supporting the need for the study.

As the data saturation was started occurring in qualitative part data collection was stopped, due to shorter duration and COVID-19 pandemic.

Following steps were carried out further-

1. Investigator was introducing herself / himself, later briefly introduce about the topic after that parents' consent will be taken.
2. Considering the inclusion criteria parents of child admitted in paediatric wards were be enrolled in the study.
3. Filling of demographic forms
4. Assessment of parents of child admitted in paediatric wards were be done when patient was eligible for discharge. Study will be conducted using both Measure of process of care (MPOC 56) scale i.e., self-administered questionnaire and in – depth interview. Interview was conducted as per convenience of the parents of child in the side room of paediatric ward to maintain the privacy. That same interview will be recorded in which identity of parent will not be revealed. Principles of privacy and confidentiality shall be strictly followed. Later data was coded using unique identifiers and parents and child will not be identified anywhere. The privacy was maintained as per protocol.

Data Collection-

Each participant of the study was interviewed in in – depth interview to know the parental expectations from health care providers.

In – depth interview guide-In the beginning I noted the date, participant details. As being an investigator, I introduced myself. later I gave an overview about study topic 'Parental expectations from health care providers of paediatric wards in tertiary care hospital on the basis of Family- centred approach 'and need for it. I explained the purpose of the interview and then verbal and written consent will be taken. Following questions will be asked. All interviews will be conducted in Hindi, Marathi or English language. Investigator explained about the recorder and its confidentiality before starting in - depth interview. The questions which will be asked during interview are-

1] How long it has been since your child is admitted?
2] What was your family's expectations when child is admitted?
3] What were you informed about the progress of child?
4] How much did you understand about your child's condition?
5] What is your current understanding about treatment of your child? And what are your expectations?
6] Are you aware about the changes in the treatment?
7] What are your expectations about child care from administration, staff?

If needed, Prompts and guides, were provided by the interviewer during the interview. After taking consent individually, audio recording was done to collect the data and field notes were made during the interview. 2-3 parents were denied for the audio recording during the study their samples were excluded from the study due to discomfort. All interviews were conducted in the tertiary care setting only. Also, many times mother or father were accompanied by the child during the interview. This interview lasted for 15-20 minutes followed by the administration of the scale.

Standardized scale Measure of process of care (MPOC-56) was used.

Analysis and Findings-

Data Analysis-

For quantitative study 200 participants data obtained was compiled on a MS Office Excel Sheet (v 2019, Microsoft Redmond Campus, Redmond, Washington, United States). Data was subjected to statistical analysis using Statistical package for social sciences (SPSS v 26.0, IBM). Descriptive statistics like frequencies and percentage for categorical data, Mean & SD for numerical data has been depicted. Inter group comparison (2 groups) was done using t test. Comparison of frequencies of categories of variables with groups was done using chi square test. For all the statistical tests, $p<0.05$ was considered to be statistically significant, keeping α error at 5% and β error at 20%, thus giving a power to the study as 80%.

Total 85 participants participated for the qualitative study audio recording of this parents were transcribed with the help of MAXQDA analytics software and paper- pencil method. Charts were made to compile and segregate various codes obtained out of each participant recording. Master chart was prepared after collecting all themes and codes. Both researchers reviewed the transcript and compared coding and themes. Each then coded each quote and grouped those with similar content using the open coding method of thematic analysis. Transcript coding were assembled and themes representing the main messages conveyed by the data were extracted by both the researchers.

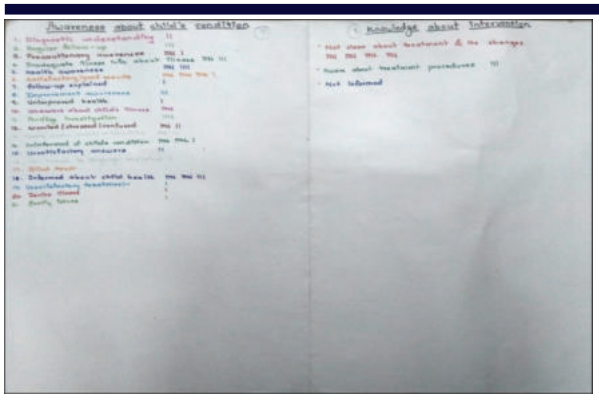

Diagram 2: Master chart of qualitative analysis containing themes and codes

Reporting-
Participant quotations were presented to illustrate the themes. Major themes were clearly presented in the findings.

