Strategies for Improving Family Engagement During Family-Centered Rounds

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BACKGROUND: Family-centered rounds (FCR) are recommended as standard practice in the pediatric inpatient setting; however, limited data exist on best practices promoting family engagement during rounds.

OBJECTIVE: To identify strategies to enhance family engagement during FCR using a recognized systems engineering approach.

METHODS: In this qualitative study, stimulated recall interviews using video-recorded rounding sessions were conducted with participants representing the various stakeholders on rounds (15 parents/children and 22 healthcare team [HCT] members) from 4 inpatient services at a children’s hospital in Wisconsin. On video review, participants were asked to provide strategies that would increase family engagement on FCR. Qualitative content analysis of interview transcripts was performed in an iterative process.

RESULTS: We identified 21 categories of strategies corresponding to 2 themes related to the structure and process of FCR. Strategies related to the structure of FCR were associated with all five recognized work system elements: people (HCT composition), tasks (HCT roles), organization (scheduling of rounds and HCT training), environment (location of rounds and HCT positioning), and tools and technologies (computer use). Strategies related to the FCR process were associated with three rounding phases: before (HCT and family preparation), during (eg, introductions, presentation content, communication style), and after (follow-up) FCR.

CONCLUSIONS: We identified a range of strategies to enhance family engagement during FCR. These strategies both confirm prior work on the importance of the content and style of communication on rounds and highlight other factors within the hospital work system, like scheduling and computer use, which may affect family engagement in care. Journal of Hospital Medicine 2013;8:201–207. © 2013 Society of Hospital Medicine

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METHODS

Study Design
Semistructured interviews using the stimulated recall approach20,21 were conducted to understand the cognitive processes of families and healthcare team (HCT) members during FCR. This qualitative study design allowed us to capture comprehensive information from the perspectives of a diverse group of stakeholders on strategies for improving family engagement during FCR.

Setting and Participants
This study was conducted at a children’s hospital in Wisconsin, where FCR were initiated in 2007 with the transition to a new hospital facility. The expectation is that FCR are conducted daily with the family and the patient’s HCT, consisting of at least an attending physician and nurse. Typically, multiple residents, interns, and medical students are present along with a combination of other providers, including consulting subspecialists, a fellow, nurse practitioner, respiratory therapist, or pharmacist. When this study was conducted, attendees received little to no formal training regarding their role on FCR. As part of a larger study, English-speaking patients and/or families admitted to 1 of 4 inpatient services (2 hospitalist, 1 pulmonary, and 1 hematology/oncology), and their associated HCT members were enrolled and their bedside rounds were video recorded. A purposive sampling technique22,23 was employed, recruiting interviewees that represented the various groups of stakeholders of rounds, including parents, children, attending physicians, resident physicians, medical students, and nurses. For child interviews, we restricted selection to children aged 8 to 17 years to ensure the ability to understand the interviewing process and provide feedback. Families were consented and children were assented. The University of Wisconsin-Madison Health Sciences Institutional Review Board approved this study.

Interviews and analysis occurred concurrently in an iterative process, informing each other. Thus, recruitment continued until we reached theoretical saturation,24,25 the point at which additional interviews did not provide new information or further conceptual development.

Study Procedures
All interviews were conducted by trained researchers, who used the same semistructured interview guide. During each interview, the interviewee was instructed to watch his/her own rounding video and pause when noticing something that made it easy (facilitator) or hard (barrier) to engage the family. Every time the interviewee paused the video to describe what was noticed, the interviewer then asked follow-up, open-ended questions to solicit specific information that focused on strategies for enhancing family engagement during FCR. For instance, if the issue identified was a barrier, the interviewer asked, “What would you have wanted to happen differently?” and if the issue identified was a facilitator, the interviewer asked, “How could we ensure that would happen for everyone?” The interviewee rewound the video as needed. If the interviewee had not stopped the video by the halfway point, the interviewer would pause the video and review the instructions. After the interviewee had viewed and commented on the entire rounding video, an opportunity was offered to reflect on other factors that influence family engagement during rounds, and additional questions were asked as necessary to fully understand the interviewee’s views. All interviews were audio recorded and personal identifiers were removed prior to data analysis.

