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Participation of Parents of Hospitalized Children in Medical Rounds: A Qualitative Study on Contributory Factors

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ABSTRACT

Purpose: Factors that promote parents' participation during medical rounds on their hospitalized child have not been fully addressed. The aim of this study was to identify factors that promote the participation of family members during medical rounds.

Design and methods: This was a descriptive qualitative study using elements of analysis from the grounded theory method. Semi-structured interviews and non-participant observations were performed from December 2015 until June 2016 and took place on a general academic pediatric ward where the age of children did not exceed 12 months.

Results: In total 20 participants were interviewed: 10 pediatric nurses, 4 pediatricians and 6 parents. In addition, five medical rounds were videotaped. Five themes emerged from the analyses of the interviews and videotapes: "conditions", "structure of medical rounds", "cast", "adaptive professionals" and "parents' participation as a process".

Conclusion: Contextual factors, such as the room and seating arrangement, as well as the willingness of healthcare professionals to work together with the parents are important in enabling parents' participation. To promote active participation, professionals have to communicate in layman's terms and information given by parents has to be taken seriously. Support and coaching of parents during the medical rounds and evaluating the rounds are meaningful factors.

Practice implications: These findings help healthcare professionals to restructure the traditional medical rounds to enable parents' participation. The identified communication skills and attitudes can enhance the competencies of nurses and doctors as communicators and collaborators. This urge the need for more specific education for professionals to promote parents' participation.

Introduction

In recent decades, family participation in children's hospitals has shifted in encouraging more participation of family members in care (Coyne & Cowley, 2007; Franck & Callery, 2004; Mikkelsen & Frederiksen, 2011). The role of family members in hospital care developed from providing emotional support only to a more extensive involvement in the actual care of the child (Callery & Smith, 1991). This process is motivated by a growing body of evidence showing that greater family involvement improves patient outcomes, including less pain and a significantly higher weight gain. Moreover, family participation appears to reduce the adverse effects of hospitalization, especially anxiety and stress for both children and their parents (O'Brien et al., 2013; Power & Franck, 2008; Wolfer & Visintainer, 1975).

A new approach on family participation has emerged, known as "Family Integrated Care" (FIC). FIC promotes active participation of family members in hospital care, where healthcare professionals enable family members[1] to take part in the care and in decision making process. It is believed that this promotes a partnership between patients, family members and healthcare professionals (Bracht, O'Leary, Lee, & O'Brien, 2013). Recent studies have shown that shared responsibility

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[1] Family is defined as individuals, who are related by blood or are designated as significant others.

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in child's health is a key element of this partnership. In addition, open communication, sharing information, negotiation, respect and valuing parents as care-givers have been reported as relevant aspects of active participation (MacKean, Thurston, & Scott, 2005; Mikkelsen & Frederiksen, 2011; Smith, Swallow, & Coyne, 2015; Ygge, Lindholm, & Arnetz, 2006).

A number of studies have been published on participation of parents in pediatric hospital care (Cameron, Schleien, & Morris, 2009; Power & Franck, 2008; Shields et al., 2012; Shields, Pratt, & Hunter, 2006). Most of these previous studies focused on the experiences and perceptions of parents and healthcare professionals. Although, Power and Franck (2008) showed that attitudes and activities of healthcare professionals can be both barriers and facilitators to parents' participation.

Cameron et al. (2009) evaluated the effect of parental participation specifically in medical rounds. In that study parents reported an increased understanding of the child's condition and treatment plan, which lead to greater overall satisfaction with their child's care (Cameron et al., 2009). Furthermore, Aarthun and Akerjordet (2014) concluded that by changing routines, resources and the culture, parents' involvement in decision making can be facilitated. Palokas, Northington, Wilkerson, and Boss (2015) showed the importance of creating a flow diagram of the rounding process for the implementation of family centered rounds. However, previous studies have not fully addressed factors, such as the behavior and skills of healthcare professionals, that are needed to enable and promote parents' participation during medical rounds. If we can gain additional knowledge by an in-depth exploration of parents' participation during medical rounds, effective interventions could be developed and implemented. Therefore, a qualitative study was conducted on factors that influence the active participation of parents during medical rounds, as perceived by parents, nurses and doctors.