RESULTS-
Descriptive Statistics-
Total 200 parents participated in the study of quantitative analysis. 85 parents were participated in interview of qualitative analysis till saturation.

Quantitative Data-
1] Descriptive table of parents participated in study and their relationship with child [Table1]

Table 1: Descriptive table of participated parents and their relationship with child

	Frequency	Percent
Mother	158	79.0
Father	40	20,0
Brother	2	1
Total	200	100,0

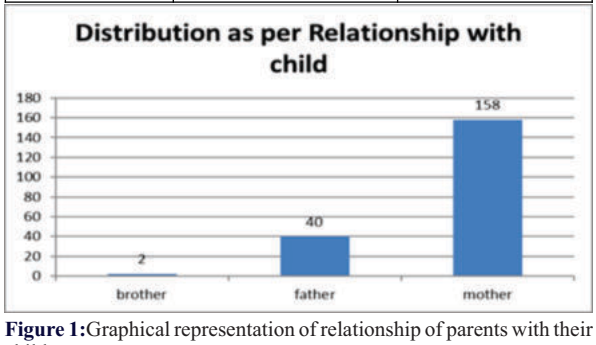

Figure 1: Graphical representation of relationship of parents with their child

Table no 1 and graph no 1 gives details about relation of participated parents towards admitted child. In which majority of participated parents were mother, later some of them were father and few brothers.

2] Distribution Of Child Gender [Table2]

Table 2:Gender distribution of admitted child

	Frequency	Percent
Male	117	58.5
Female	83	41.5
Total	200	100.0

Graph- [Figure2]

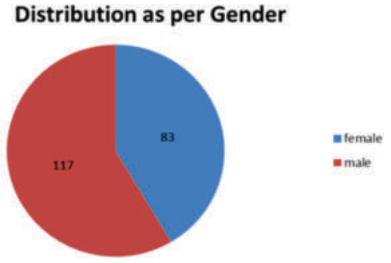

Figure 3: Gender distribution of admitted child

Table no 2 and graph no 2 shows gender distribution of the admitted child. In which majority child were male and some of them were female out of 200.

3] Mean Age Of The Admitted Child Of Parents [Table3]-

Table 3: Mean age of admitted child of parents

	N	Minimum	Maximum	Mean	Std. Deviation
Age of the child year	200	3.0	11.5	7.105	2.7439

Table no 3 gives the mean age of admitted child. As we collected parents of hospitalized children between age group 3 years to 12 years the mean age group was found to be 7.1 years.

4] Distribution of education of parents participated in study-

Table 4: Distribution of parents as per education

	Frequency	Percent
10	54	27.0
11	1	.5
12	30	15.0
2	1	.5
3	11	5.5
4	9	4.5
5	27	13.5
6	10	5.0
7	10	5.0
8	9	4.5
9	11	5.5
BA	1	.5
graduate	1	.5
graduated	12	6.0
non educated	13	6.5
Total	200	100.0

Graph [Figure4]

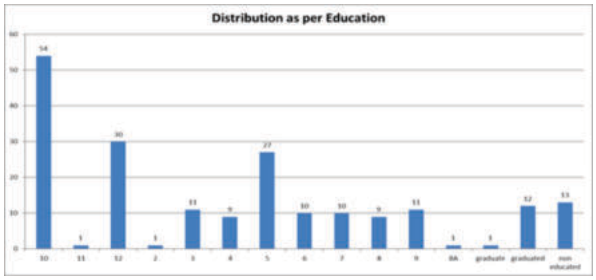

Figure 4: Graphical representation of parents as per education

Table no 4 and graph no 4-shows distribution as per the education of 200 study participated parents. In which largest parents' population education were 10th pass and later some of them 12th, 9th, 11th, graduated, etc.