Data Analysis
Two research assistants reviewed the audio recordings and identified all instances related to strategies for improving family engagement during FCR. There was no screening of strategies (ie, if an interviewee suggested a strategy was related to improving family engagement, it was categorized as such). To ensure intercoder reliability, these assistants, under the supervision of a researcher (L.D.), reviewed the coding process together, held consensus meetings, and cross-checked interviews for coding consensus. A researcher (A.X.) transcribed all strategy-related instances, which were then reviewed by two additional researchers (M.K., P.C.). To organize, sort, and code the data, interview transcripts were imported in the NVivo qualitative data analysis software (QSR International, Doncaster, Victoria, Australia). The research group then performed a qualitative content analysis of the transcripts26 and categorized the strategies in an iterative process (information provided on request).

To ensure that all strategies remained conceptually similar within categories, the constant comparative method27,28 was applied to the coding process. This involved comparing: 1) strategy-related instances from the same participants, 2) strategy-related instances from different participants in the same groups, 3) strategy-related instances from different participants in different groups, 4) a coded strategy with other coded strategies, 5) coded strategies with categories, and 6) a category with other categories. A strategy-related instance could be coded under more than one strategy or category. For instance, one interviewee said “conducting things that can be done without family beforehand, and presenting and reviewing the plan with family.” This was coded under both the strategy “conducting rounds in another location without family and then at the bedside with family” in the “location of FCR” category and the strategy “focusing presentation on assessment and plan” in the “communication style” category.

RESULTS
A total of 37 interviews were conducted with 11 parents, 4 children, and 22 HCT members (8 attending physicians, 6 resident physicians, 5 medical students, and 3 nurses) in 24 videos of rounding sessions.
The duration of the interviews ranged from 30 to 60 minutes.

A total of 338 separate instances related to strategies for improving family engagement on FCR were identified and sorted into 21 categories. Using the SEIPS model, these categories were organized into 2 themes: the work system and process of FCR (Figure 1). Of the 21 categories, 12 were mentioned by both families (parents and/or children) and HCT members and 9 were solely mentioned by the HCT.

**Work System of FCR**

Table 1 shows the categories of strategies related to the 5 elements of the FCR work system. Illustrative quotes from the interviews (Q) are presented in Table 2.

**People**

Two seemingly contradictory strategies were proposed. Some interviewees suggested a smaller HCT with members most familiar to the family (Q1), whereas other interviewees stressed the need to involve different relevant disciplines (eg, social worker, nutritionist) during rounds (Q2).

**Tasks**

Both attending and resident physicians emphasized the importance of defining the role of each HCT member before rounding (Q3). Interviewees also suggested these roles should be explained to families, ideally at admission.

**Organization**

Many interviewees suggested the need to consistently schedule rounds (Q4) and to inform families and nurses of the schedule so all parties could plan ahead (Q5). Some resident physicians and medical students recommended training of learners on how to give a family-centered presentation using methods such as role modeling (Q6) and practicing with the senior resident physician (Q7) or in small groups (Q8).

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**TABLE 1. Categories of Strategies for Improving Family Engagement During FCR—Work System of FCR**

<table>
<thead>
<tr>
<th>Work System Elements</th>
<th>Categories</th>
<th>Strategies</th>
<th>P (11)</th>
<th>C (4)</th>
<th>Att. (8)</th>
<th>Res. (6)</th>
<th>MS (5)</th>
<th>RN (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>1. Size and composition of HCT</td>
<td>Have a smaller HCT conduct FCR</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Roles and duties of HCT members</td>
<td>Ensure all relevant disciplines present on FCR</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Timing and scheduling of FCR</td>
<td>Define roles/duties of HCT members on FCR</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Training of HCT for FCR</td>
<td>Schedule FCR, inform participants beforehand</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Location of FCR</td>
<td>Train HCT on how to present on FCR</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Positioning of HCT members on FCR</td>
<td>At bedside with family and patient</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Use of computers on FCR</td>
<td>In another location with HCT, then at bedside</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Use of coins on FCR</td>
<td>In another location with family but without child</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Use of dice on FCR</td>
<td>Sit down with family</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Use of cards on FCR</td>
<td>Stand close to or in a semicircle around family</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Use of question cards</td>
<td>Use computer to support family interaction</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Use of games</td>
<td>Don’t use a computer</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Abbreviations: Att., attending physician; C, child; FCR, family-centered rounds; HCT, healthcare team; MS, medical student; P, parent; Res., resident physician; RN, nurse; X, 1 or more participants mentioned this strategy.