Study aim

The aim of this study was to identify factors (context, behavior, skills and attitudes) that enable and promote participation of parents during medical rounds.

Method

Design

We performed a qualitative study with semi-structured interviews and non-participant observations. This study was guided by a constructivist approach and elements of the grounded theory of Charmaz (2011). This approach increased our understanding of human behavior in social situations where understanding is lacking, such as the factors that influence parents' participation during medical rounds.

Setting

The study took place at Emma Children's Hospital, which is part of the Amsterdam University Medical Centers and the University of Amsterdam. The study was conducted on a general pediatric ward with children from birth to 12 months of age. The condition, treatment and care of all children are discussed on a daily basis by pediatricians, residents and pediatric nurses during medical rounds. Prior to this study, the ward restructured the procedure and started inviting parents to participate in these medical rounds.

Participants

Parents of children admitted at the general pediatric ward were invited to participate in the study, along with pediatric nurses, residents and pediatricians. The participants were selected based on purposively sampling, only participants who had experiences with the most important topic related to the purpose of this study were selected (Coyne, 1997). Therefore, participants were expected to have experience with participation in medical rounds. To ensure a heterogeneous sample, participants with a diversity in age, gender, nationality of parents and years of experience of healthcare professionals were included. During the initial stage six parents, five nurses and one medical resident were interviewed. After analyzing these data, additional participants were selected through theoretical sampling, whereby participants were selected for the development of categories (Charmaz, 2011; Coyne & Cowley, 2006). The selection criteria from the initial stage were maintained in the subsequent stage. Additionally, we selected participants with experiences that differed from those recounted in the first interviews, as this enriches the data (Boeije, 2016; Coyne, 1997; Plochg, Juttmann, & Klazinga, 2012). We therefore recruited five nurses and three pediatricians with a reluctant attitude about or limited experience with parents' participation during medical rounds. The sample size was determined by reaching data and theoretical saturation. Participants' characteristics are summarized in Table 1.

Data collection

The interviews were conducted by the principal researcher (PvO) with a background in nursing and social science (MSc). Data were collected through semi-structured, face-to face interviews. There was no formal hierarchical relationship of the researcher with the participants. Sensitizing concepts were used as a starting point and the questioning evolved based on the answers of the respondent (Charmaz, 2011). The structure of the interviews was guided by a topic list (Appendix 1), that was based on two sensitizing concepts: participation and trust (Coyne & Cowley, 2007; Power & Franck, 2008; Schmeets & Riele, 2010; Smith et al., 2015). Participation was defined as behavior, specified as perceptible actions and interactions performed by healthcare professionals and parents (Schmeets & Riele, 2010). Trust was defined as the perception which facilitates the actions and cooperation between healthcare professionals and parents (Schmeets & Riele, 2010). All interviews took place in a meeting room at the Emma Child's Hospital between December 2015 and June 2016. The duration of the interviews ranged between 23 and 54 min. The interviews were audio recorded and field notes were taken. The audio recordings were transcribed verbatim by a research assistant (GS).

In addition to the interviews, the principal researcher (PvO) conducted five non-participant structured observation sessions during medical rounds in which parents, pediatric nurses, residents and pediatricians took part. The medical rounds were randomly selected and the duration of the rounds ranged between 5 and 15 min. These five rounds

Table 1
Demographic characteristics of the participants.

	Parents (n = 6)	Nurses (n = 10)	Doctors (n = 4)
Female, number	4	10	3
Age			
25–35 years	4	5	1
36–45 years	2	2	2
46–56 years	0	3	1
Education, EQF (1–8)	Between level 4 and 7	Level 6	Level 8
Working experience		Between 1 and 26 years	Between 1 and 6 years
Country of origin, number			
the Netherlands	4		
Curaçao	1		
Belgium	1		
Admission			
First	4		
Third	2		
Length of hospital stay	Between 5 days and 20 weeks		

were videotaped by the principal researcher (PvO). With these observations we analyzed differences between the perception and intentions of the participants as stated in the interviews and their actual behavior, skills and attitude during the medical rounds.