6] Intergroup comparison of each domain of Measure of Process of Care-56 scale [Table6]-

Table 6 Intergroup comparison of each domain of Measure of process of care - 56 scale

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	Upper Bound	Minimum	Maximum	F value
Enabling and partnership	200	4.84188	1.411728	.099824	4.64503	5.03872	1.000	9.750	
Providing general information	200	2.85167	1.227681	.086810	2.68048	3.02285	.778	6.000	
Providing specific information about the child	200	2.72100	1.488244	.105305	2.51334	2.92866	.400	7.000	134.321
Coordinated&comprehensive care	200	4.30805	1.095681	.077477	4.15527	4.46083	1.118	6.412	
Respectful & supportive care	200	4.96667	1.338812	.094668	4.77998	5.15335	1.000	7.000	
Total	1000	3.93783	1.634261	.051680	3.83644	4.03927	.400	9.750	

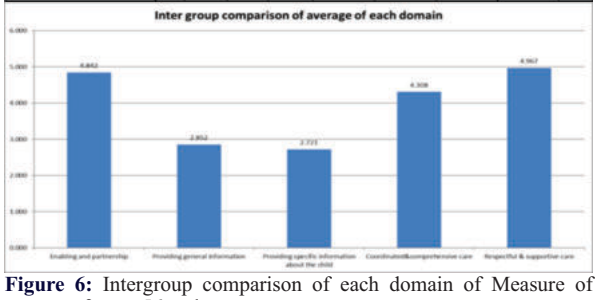

Figure 6: Intergroup comparison of each domain of Measure of process of care - 56 scale

Table no 6 and Graph 6 shows comparison of data obtained from each domain of Measure of process of care-56 scale. This table shows there was a statistically highly significant difference seen for the values between the groups ($p<0.01$) with higher values in Respectful & supportive care and least values in Providing specific information about the child.

Qualitative Analysis-

Total 85 parents were interviewed, data from parent's interview were thematically analysed. Themes were obtained from data are Family expectations, Expectations from staff, live through, Perception, Knowledge about intervention, Awareness about child health. In the following section obtained frequency of codes during analysis is mentioned in front of code name. for example, code- Correct treatment (9).

Family Expectation Domain-

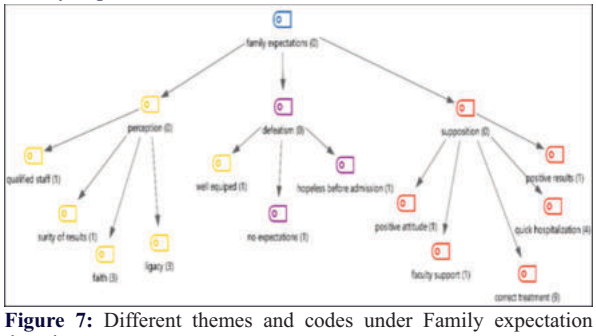

Figure 7: Different themes and codes under Family expectation domain

Parents expectations from health care providers while admitting child were analysed in Family expectation domain. 7 codes were obtained and 2 themes was yielded; **Supposition, Perception and Defeatism.**

Supposition means a belief held without proof or certain knowledge, an assumption or hypothesis[24]

In our study supposition means expecting positive things from different health care worker while admitting the child. This theme describes attitude of parents towards hospital, while admitting expectation of positive results about the child health improvement, correct treatment and support from faculty. Defeatism means the attitude of expecting something to end in failure[25]

In our study it means parents having negative thoughts while admitting child in the hospital. Defeatism includes parents having no any particular expectations during child admission. As well as some parents not having any hopes from health care professionals towards the improvement of child before admission. Perception means the ability to notice or understand something. It also means a particular way of looking at or understanding something an opinion[26]

In our study perception shows parents own assumptions towards a particular hospital before or during the hospitalisation about child heath. Perception includes faith on qualified medical faculty of tertiary care hospital, legacy and surety about results from health care professionals.

Live Through-

Live through meaning as per Cambridge Dictionary to experience something difficult or painful and continue to live. In this study it describes parents experience during hospitalization of their child in tertiary care set up[27] Parents experiences some positive as well as negative aspects from the hospital environment. Which gives two major themes **Satisfaction and Displeased**. These 2 major themes give 22 codes.

Satisfaction means good enough for a particular purpose; acceptable[28]

In this study satisfaction gives explanation about various good experience of parents during hospital stay with their children. Which includes feelings about getting solutions, free treatment, good past experience, getting financial help towards the treatment of their own child.

Displeased means to cause someone to be annoyed or unhappy as per Cambridge dictionary.

