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Child and Family Centred Care: A Three-Phased Principle-Based Concept Analysis

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ABSTRACT

Introduction: Despite a growing multidisciplinary interest in the Child and Family Centred Care approach, its meaning remains unclear in extant literature. It is, therefore, crucial to explore, analyse, describe, and clarify the concept of the Child and Family Centred Care approach and its associated terms.

Method: A three-phased principle-based concept analysis approach was used to analyse the concept of Child and Family Centred Care. A systematic search of literature was completed using the CINAHL, PsycINFO, Medline, Scopus, and Web of Science databases. Peer-reviewed articles on Child and Family Centred Care, published from inception to 2023 were included if they were available in English and discussed children aged zero to 17 years, healthcare providers, and/or caregivers. A systematic screening of articles was undertaken to remove duplicates and articles that did not meet the inclusion criteria. A concept quality criteria assessment was performed independently based on a recommended appraisal tool.

Results: Full texts of the retained 23 titles were included in the deductive thematic analysis. Guided by the three-phased principle-based concept analysis approach, data were grouped into epistemological, pragmatic, linguistic, and logical principles. The study revealed various characteristics of the concept of interest to highlight the common terms associated with the concept, primarily being collaboration, participation, communication, and respect/dignity.

Conclusions and Implications: This concept analysis provides a theoretical definition of the Child and Family Centred Care approach. The definition emphasises the child as an individual and an active collaborator with healthcare providers and their family. Standardised language improving health outcomes, patient satisfaction, and healthcare systems.

No Patient or Public Contribution.

Julie Blamires and Mandie Foster made equal contribution.

Mohammad Al-Motlaq and Therese A. O'Sullivan made equal contribution.

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Summary

- Impact
  - This concept analysis provides a theoretical foundation to understand the concept of Child and Family Centred Care to further provide standardised language for future research, health systems and education.
  - The successful implementation of Child and Family Centred Care is influenced by the knowledge and skills of the healthcare task force and the organisational support through the development of evidence-based policies and guidelines.
- What does this paper contribute to the wider global clinical community?
  - This analysis revealed important aspects and implications for the Child and Family Centred Care approach which are relevant for nurses, other healthcare providers and stakeholders who are involved with and work with children.
  - The analysis has further highlighted the potential benefits (consequences) of Child and Family Centred Care, including physical, psychological, and social outcomes, which have direct implications for those applying Child and Family Centred Care in practice and research.
  - To further develop the maturity of the concept, interventional and feasibility studies are needed to evaluate the application of the Child and Family Centred Care approach in children from a variety of cultures, health statuses and neonatal settings.

1 | Introduction

The practice of involving parents in the care of hospitalised children has evolved with time. In the early 20th century, children were frequently separated from their families during hospital stays, particularly during the Spanish Flu and the Second World War (Isaacs 2019; Jolley and Shields 2009; Priddis and Shields 2011; Vázquez Sellán et al. 2017). This reflected a medical approach that prioritised efficiency and infection control over emotional well-being. Keeping parents away was believed to minimise risks of cross-infection in crowded and resource-limited environments. Children were often regarded as passive recipients of care rather than individuals with emotional or psychological needs, as a result, medical practices prioritised physical treatment. It was not until the 1950s that the traumatic experiences of children separated from their parents and the impact on the children's psychological well-being began to gain recognition in the western world (Priddis and Shields 2011). Since the 1960s, advancements in research and hospital care have supported the inclusion of parents in the care of a hospitalised child (Priddis and Shields 2011). Consequently, advocating for parental involvement in the care of children has become an important standard worldwide (Coyne 1996; Foster and Shields 2020; Gerlach and Varcoe 2021; Majamanda et al. 2015; Vázquez Sellán et al. 2017).

Historically, approaches to involving parents in the care of a sick child in practice have undergone significant evolution, resulting in the development and adoption of various terminologies used to describe these approaches. The terms associated with family or patient involvement in care have included, but are not limited to: Partnership in Care, Patient and Family Centred Care, Child Centred Care, Patient Centred Care, Care by Parent, and Family Centred Care (Clifford and Standen 2021; Coyne et al. 2018; Coyne 1996; Jeppesen et al. 2024; Petersen et al. 2023). For decades, Patient Centred Care, Child Centred Care, Patient and Family Centred Care, and Family Centred Care approaches have been commonly used in paediatric care settings (Coyne et al. 2018; Hsu et al. 2019). Patient Centred Care is described as an approach that focusses on patients and their experiences in collaboration with healthcare professionals (Nolbris et al. 2014). As noted by Coyne et al. (2018), Patient Centred Care is similar to Child Centred Care, with a distinction that the term 'patient' is less exclusive. In addition, the use of the term 'patient' in the definitions of various approaches and the lack of explicit inclusion of the child, raises questions about whether the approaches specifically refer to children, thereby prompting a discussion on their appropriateness in paediatric contexts. Massie (2020) has further criticised the Family Centred Care for failing to separate the individual needs of the child from the family unit.