Ethical considerations

The study was approved by the Institutional Review Board of the Academic Medical Center according to Dutch Medical Ethics law. All participants provided informed consent after they had received written information about the study. The participants agreed to the use of the videotapes by signing the permission form. The audio recordings and videotapes were stored securely in the personal file space on the university server only accessible by the principal researcher. All data were anonymized before reporting, and were used only for this study.

Data analyses

Three researchers (PvO, MS, EV), with academic degrees and experience in qualitative research (Box 1), analyzed the audio transcripts. The constant comparative method of analysis was used, which started with initial coding, followed by focused coding and theoretical coding (Charmaz, 2011). The initial coding process started with the coding of two interviews with nurses and two interviews with parents. The three researchers read and coded the transcripts independently. Two meetings were held to reach consensus about the list of initial codes and to categorize the initial codes into focused codes. After these two meetings, initial and focused coding of the remaining fifteen interviews was performed by one researcher (PvO). The coding of these remaining interviews was checked by a second researcher (MS or EV) and discussed until consensus was reached. Memos were written for each focused code. After twenty interviews, no new codes were generated and the researchers determined that data saturation was achieved.

Two researchers (RR and NvO), both with experience in qualitative research, were invited for the analyses of the video fragments (Box 1). In two meetings, the researchers (PvO, RR and NvO) coded the video fragments independently, by means of the focused code list derived from the interviews. After the coding process, the coded fragments were discussed until consensus was reached (Boeije, 2016; Plochg et al., 2012). The field notes of the coded video fragments consisted of descriptions of the behaviors, skills and attitudes of participants and the context (Holloway & Wheeler, 2013). These field notes were used for data triangulation.

Based on the coded text transcripts, memos and field notes, the categories were grouped by the principal researcher (PvO) on similarities. In a meeting with three researchers (PvO, MS, EV) the categories were compared and the researchers discussed the categories until consensus was reached on the main themes.

The data analyses were facilitated by software program MAXQDA (version 12).

Validation

Several techniques were used to increase the trustworthiness of the findings. First, methodological and investigator triangulation were used (Holloway & Wheeler, 2013). Second, member checks of the interviews were conducted. The transcripts and preliminary analyses of the interviews were sent to the participants, to confirm that these documents accurately reflected their views and experiences. Third, discussion sessions were held with the research group (PvO, MS, EV, JM) during the analysis phase of the study (Holloway & Wheeler, 2013). Finally, we used the COnsolidated criteria for REporting Qualitative research (COREQ) to ensure the accuracy of the design and execution of the study (Tong, Sainsbury, & Craig, 2007).

Box 1
Overview of researchers involved in the data analyses.

Audio analyses	Video analyses	Discussion sessions
PvO, RN MSc	PvO, RN MSc	PvO, RN MSc
MS, PT PhD	NvO, RN MSc	MS, PT PhD
EV, RN PhD	RR, RN MSc	EV, RN PhD
		JM, RN PhD

Results

Twenty participants were interviewed: 10 pediatric nurses, 4 pediatricians and 6 parents. None of the participants subsequently refused participation or dropped-out. Five medical rounds were videotaped and analyzed. Characteristics of the participants are summarized in Table 1.

Regarding the participation of parents during the medical rounds, five themes and five subthemes emerged from the analyses of the interviews and videotapes, presented in Table 2. The results are presented below, supported by verbatim quotes or field notes.

Conditions

Many parents, doctors and nurses suggested that contextual factors influence the level of parental participation. Some parents concluded that their intention to participate was inhibited by the presence of many people who did not actively participated during the medical rounds (e.g. students). To avoid interruptions, parents and nurses stated that they would prefer the medical rounds to take place in a separate room and not in the patient's room. Parents preferred to be seated in a specific arrangement: parents and nurses sitting next to each other and facing the doctor. Parents and most of the doctors and nurses explained that this facilitated eye contact among the participants.