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**FIG. 1.** Systems Engineering Initiative for Patient Safety model of strategies for improving family engagement during family-centered rounds (FCR). Abbreviations: HCT, healthcare team.


TABLE 2. Quotations Regarding Strategies Related to the Work System of FCR

Q1: “I’m intimidated to ask a question. It seems like there are too many people. I like a smaller group.” (P5)
Q2: “Sometimes rounds are the only time that the parents are there to see the entire team. . . . so in that way, including [the entire team] at the rounds makes more sense.” (MS1)
Q3: “There needs to be much more clear roles about who is supposed to do what, and it should be predictable.” (Att.2)
Q4: “[T]iming of rounds) is a huge source of frustration for families. If [physicians] know in which order they will go for patients, they can call our charge nurse or unit clerk or page nurses with that information.” (RN1)
Q5: “[W]ith a notice of the rounding schedule, I can be ahead of time, trying to think of questions.” (P10)
Q6: “[O]f course we feel today . . . somebody do a presentation in a medical eye’s version and then also in the family-centered version.” (MS5)
Q7: “[G]iving the medical students practice with the senior resident. . . . is a good way of doing it.” (Res.4)
Q8: “[M]aybe some small groups where you practice this among students.” (MS5)
Q9: “It would be better to be in the room for communication.” (P1)
Q10: “You could have sort of hallway rounds, which is much more medical oriented, and inside-the-room rounds, which is much more talking with the parent.” (Res.5)
Q11: “Have sit-down rounds with parents and families.” (Res.5)
Q12: “I’ve seen some attending physicians who sat down. I think that could be helpful to be on the same level as the patient and family.” (Res.2)
Q13: “[M]aybe formation of semicircle or something like that, where we can see everybody a little more clearly. I think that would be very helpful.” (P10)
Q14: “I find the presence of a computer incredibly offensive and obstructive . . . when you are supposed to be able to interact with the patient.” (Att.6)
Q15: “One of the things I started doing is having one of the other resident physicians have the computer, so just relying on them to do the orders, and me just being there mainly for being the presenter of rounds.” (Res.4)

NOTE: Abbreviations: Att., attending physician; FCR, family-centered rounds; MS, medical student; P, parent; Res., resident physician; RN, registered nurse.

Environment

Some interviewees suggested conducting rounds in patient rooms (Q9). Others suggested conducting rounds first in another location (eg, hallway) without the family and then going to the bedside to round with the family (Q10). There were also interviewees who suggested conducting rounds in another location (eg, conference room) with the family (Q11). When conducting rounds in the patient room, some interviewees suggested that some HCT members (eg, attending and senior resident physicians) could sit down with the family (Q12), with the rest of the HCT standing close to the family in a semicircle (Q13).

Tools and Technologies

Some interviewees thought that conversation with families could be negatively affected by the use of computers, and therefore suggested not using them on FCR (Q14). Alternatively, other interviewees considered computers a tool to facilitate the interaction between the HCT and families, such as showing x-rays or lab values. Several interviewees suggested that

TABLE 3. Categories of Strategies for Improving Family Engagement During FCR—Process of FCR