Following this history and building on the concept of Family Centred Care and Child Centred Care, the Child and Family Centred Care (CFCC) concept was developed recently to address the shortcomings mentioned above and has since received international recognition in paediatric healthcare settings (Al-Motlaq et al. 2019; Coyne et al. 2018; Gerlach and Varcoe 2021). Despite international recognition, the extent to which the concept of CFCC is understood and applied is unclear and can be confusing to both healthcare providers and consumers (Al-Motlaq et al. 2019). Both research and evidence-based practice require a clear definition of concepts being studied or applied to practice (Foley and Davis 2017). Therefore, conducting a concept analysis to rigorously refine the definition and provide an in-depth understanding of CFCC cannot be overstated.

Several concept analyses have been published on CFCC competing concepts including Patient and Family Centred Care (Håkansson Eklund et al. 2019; Seniwati et al. 2023); and Family Centred Care (Hutchfield 1999; Larocque et al. 2021; Mikkelsen and Frederiksen 2011; Smith 2018). To our knowledge, a concept analysis of CFCC has not yet been published. We aimed to clarify the concept of CFCC, which includes distinguishing the CFCC concept from other concepts, clarifying its boundaries, identifying the meaning, use, and usefulness of CFCC within healthcare and research, and establishing an understanding of the conceptual components of CFCC. Clarifying the CFCC concept will enable researchers, healthcare practitioners, managers, and policymakers within the health system to better understand and incorporate the concept of CFCC into practice, research, and education.

2 | Methods and Data Sources

2.1 | Study Design

This concept analysis was guided by a three-phased principle-based methodology (Smith and Mörelius 2021). The three phases are preparation, analysis, and results. There are four stages

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within each phase to allow a rigorous and systematic approach to concept analysis and provide an audit trail for replication and transparency (Smith et al. 2022).

2.2 | Phase 1: Preparation

This phase involved establishing a research question and problem statement regarding the need for a concept analysis and outlining the methods through undertaking the following stages (1) determining the concept of interest, (2) developing a protocol, (3) systematic literature search, and (4) screening of articles.

2.2.1 | Phase 1, Stage 1: Determining the Concept of Interest

The concept of interest was CFCC.

2.2.2 | Phase 1, Stage 2: Developing a Protocol

A protocol was developed to conduct this principle-based concept analysis. The protocol includes inclusion and exclusion criteria, a systematic search strategy, data extraction, quality appraisal, and data synthesis.

Articles were included if they reported on children (defined as aged 0 to 17 years), childcare providers, and/or parents/caregivers. Only articles written in English were included due to logistical limitations associated with translating other languages. In addition, the included articles had to discuss the concept of interest (CFCC) and be published in peer-reviewed journals. Articles were included irrespective of geographical locations and research methodologies.

2.2.3 | Phase 1, Stage 3: Systematic Literature Search

In consultation with an experienced university librarian, a systematic search strategy was developed. For a comprehensive overview of extant literature on the topic, the search terms (Child and family centred care) OR (Child and family centered care) were used to search for tittles across five databases (CINAHL, PsycINFO, Medline, Scopus, and Web of Science) from their inception to 2023 (see Table 1). To obtain more relevant search results, a final search was conducted across the databases, utilising filters for exact matches with the search terms “Child and Family Centred Care” OR “Child and Family Centered Care.” MF searched the databases for articles and recorded the findings, and this was independently verified by MZ. A hand-search was also conducted of article reference lists, Google Scholar, and ResearchGate. Ulrichsweb was used to confirm that all articles were published in peer-reviewed journals.

TABLE 1 | Search strategy.

Search	Search terms
Initial search	(Child and family centred care) OR (Child and family centered care)
Final search	“Child and family centred care” OR “Child and family centered care”

2.2.4 | Phase 1, Stage 4: Screening of Articles

All identified titles were imported to Endnote version 20.1 (The Endnote Team 2021). Duplicates were removed before exporting the titles and abstracts to Rayyan (Ouzzani et al. 2016). To aid the independent selection of eligible titles, MZ, JB, MF and EM independently screened the titles and abstract for eligibility. Full texts of the retained titles and abstracts were retrieved and read by all four reviewers to determine eligibility. Reviewers made notes on reasons for exclusion as illustrated in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart (Figure 1) (Moher et al. 2009).