> And those parents are always seated at the head of the table. I think it's entirely the wrong position, because it feels a bit like a tribunal. If you seat parents between the nurses, then it feels more like they are on the team [*Doctor - ID 3003*]

Furthermore, most of the doctors and nurses expressed a great willingness to work together with the parents. They considered parents to be a valuable source of information. As noticed by the doctors, this acknowledgement promotes active involvement of parents by giving them the opportunity to share their opinion about the condition of their child. Moreover, most of the participants (parents, doctors and nurses) explained that parents are the key persons to give reliable information about the behavior (deviant or otherwise) of their child.

> If the parent says: “he really urinates a lot” and the nurse replies: “not really, he doesn't urinate that much.” Then you should just ask: “Why do you think he urinates a lot?”, because parents have known their child longer than all of us together. [*Doctor - ID 3001*]

Table 2
Themes and subthemes which affect parents' participation.

Themes	Subthemes
Conditions	
Structure of medical rounds	
Cast	• Doctor as moderator • Nurse as mentor • Parents as expert of their child
Adaptive professionals	• Communication • Support of parents
Parents' participation as a process	

Structure of medical rounds

Many nurses, doctors and parents emphasized the importance of a clearly structured medical rounds. Standardizing the daily rounds in time and procedure was believed to promote participation, as it increases the predictability for parents. Some parents found it helpful to know at which time in the rounds they could share their information and concerns. The preferred structure of the medical rounds, as described by the participants, is shown in Fig. 1.

> You know what is coming and what is going to happen. Yes, then you really know where you stand. [*Parent - ID 2004*]

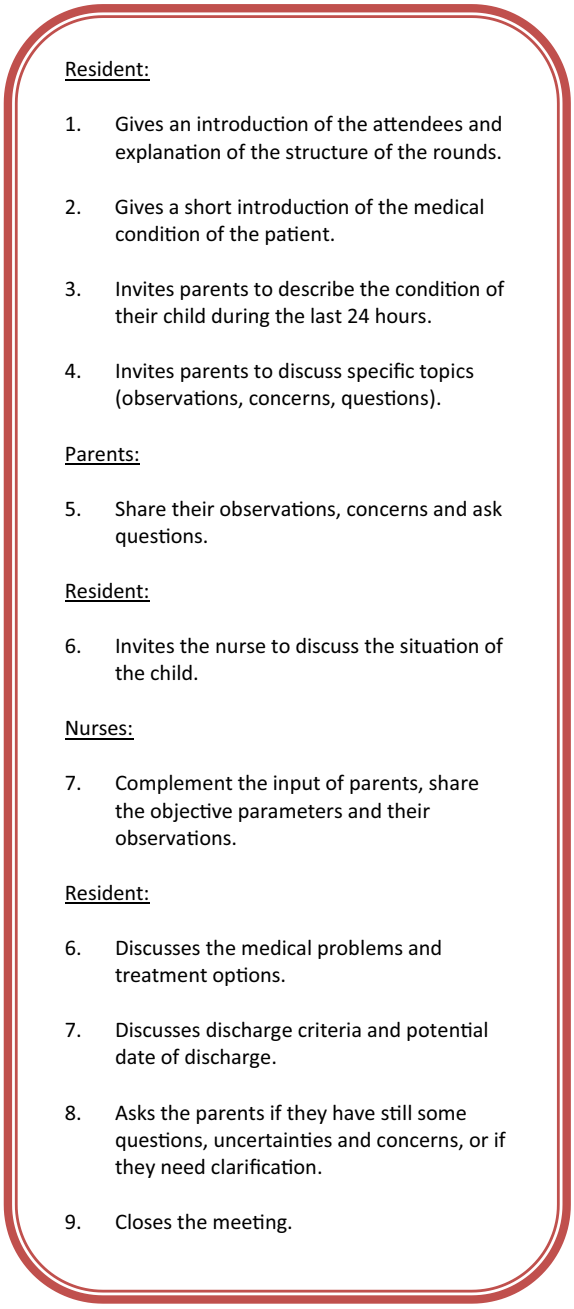

Fig. 1. Structure of the process of the medical rounds.