In our study it means various unsatisfied experiences of parents during hospital admission[29]

It includes mixed feeling of parents like unhappy, anxious, stress, confusion worried due to their own children health. Some parents having their own cultural beliefs [diagnosis should not be revealed to child], blaming to health care professional for everything. Various parents experienced about faculty impartiality, misguided and misdirected by staff, not informed about child health, unsatisfied with discharge, staff negligence, etc.

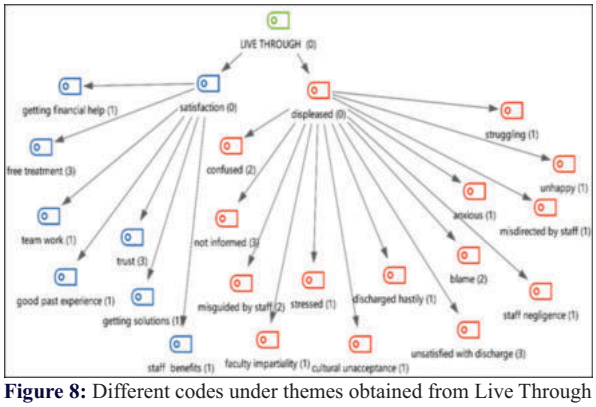

Figure 8: Different codes under themes obtained from Live Through domain

Staff Expectation

Staff expectation meaning as per Cambridge Dictionary is the feeling that good things are going to happen in the future. [30] In this study it includes all the parental expectations from health care providers of this tertiary care hospital.

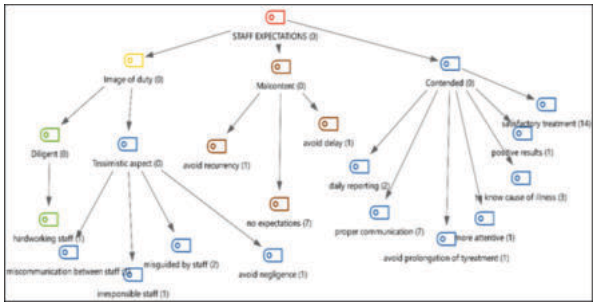

Figure 9: Different codes and themes under Staff expectation domain

Themes obtained from staff expectation domain was **Contended, Malcontent, Image of duty**. Image of duty again subdivided into **Diligent and Pessimistic aspect**. Total 15 codes were obtained from these themes.

Contended means to say or argue that something is true[31]

In this study contended gives various expectations of parents from health care professions about satisfaction of treatment.

It includes treatment satisfaction, positive results, proper communication, to know cause of illness, daily reporting, complete treatment preference, avoid prolongation of treatment, more attentive these are the various expectations of parents from different health care professionals.

Malcontent means a person who is not satisfied with a situation and complains or rebels about it[32]

In our study it means parents are not having any expectations and not satisfied too. It includes no expectations, avoid recurrency and avoid delay these are the parent's concerns.

Image of duty theme was sub-divided into **Diligent and Pessimistic** aspect. **Diligen**t means showing care and effort in your work or duties[33] In this study diligent means health care worker showing hard work towards their duty. **Pessimistic** aspect describes state of mind of someone who always expect the worst [34]A pessimistic attitude isn't very hopeful, shows little optimism, and can be a downer for everyone else.

Familial Context-

Family as context, a family system in which your primary focus is on the health and development of an individual member existing within a specific environment.

In this study familial context include surrounding environment of particular family. In familial context family is having lot of emotions while admitting their own child, sibling issue at home, economic crisis, transport problems, etc.

Awareness About Child's Condition-

This domain includes how much child are aware about their own child health condition. It includes major 2 themes like Cognizant and Inconsideration. As per Cambridge dictionary Cognizant means understanding or realizing something. Inconsideration means the act of not in consideration [thoughtful or sympathetic regard or respect].

In this study cognizant means knowledge about health awareness of their own child. Inconsideration means various things which parents are not aware about their own child health.

Cognizant includes parents' knowledge about precautions, health changes, diagnostic understanding, aware about child difficulties, regular follow up in future and blind trust on hospital faculty. Inconsideration includes unawareness of parents towards child health condition, unimproved health, unsatisfactory treatment of their child.