2.3 | Phase 2: Analysis

2.3.1 | Phase 2, Stage 1: Notetaking

Initial reading of articles was undertaken by the same four reviewers, who focused to familiarise themselves with the content and highlight anything interesting and related to the context. During this independent in-depth reading of articles, everything concerning CFCC was highlighted. This included definitions, attributes, methods used to measure the concept, measurements, associated terms, tenets, or theoretical discussions. The same reviewers read the articles for a second time to take notes on relevant observations of the articles in line with the quality criteria tool (Smith and Mörelius 2021). A third reading was undertaken to extract relevant data to populate an Excel sheet under the following headings epistemological, pragmatic, linguistic, logical, associated terms, and general comments. Finally, each of the four reviewers extracted data from approximately four articles. In total, there were five reads of the titles' full-text review to data extraction. In addition, the characteristics of the articles were also tabulated (Table 2).

2.3.2 | Phase 2, Stage 2: Adapting and Pilot Testing the Quality Criteria Tool

The team met to discuss how the quality criteria tool (Smith and Mörelius 2021) could be adapted before the lead author amended the tool to align with the context of this concept analysis. EM, JB, and MF then reviewed the tool, and the team met again to discuss the proposed adaptations. Thereafter, MZ and JB independently piloted the tool on two articles and, with the results being brought back to the team for discussion, rectifying differences, and reaching a consensus in the understanding of the questions within the tool.

2.3.3 | Phase 2, Stage 3: Quality Criteria Assessment

The quality criteria tool (Table 3) has four principles that are, epistemological, pragmatic, linguistic, and logical, each having

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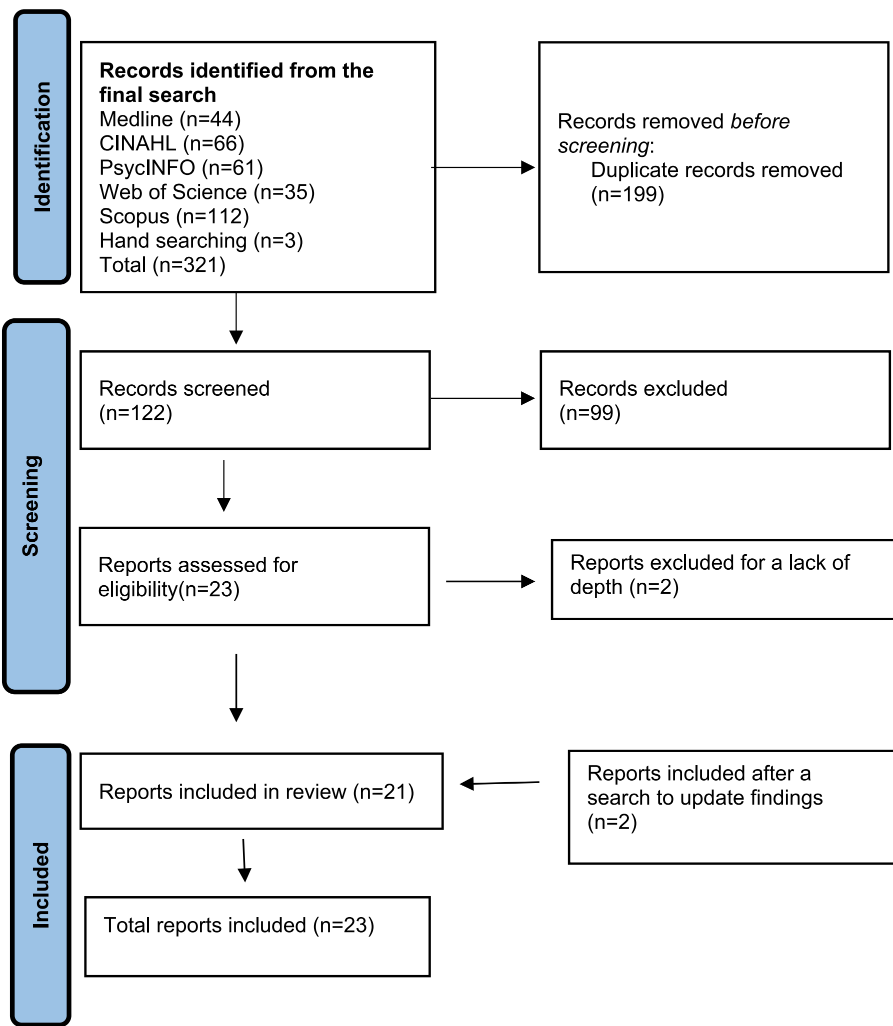

FIGURE 1 | PRISMA flow diagram showing how studies were selected for the CFCC concept analysis.

two questions except for logical, which has only one (Smith and Mörelius 2021). The epistemological principle seeks to assess whether the concept is defined clearly with details, partially defined or not defined in the article and whether there is a clear, partial clarity or no distinctions between the concept and subconcepts. The pragmatic principle seeks to assess whether the concept is useful and applicable and is appropriately measured/explored and evaluated. The linguistic principle seeks to assess whether the concept or its language/key attributes have been used consistently and appropriately. The logical principle seeks only to assess whether the concept is held within its boundaries through theoretical integration with other concepts. Three choices are presented in response to each question: 'yes' (scores 2), 'partly' (scores 1), and 'no' (scores 0). To advance the understanding of the concept, an overall score of 12–14, 9–11, 5–8 and 0–4 provides significant, good, some, and minimal information, respectively (Smith and Mörelius 2021).