Cast

Nurses and doctors noted that when parents participated during the medical rounds, each of them has a specific role. The theme "cast" represents the configuration of these roles and will be illustrated in three subthemes: the doctor as moderator, the nurse as mentor and the parents as experts of their child.

> For me, however, it is very clear what the doctor is doing and what the nurse is doing, and that is completely, entirely separate. You really understand this. And the nurse also explains this: "That is something for the doctor, and we will have to discuss it with the doctor". [*Parent - ID 2001*]

Doctor as moderator

Many parents, nurses and doctors said that the doctor is the moderator during the medical rounds, systematically following the procedure. This was supported by the observations, which showed that the doctor facilitated parents and nurses in sharing information, concerns or asking questions regarding the situation of the child.

> I start with an introduction of the child. Thereafter, the discussion with the parents begins, and I say, very actively: "Now let's talk about the interview with the nurse" and then continue with more details about the care. [*Doctor - ID 3001*]

Nurse as mentor

In the observed medical rounds, there were situations with parents who shared information which was related to the professional domain of the nurse. In the interviews, nurses confirmed this kind of situations. Moreover, they said there are sometimes differences in perception between parents and nurses. Some nurses stated that this resulted in feelings of role ambiguity. Other nurses experienced a shift in their role from an autonomous nurse to a mentor.

> You are, I think, primarily a coach for the parents, because if parents are well instructed, then I am really superfluous. In any case … then I'm not … then I can still add or confirm things.[Nurse - ID 1010]

Many parents experienced being coached and supported by the nurses during medical rounds. The nurses encouraged them to ask questions and share information, observations and concerns. However, many nurses and doctors stressed that information about the condition of the child provided by parents needed to be clarified and verified with objective data. The videos showed that nurses were the key persons to objectify the input of parents by presenting parameters or observations. Nurses were also characterized as advocate of parents and their child.

> I do have the feeling that she is little bit like our advocate. Because she of course sees much more than the doctors during the day. She can sometimes really confirm something that we have seen. [*Parent - ID* 2002]

Parents as experts about their child

Many doctors and nurses considered the experiences of parents with their child as valuable, because they believed parents know the most about their child's behavior which was also experienced by a mother.

> I think parents know the most, because they are truly involved 24 hours a day. I have the impression that doctors and nurses also perceived this way. That parents are really perceived this way, that they are real experts, in any case that they know their child's behavior. [Parent - ID 2002]

Adaptive professionals

Most nurses and doctors explained that they have to adapt themselves to the participation of parents during medical rounds. In particular, they noted two important topics which were elaborated in two subthemes: the communication with parents and the support of parents.

Communication

Nurses and doctors said that they had to communicate in layman's terms. When medical terms were used, they had to provide clarification. Additionally, they had to explained and specified the proposals related to the medical plan. Some doctors and nurses stressed that it was also important to check if the information was understood by parents.

> I think that our task is to make sure that the information is correctly understood, so we have to break it down into smaller, comprehensible pieces or use different language. [*Doctor - ID 3001*]

Many parents experienced the interactions with the doctors and nurses as respectful. However, some nurses experienced difficulties when information given by the parents had to be nuanced with objective parameters or professional observations, and they were concerned about losing empathy and respect.

> Sometimes, of course, finding the right words is difficult, because you try to do it in a way that doesn't put the parents on the sidelines. You also don't want to contradict them, because it is their observation, their feeling. But you also want the doctor to know if we see it differently as nurses. [*Nurse - ID 1007*]

Many parents also noticed that professionals communicated openly and honestly. They perceived that the information provided by them was taken seriously by the doctors and transferred into action.

> I also notice that we are asked many questions, such as, "Do you recognize that? Does she also do that at home?" Because if she always does something at home, then it is familiar and is typical for her! This is taken seriously. [*Parent - ID 2003*]

Support of parents

Some nurses and parents expressed the importance of preparing the medical rounds with the parents. As stated by one father, the emotional state of parents surely affects their input.