<table>
<thead>
<tr>
<th>Process Phases</th>
<th>Categories</th>
<th>Strategies</th>
<th>P (11)</th>
<th>C (4)</th>
<th>Att. (8)</th>
<th>Res. (6)</th>
<th>MS (5)</th>
<th>RN (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before FCR</td>
<td>8. HCT preparation</td>
<td>Collect and prepare pertinent information</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>9. Family preparation</td>
<td>Orient family to rounding process</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Build relationship with family</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask family for permission and preferences</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>During FCR</td>
<td>10. Introduction and explanation of FCR</td>
<td>Introduce HCT and family to each other</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain interactive rounding process</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>11. Active involvement of nurse</td>
<td>Giving nurse opportunity to actively participate</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>12. Communication with family</td>
<td>Give family opportunity to actively participate</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Address family’s questions/concerns</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain tests, findings and results to family</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>13. Giving presentation</td>
<td>Restructure the presentation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shorten the presentation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus presentation on assessment and plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>14. Communication style</td>
<td>Present in a conversational manner</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use an engaging communication style</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>15. Language used</td>
<td>Use qualitative language</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use plain language</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>16. Performing physical exam</td>
<td>Pause and confirm physical exam</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>17. Managing distractions</td>
<td>Minimize distractions and interruptions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>18. Senior physician leading/role modeling</td>
<td>Attending/resident physician should lead, direct and be a role model on FCR rounds</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>19. Teaching</td>
<td>Ask family permission and involve in teaching</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>20. Customizing FCR for family</td>
<td>Adapt rounds to family’s needs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>21. Following up with family</td>
<td>HCT members follow up with family</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

NOTE: Abbreviations: Att., attending physician; C, child; FCR, family-centered rounds; HCT, healthcare team; MS, medical student; P, parent; Res., resident physician; RN, registered nurse; X, 1 or more participants mentioned this strategy.
computers should not be positioned to block eye contact between HCT members and families; therefore, only HCT members not presenting should use computers (Q15).

Process of FCR
Table 3 shows the categories of strategies related to the process of FCR, which were categorized into 3 phases. Illustrative quotes are presented in Table 4.

Before FCR
To engage families during FCR, many interviewees suggested that both the HCT and families need preparation. HCT members suggested that medical students should collect up-to-date patient information and review it with the senior resident physicians (Q1) to reach a consensus before starting FCR (Q2). To prepare families for rounds, parents and HCT members suggested that the HCT should orient families to the rounding process (Q3), build relationships with families (Q4), and ask for their permission and preference regarding participation in rounds (Q5).

During FCR
A number of strategies focused on the beginning of rounds. Parents, children, and HCT members stressed the need to introduce HCT members by role (Q6) and inform families to whom to direct questions (Q7). It was also suggested that parents introduce themselves to the team. Some interviewees recommended that the HCT explain the rounding process to families at this time (Q8).

Interviewees recommended strategies related to communication between the HCT and families during rounds. Many interviewees suggested restructuring and shortening the presentation by focusing on the assessment and plan (Q9). According to all interviewees, the HCT should present in a conversational manner and use an engaging communication style (eg, smiling, making eye contact, using appropriate humor) and appropriate language (eg, qualitative trend instead of numbers, plain language instead of medical jargon) to communicate with families. To ensure families understanding, HCT members should encourage and address their questions and concerns (Q10). In addition, families should be given the opportunity to provide information (eg, patient history and overnight events) and to express their opinions about the plan (Q11). If teaching is done during rounds, the HCT should involve families and ask for permission (Q12).

Other strategies on rounds were suggested, such as giving nurses the opportunity to actively participate (Q13), pausing and confirming physical exam findings (Q14), minimizing distractions and interruptions (Q15), attending and/or senior resident physicians leading and being role models for FCR (Q16), and adapting rounds to families’ needs (Q17).

After FCR
Some HCT members talked about the importance of following up with families after rounds. Specifically, suggestions that nurses could stay with families immediately after rounds (Q18) were made, whereas physicians could return to families later in the day (Q19).

DISCUSSION
Using recognized qualitative systems engineering methods, we identified a broad range of strategies for enhancing family engagement on FCR from the perspectives of a diverse group of stakeholders on rounds and described how these strategies target known fundamental elements in both the hospital work system.
and rounding process. We highlight recommendations on the content and style of communication during rounds with families, but also introduce more complex system-wide elements that likely play a role in family engagement, such as the composition of the HCT; organization and environment of rounds; tools and technologies used; and preparation of the HCT, families, and patients beforehand.