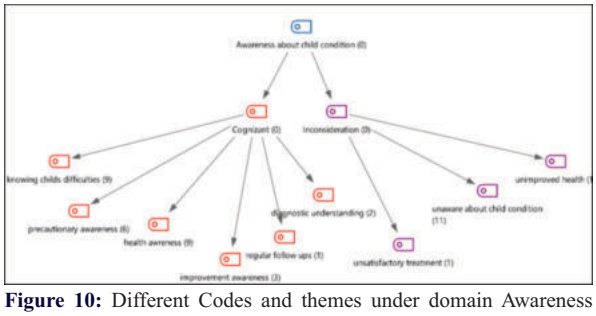

Figure 10: Different Codes and themes under domain Awareness about their child's condition

Knowledge About Intervention-

It gives mirror about parents understanding towards intervention and its changes of their child health. This domain includes 3 codes like parents not clear about treatment and its changes, not informed by health faculty, and parents aware about their child's treatment and procedures.

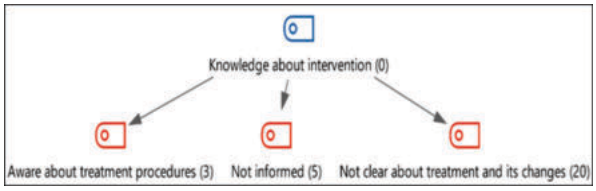

Figure 11: Codes under Knowledge about intervention domain

Family Occupation-

Family occupations occur when whole family is engaged in an occupation together. However, the shared engagement in the occupation may not be parallel or equal among family members and their purposes and experiences may be different. One commonly studied family occupation is family dinner. This domain includes 4 codes disturbed routine, family issues, financial crisis, Inattentive towards sibling.

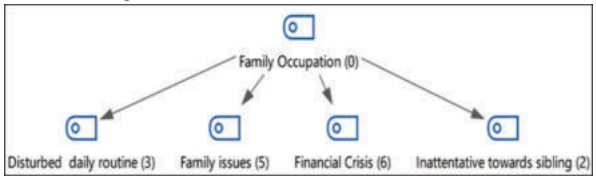

Figure12: Codes under Family occupation domain

This figure depicts the various codes obtained from family occupation domain. Due to hospitalisation of child whole family is disturbed. In this context all family members **daily routine** work is **disturbed.**

As the child is hospitalised family members are facing various **family issues** such as transportation, work related, responsibility problems, etc. Because of this sudden hospitalisation family members are facing **financial crisis.** Which will disturb their daily routine and add as stress factor on family members.

As commonly mother is staying in the hospital during child's hospitalisation the other sibling of family is at home. Even other family members are also involved in the care of hospitalised child, which will lead to **inattention towards sibling** at home in various thing like schooling, playing with them, taking studies, caring, etc.

In Qualitative analysis 85 interviews were further analysed on the basis of Family centered care principles like Respect and dignity, Information sharing, Participation, collaboration and Responsive care.

Table 7: Frequency results in percentage obtained from in- depth interview

Principles of FCC	Frequency
Respect and dignity	96.5%
Information sharing	36.5%
Participation	88.2%
Collaboration	62.4%
Responsive care	88.2%

In Table no 7 as per Family centered care principles Information and sharing principle of FCC showing lowest frequency 36.5% and Respect and dignity shows highest 96.5% frequency rate.

DISCUSSION-

Role of the whole family is important in the treatment of child. Development of child will depend on the family and surrounding environment. During the hospitalization of child collaborative approach between the health care team and family members is required for better health improvement of child. Because of this hospitalization whole family may be affected in any of the way. Family centered care is one of caring for children in hospital. It is a way of caring for children and their families within health service which ensures that care is planned around the whole family not just the individual child and which all the family members are recognized as care recipients[7]

By engaging in occupations together, families with children fulfil the functions of family unit expected of them by members of their community. A family functions as a dynamic system in which its members comprising subsystems, engage in occupations together to fulfil the functions of family.