> During the first rounds there were questions because it is the first time that you did something like that and then you talk about it later with the nurse and … you normally don't have that if you slept well and your brain is working. [*Parent – ID 2006*]

> When the rounds are going well and everything has been discussed with the parents, then I think: "so, I did rather well!" I did my homework [*Nurse - ID 1010*]

Many parents and nurses indicated that the exploration of information needs of the parents was not well-guided by the nurses and doctors. The videos confirmed this, although doctors tried to explore the information needs, this was done quickly and tended to be superficial.

> Sometimes people ask what my needs are, and then I answer, but people don't always act accordingly. It just came up, and maybe we should have responded more, but I felt uncomfortable about going into this in detail, there was underlying time pressure, which I also gave into.[Parent - ID 2002]

Finally, parents and nurses both noted the importance of an evaluation of the medical rounds afterwards. This time was used to discuss the role and input of parents, to check if the given information was correctly understood.

> For parents, there are very many impressions at such a time. You sometimes notice this, and then you wonder afterwards if they have understood everything that was discussed during the rounds or if there are still questions. Then they often ask us these questions. [*Nurse - ID 1004*]

Parent participation as a process

The way parents participated during medical rounds was described by the doctors and nurses as a process that evolves during the course of an admission. Most of the participants (parents, doctors and nurses) perceived that the level of participation of parents during medical rounds varied per person and over time.

> There are people who are of course very cautious at first, but they gradually have their say and fulfill their role. And sometimes they do this so well that the nurses hardly need to add anything. Other parents only talk about how it is going with their child during the introduction of the rounds. [*Doctor - ID 3002*]

However, many doctors and nurses suggested that family-related and personal characteristics, like socioeconomic status and family structure, influenced how parents participate. In addition, parents and nurses suggested that the level of participation may also be influenced by the cultural background and personality of parents. Several nurses stated that some parents are more eager to learn about the medical condition of their child than others. Additionally, many nurses and doctors stressed the importance of mastering the language of the country of residence.

> Maybe there is a relationship with socioeconomic status. Because you see well-educated parents who do take that role. They are much more proactive and they dare to ask many more questions. While people with lower socioeconomic status, I think, tend to listen passively and do not ask critical questions. [*Doctor - ID 3003*]

Many parents, doctors and nurses noted that parents who participated during medical rounds learned from their experiences. On the first day of admission, for example, many parents emphasized that they wanted to be informed by the nurses about the possibility of participating in a medical round. Nurses and doctors expressed the importance of giving adequate information and instructions about the procedure of medical rounds. Nurses and parents also suggested that at the start of medical rounds with a new parent, the expectations of each parent should be discussed to avoid irrelevant reactions.

> It is good to know some things in advance: as a parent should you pay attention to something or do we expect you to answer certain questions? The context should be clear and so should the objective of the rounds. [*Parent - ID 2003*]

Many parents, doctors and nurses also noted that the level of parents' participation fluctuated from obtaining information (passive) to debating with the doctors and nurses (active). According to some doctors and nurses, parents became more familiar with medical jargon and were more capable of sharing relevant information, as their experiences grew.

> After four or five months of experience, you have become so familiar with all the terms that you understand them. [*Parent –ID 2004*]

> If parents are doing it for the first time, they say: "Yes, it is going well!" When parents have more experience with the rounds … It

is possible that parents say exactly what the doctor wants to hear, so that you as a nurse can affirm this or perhaps add more detail. [*Nurse – ID 1008*]

Moreover, many parents noticed that doctors provided information without checking the information needs of parents. As a result, one mother described how she actively searched for information beforehand so she could ask the healthcare professionals informed questions.

For example, I searched on the Internet, enabling me to ask some specific questions. The attending physician then said something like: you are looking this up yourself, so we will take account of this. But, yeah, it had to come from me first, before they told me everything. [Parent - ID 2001]

Discussion

The findings revealed that context, procedure and the structure of medical rounds can enable active participation of parents. To promote active participation, parents' have to be supported and coached. Thereby it is essential that doctors and nurses adapt their communication and behavior to the presence of parents.