Our research both confirms and builds upon practices previously described in the FCR literature. In a case report by Muething et al., recommendations were developed using a series of plan-do-study-act cycles to determine the components needed to conduct FCR. These components included: 1) determining family preference prior to rounds, 2) defining HCT roles, 3) introducing HCT to family and explaining the purpose of rounds, 4) describing what is shared and how it is said on rounds, 5) describing the contribution of families, nurses, and ancillary staff, and 6) providing teaching recommendations to senior physicians on rounds. All of these components are suggested by one or more of the participants in our study. In addition, our research identifies a variety of new work system-related strategies, such as scheduling rounds, using computers appropriately on rounds, and providing training of HCT members beforehand.

Of particular interest was the discordance between strategies mentioned by families and the various members of the HCT. Although HCT members mentioned all identified strategies, families were interested in certain ones. Regarding the structure of FCR, families showed particular interest in HCT composition, timing and scheduling of rounds, location of rounds, and positioning of the HCT. In comparison, families did not mention the importance of the roles and duties of HCT members, HCT preparation for rounds, and use of computers during rounds. With respect to the FCR process, families stressed the importance of family preparation beforehand, introduction and explanation of rounds at the beginning, presentation style and communication style, customization, and management of distractions during rounds. None of the families, however, mentioned the rest of the strategies, including HCT preparation before rounds, involvement of the nurse, teaching and performing the physical exam, the role of the attending and senior resident roles during rounds, and following up with the family after rounds. These different perspectives are likely, in part, inherent to the different roles and experiences of parents and HCT members. For example, parents’ knowledge of what goes on in the hospital outside of FCR, such as orientation and preparation of HCT members for rounds, is relatively limited. Future research using methods to evaluate and prioritize strategies as well as understanding reasons for contradicting strategies is warranted.

We recognize that, although family engagement is recommended as a critical component of care, strategies to improve engagement may be in direct opposition to other goals of the HCT. For example, some of our participants suggest having a smaller team may be more beneficial for family engagement on rounds. In some settings, it may be feasible to have a small team; however, in institutions that accommodate a large number of learners, excluding students from the teaching opportunity of rounds may actually compromise educational experiences. In patients with chronic and/or complex care, a larger multidisciplinary team may better facilitate information exchange among disciplines and expedite discharge planning. Moreover, one might speculate that it may not be that the size affects family engagement as much as the composition of the team, especially if tailored to the needs of the patient. For example, a large team consisting of primarily physicians and trainees may not be as engaging as the same sized team with one attending physician and a respiratory therapist, case manager, and consulting subspecialist. Finding a balance between engaging families, teaching learners, and maintaining efficiency is paramount and needs to be studied further.

This study has several limitations. Our data are from a single academic children’s hospital, which may limit generalizability due to a small sampling of multiple stakeholders on different services, our specific patient population, HCT composition and roles, and teaching needs. However, we face similar barriers to engaging families during rounds as those published from both another single institution and a national sampling of pediatric hospitals. Furthermore, our recommended strategies to address the FCR process are supported by prior work. Because this study was voluntary, our interviewees were likely more engaged participants in general. Specifically, the viewpoints of engaged families and HCT members may not represent the viewpoints of those who are less engaged or supportive of FCR. We did not enroll non–English-speaking patients and families, which is a potential direction for future research. In our interviews, we also relied solely on the perceptions of rounding participants, rather than those of outside observers or researchers, which may only provide a partial perspective of potential strategies to improve family engagement. Last, this qualitative research approach does not provide quantitative information regarding whether certain strategies are preferred by a majority of participants, which we hope to address in future research.

This work is part of a larger study that aims to implement a bundle of these strategies after stakeholder prioritization based on impact on family engagement, feasibility, and sustainability. We plan to systematically evaluate the implementation process of these strategies and measure their impact on family engagement and, ultimately, patient safety. One or more of these strategies could be implemented in a...
similar manner at other hospitals depending on specific institutional needs.

In conclusion, as recently reflected by Barry et al. in The New England Journal of Medicine, “Although talk about patient-centered care is ubiquitous in modern health care, one of the greatest challenges of turning the rhetoric into reality continues to be routinely engaging patients in decision making.” \(^\text{33}\) FCR provide a crucial opportunity for family involvement in daily care decisions in the pediatric inpatient setting. This study highlights the importance of prior work defining the components of involving families in this process, while emphasizing new systems-based strategies that further facilitate the expectation of family engagement in the care of hospitalized children.

Disclosures
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