Occupational therapist can support families in various components of their child care and family life like development of independence in self-care, participation in recreational and leisure activities, socialization and participation in social activities. While working with paediatric population occupational therapist should understand each family system, style, culture, values, beliefs, economic status, etc because each family is unique for better outcome of their child health. [35]

In consideration of this multidisciplinary system parental expectations is most important factor. This one is the major primary objective of the study. To assess the current situation of tertiary care hospital on the basis of family centered approach was the secondary objective of the study. This content was obtained through both quantitative and qualitative data. To fulfil this objective, mix methodology was preferred including qualitative part from in depth interviews and quantitative part by Measure of process of care -56 (MPOC-56) scale. For the qualitative study part in depth interviews were analysed in thematic analysis and on the basis of Family centered care principles. MAXQDA software was used in thematic analysis. Family centered care is based on the following principles-

1] Respect and dignity
2] Information sharing
3] Participation
4] Collaboration
5] Responsive care

This study shows that Respect and dignity principles of family centered care are highly followed. It means as per parents in this tertiary care hospital while taking care of child's parents are treated respectfully. Responsive care component also shows higher satisfaction which means all health care faculty is doing their duty with great responsibility. Child care should be taken care of. In the component of information sharing maybe it is lacking because of the workload in tertiary care hospital, language barrier, education and cultural background of the parents. Emmanuel M (2006) in his study analysed children with special health care needs from national survey. Though study settings are different language barrier for both the studies is same. This study also suggests strategies to reduce language barrier is needed which will improve the satisfaction among families[23]

Family centered care current application and future direction in paediatric health care (Dennis Z. Kuo, 2011) this article enumerates the core principles of family centered care and its importance in paediatric health care[36]

In this mix methodology quantitative part of Measure of process of care -56 (MPOC-56) scale gives an idea of how the interpersonal aspects of health care delivery are perceived by parents and thus provides useful information about the extent to which the services meet the need of parents. This scale is based on the subcomponent s Enabling and partnership, Providing general information about the child, Co-ordinated and responsive care, Respectful and supportive care.

Correlation between Family centered care (FCC) principles of (Qualitative study) and Measure of process of care -56 (MPOC-56) of subcomponents (Quantitative study)-

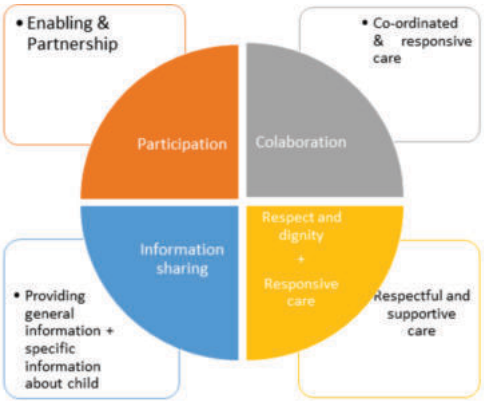

Figure 13: Correlation between FCC principles (Qualitative study) and MPOC-56 subcomponents (Quantitative study)

In the figure 13- correlation between family centered care principles obtained from qualitative study and Measure of process of care from quantitative study is explained. Filled part of this figure depicting family centered care principles derived from qualitative part of study and unfilled part from the components of Measure of process of care – 56 scale derived from quantitative part of the study. For instance, in the red colour part of figure shows Qualitative part of study depicting participation principle of family centered care is correlating with the outer red colour part of diagram quantitative part of the study enabling partnership which is subcomponent of Measure of process of care-56 scale. Similarly, it applies to all the other quadrants of diagram.

Enabling partnership is correlating with participation principle of family centered care. It says that patient and clinicians are partners in the decision making. Which encourage parents to participate in their child treatment effectively. It shows parents to participate in their child treatment effectively. It means parents are moderately satisfied about their expectations from health care faculty in this study. Depicting that approx. 50 percent parents are also participating in the treatment procedure. Parents are aware about 'health improvement', 'changes in child's condition' as per interviews codes. [आम्हाला आमच्या मुलाच्या तब्येतीबद्दल माहिती आहे, सुधारणेबाबत आणि अजून काय काळजी घ्यायची ते पण सांगितले आहे.]

Providing general information and Providing specific information about the child subcomponent of Measure of process of care-56 (MPOC-56) scale is based on Information sharing principle of family centered care. It says that clinician or other medical faculty should share the complete accurate information to the parents, which allow them to effectively participate in the treatment procedure. During interview some parents are saying about 'not informed', 'not clear about treatment and its changes' in that Information sharing principle is lacking in this tertiary care hospital may be because of heavy workload, time constraints, language barrier, parents understanding, education, etc.

(हमे बच्चे के ईलाज के बारेमे कुछ भी नही बताया अब तक)

Coordinated and responsive care subcomponents of MPOC-56 correlate with the collaboration principle of family centered care. Collaborative approach is important in health service design, evaluation and professional development, to improve child health. It also falls in the moderate category of satisfied parents. Parents during interviews expecting for 'team work' which is the core concept of the collaborative approach. (सगळ्यांनी आम्हाला समजून घेऊन सांगितले पाहिजे म्हणजे आम्ही पण आमच्या मुलाची तशी काळजी घेऊ.)