Enabling parents' participation

In our study we showed that specific conditions in the organization and procedures of the medical rounds are important to enable parents' participation. Prior research has also shown that organizational factors, such as resources, documentation and facilities, can enable parents' participation (Aarthun & Akerjordet, 2014; Coyne, 2015; Lam, Chang, & Morrissey, 2006). Some of these factors such as the documentation and resources which enabled active participation of parents were available in our study setting. The medical rounds were structured like a meeting with a time schedule, organized procedure and well thought-out context, and documented in a flowchart. This resulted in an increased ability for parents who wanted to participate. An important skill of the doctor is to maintain the structure of the medical rounds, which should improve the predictability. This is important for parents, Thompson, Hupcey, and Clark (2003) has shown that hidden expectations and a lack of guidance may cause stress or a feeling of abandonment by parents.

Moreover, Redley et al. (2018) showed that environmental factors could hinder the opportunity for patient participation. In this study the rounds were in a meeting room with a fixed seating arrangement (see Fig. 2). This avoids distractions, facilitates eye contact between the parents, nurses and doctors, and parents can be physically positioned as members of the team. In addition, the standardized procedure facilitated open communication, sharing information and valuing of parents as experts, all elements that promotes interaction between parents and healthcare professionals (MacKean et al., 2005; Mikkelsen & Frederiksen, 2011; Smith et al., 2015; Ygge et al., 2006).

Promoting parents' participation

Attitudes and activities of healthcare professionals may act as barriers or facilitators of parents' participation (Power & Franck, 2008). Thereby, medical rounds are formal meetings led by medical staff and represent a medical dominated model. However, in our study we show that an important factor in promoting parents' participation during medical rounds is the acknowledgement of healthcare professionals that parents are the experts about their child. Furthermore, when parents participated, a “cast” with specific roles and tasks appeared. In this study nurses acted as mentors; they verified information given by parents and they also coached and supported parents to express their information, concerns and to ask questions during the medical rounds. Furthermore, they were considered to be advocates of the parents and their child.

A recent study showed that patients could meaningfully contribute to rounds when they received information delivered in a way they could understand and feeling respected by the healthcare professionals (Redley et al., 2018). In our study, we found the importance of the adaptation of healthcare professionals to the presence of parents. Professionals have to communicate in layman's terms and information given by parents has to be taken seriously. In the present study the interaction was characterized by honesty, respect and with the attitude that parents

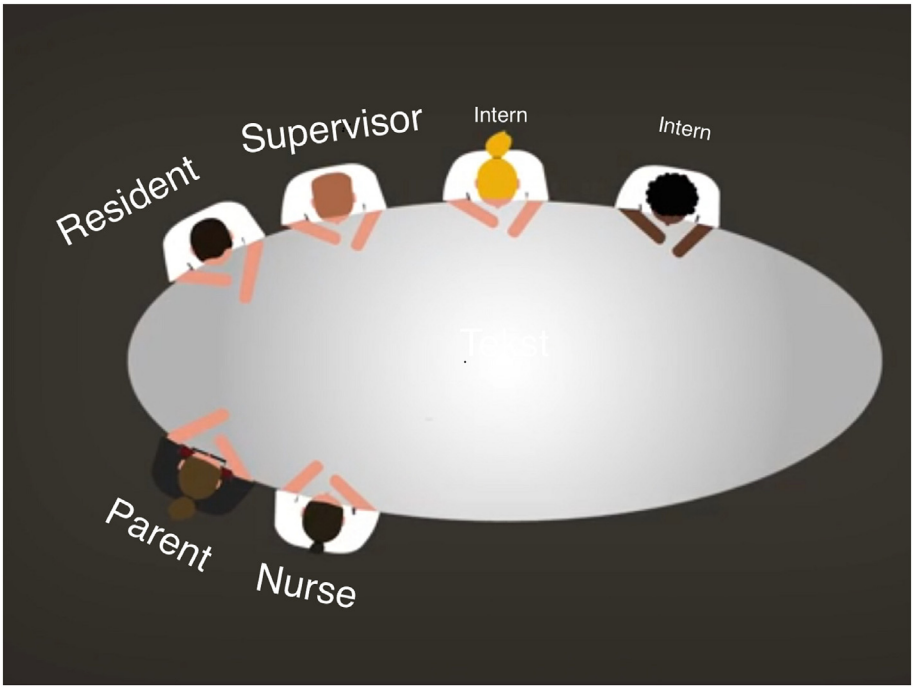

Fig. 2. Seating arrangement.

and healthcare professionals were working together as a team. This relationship can be defined as collaborative partnership (DeMaso & Bujoreanu, 2013). In this study, however, the needs of parents were not always elicited and explored by doctors. This suggests there is a need for more focus on the unique needs of each parent and their level of understanding (Beck, Meyer, Kind, & Bhansali, 2015). Parents feel supported when they are given information and instructions about the medical rounds. This result was also reported in a previous study, from which the authors concluded that parents' participation would increase if they received instructions and guidance (Kristensson-Hallstrom & Elander, 1994).

Future research

In this study, it was suggested that the level of parents' participation may be influenced by the characteristics of parents, such as cultural background, educational level and socio-economic status. However, by promoting parents' participation, parents' access to health information could improve. The ability of parents to use this information effectively is also related to the level of their health literacy (Nutbeam, 2000). Future research should focus therefore on parents who are reluctant to participate. In addition, the influence of the characteristics of the parents on participation and the negative experiences of participating related to their health literacy needs further exploration.

Strengths and limitations

We used elements of a robust methodology for data collection and analyses following the COREQ recommendations. (Charmaz, 2011; Tong et al., 2007). The trustworthiness of the findings is assured by investigator and data triangulation, and by research meetings in which the analyses were discussed. There were also several limitations. We studied the participation of the parents on a ward with children from birth to 12 months old only. This may influence the transferability of the findings, as the role of the parents may change when the child becomes older. Thereby, only parents who had experience with participation during medical rounds were included and we did not interview parents who declined to participate. As a result, we did not study the opinions of all parents about participation during the medical rounds.

Practice implications

Based on the identified skills and behavior in this study, such as communication, the competencies of nurses and doctors as communicators, collaborators and health advocates related to parents' participation can be enhanced. In this way healthcare professionals can be educated and enabled to include parents as a central member of the care team and to promote parents' participation during medical rounds. Thereby, identified factors, such as structure of medical rounds, could help the doctors and nurses to restructure the traditional medical rounds and to enable parents' participation.

Conclusion

Parents are acknowledged as experts of their child and are given the opportunity to share their observations and concerns. In this study, doctors facilitate parents to participate actively, while nurses support the parents. In addition, to promote parents' participation actively, healthcare professionals should adapt their communication to the presence of parents by talking in layman's terms. Nurses can support parents by instructing them before the medical rounds, coaching during and evaluating the medical rounds afterwards. However, the results of this study suggest that the conditions and the structure of the medical rounds are important factors to enable parents' participation. The structure and procedure of the medical rounds has to be clear for all the participants. The contextual factors, such as the room and seating arrangement, as well as the willingness of healthcare professionals to work together with the parents are considered important in enabling parents' participation.

CRediT authorship contribution statement

Peter J.S. van Oort: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Visualization, Project administration. **Jolanda M. Maaskant:** Conceptualization, Methodology, Validation, Formal analysis, Resources, Writing - review & editing, Supervision, Project administration. **Marian Smeulers:** Methodology, Validation, Formal analysis, Writing - review & editing. **Nicky van Oostrum:** Writing - review & editing. **Eric Vermeulen:** Methodology, Validation, Formal analysis, Writing - review & editing. **Johannes B. van Goudoever:** Resources, Writing - review & editing, Supervision.

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Conflict of interest

We have no conflict of interest to declare.

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Appendix 1. Topic list

Topics	Sub topics
Interpretation of the definition of participation	
Considerations about participation	
Factors which influence active participation	
Collaboration with the participants during the medical rounds	
	Shared goal setting
Providing information during the medical rounds	
	Considerations Barriers
Receiving information during the medical rounds	
	Considerations Barriers
Language use during the medical rounds	
Relationship with the participants in the medical rounds	
	Equality Negotiation
Expectations of other participants during the medical rounds	
Trust in others	
Interpretation of a respectful collaboration	

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