As per the obtained results from interviews Information sharing principle of family centered care is showing lowest parental satisfaction towards delivery of care. Parent says during interviews that 'they are not clear about treatment and its changes', 'not informed anything related to child health', even some parents don't understand the explained things which were told by various faculty members. This gap may be due to language issues, excessive workload on the management and hospital staff. (आम्हाला अजून काही च सांगितले नाही, उपचाराबद्दल सद्या काहीच अजून माहीत नाही, आम्हाला इंग्रजी कळत नसल्याने डॉक्टर काय बोलून गेले ते समजले नाही.)

Respectful and supportive care subscale component is correlating with the principles of family centered care Respect and dignity and Responsive care. Which says that as per family centered care principles Respect and dignity clinicians listen to and respect patient and carer values, preferences, beliefs and cultural background. The patient and carer perspective influence the planning and delivery of care. Responsive care means it provides all patients with an opportunity to participate in their care and treatment in a supportive clinician environment. Both these components are showing highest parental satisfaction from obtained results. It reflecting that in this tertiary care hospital Respect and dignity and responsive care is highly followed. Parents explained during interviews that because that because of 'blind trust' and 'faith' on this hospital they admitted their child. They satisfied for 'correct treatment' and 'proper communication'

during hospitalization. (आमचा विश्वास होता म्हणून आम्ही इथे आलो. इथे काळजीने लक्ष दिले जाते).

After analysing various interviews and parents' perception of care we considered parents expectations are at priority while treating any particular child.

From the Measure of process of care -56 (MPOC-56) scale (Quantitative part) reflecting parental perception of care provided in tertiary care hospital during their hospitalization. Table no 6 shows intergroup results obtained from each subscale of the group. Parents reflecting that Respectful and supportive care showing highest parental satisfaction about care on the other side Providing information about the child shows lowest parental satisfaction. All the other subcomponents of Measure of process of care-56 (MPOC-56) scales like Co-ordinated and Responsive care, Enabling and Partnership falls under average satisfactory category. Use of Measure of process of care -56 (MPOC-56) and Measure of process of care-Service provider (MPOC-SP) to evaluate family centered services in paediatric disability setting also states that Respectful and supportive care component of Measure of process of care -56 (MPOC-56) scale is highest and Providing general information is lowest as per their results. This study completely matches with our study results. (Dyke, 2006) [38]

Currently, this tertiary care hospital's practice must include an information sharing element. This knowledge will assist parents in better understanding their own child's health, allowing them to engage more positively during care. The gradual implementation of a Family Centered Approach can continue to promote child health in a positive way.

The existing state of tertiary care hospitals demonstrates the need for a family-centered care model to be implemented in these facilities. Proper preparation is expected for this newer adaptation in the health-care system.

CONCLUSION-

During our interviews with diverse parents, we discovered that when it comes to treating them, the interests of the parents should take precedence. It has been discovered that including parents in the recovery process improves the treatment outcome. In the end, it improves health-care quality. We were able to assess the current state of family involvement in this public hospital using the scale. This public hospital, according to this study, follows family-centered care values such as respect and honesty, as well as compassionate care. During their child's hospital stay, however, parents demand more detailed details about their child's health.

They also want to engage in the treatment and expect a collaborative approach during it. Certain components are missing in our country's public health hospitals because of the wider health-care setup, workload load, and cultural variation. With the help of health-care faculty and parents, a number of necessary changes can be made. Health-care faculty must be properly educated in order to successfully use the family-centered care approach. Reforms in management are also needed.

Limitations-

1. Sample size - as estimated sample size in methodology was 398 for the data collection. But due to time constrains and feasibly, and availability of the parents we could be able to collect 200 samples. This obtained data were collected before covid-19 pandemic later it was not collected because of probable change of parent's perspective of care and expectations also. For qualitative around 85 interviews data saturation occurred. Further analysis was done on the basis of this.
2. Majorly mothers were interviewed as fathers and other family members were not available due to various other reasons.
3. We are not able to promote Family centered care approach due to time constraints in this study but later we can continue.

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