All authors were involved in independently assessing articles using the adapted quality criteria tool, with a minimum of three reviewers per article. After ratings were allocated, the team met to discuss and resolve discrepancies arising during the appraisal process via a majority vote system.

2.3.4 | Phase 2, Stage 4: Integration of Data

A manual deductive thematic analysis approach was undertaken to code data to the four principles (epistemological, pragmatic, linguistic, and logical) based on context (Braun and Clarke 2006). The coded data was later reorganised into subthemes according to similarities in meaning. In addition, findings from each principle, along with notes made during data extraction, were further coded into the conceptual components of preconditions (phenomena that influence or proceed with the event), consequences (outcomes that follow the application of the concept) and attributes (words that are frequently used to describe the concept). MZ and JB piloted the analysis process on two articles and met to agree on the coding process in the presence of EM, who is also an esteemed Professor. Thereafter, MZ coded all data to the principles and the team reviewed the codes and subthemes (Suppl. 1).

2.4 | Phase 3: Results

Initial search returned a total of 32,036 articles. Applying filters for exact matches in the final search of the databases yielded 318 titles and a manual search identified three titles. Removing

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TABLE 2 | Study characteristics.

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Al-Motlaq et al. (2021)	Jordan, United Kingdom, Australia, Ireland, Sweden, Malawi, Kenya	Position statement	Not applicable	Paediatric healthcare settings	Not applicable	• Quality of the CFCC approach as a model established around the collaborative presence of the healthcare team, the affected child and family. • Recommendations on actual measures to be taken/followed to ensure CFCC is applied to children and families while ensuring necessary safety restrictions and regulations during the COVID-19 pandemic.
Aim: To examine the quality of the CFCC approach as a model established around the collaborative presence of the health care team, the affected child, and their family.						
Chung and Chae (2023)	Republic of Korea	Original research	Qualitative descriptive study	Paediatric intensive care unit at a tertiary children's hospital	7 interviews with mothers of hospitalised children	• The use of CFCC is necessary to ensure satisfactory hospital experiences and to promote positive health outcomes.
Aim: To explore the mother's experiences at a paediatric intensive care unit with a restrictive visitation policy and identify maternal needs and values.						
Ferreira et al. (2022)	Portugal	Letter to Editor	Letter to Editor	Not applicable	Not applicable	• Commendations for notable work that highlights the harm that results from limiting family childcare.
Aim: Response to Al-Motlaq et al. (2021) 'Position statement of the international network for CFCC': CFCC during the COVID-19 pandemic.						
Foster and Blamires (2023)	New Zealand	Editorial	Opinion piece	Not applicable	Not applicable	• CFCC is a philosophy of healthcare, which integrates and extends FCC while acknowledging that children are unique individuals with their perspectives, experiences, and needs.
Aim: To introduce a special issue in the Journal of Paediatric Nursing focussed on exploring CFCC from a global perspective.						
Foster and Shields (2020)	Australia	Discussion paper	Discussion/discursive approach	Not applicable	Not applicable	• Several models of care for children and families exist, family-centred care, family integrated care patient and family-centred care, and the newly emerging child-centred care. • This commentary paper discusses these, their components, philosophies and principles, and how they are changing over time.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To discuss the use of conversations with children & families as an intervention within healthcare to facilitate a CFCC approach.						
Foster et al. (2019)	Australia and New Zealand	Original Study	Quantitative (instrument development study stages)	Inpatient hospital ward	School-aged children (5–16 years old) Hospital admission for < 24 h	• Development and validation of the needs of children questionnaire over two countries resulted in a 16-item, four-category tool to measure the self-reported importance and fulfilment of school-aged children's needs in the hospital.
Aim: To develop and psychometrically test the NCQ, a new instrument to measure school-aged children's self-reported psychosocial and emotional needs in the hospital.						
Gerlach and Varcoe (2021)	Canada	Discussion paper	Discussion/ discursive approach	Not applicable	Families and children whose health care is likely to be compromised by multifaceted social and structural factors, including racialization, material deprivation, and historically entrenched power imbalances.	• Participation is a key element of child and family centred care. • CFCC is a participatory, dynamic, and relational process. However, what participation looks like has not been adequately explore. • Health systems and policies that support children's participation are essential. • CFCC discourses tend to reflect and reproduce Euro-western values and assumptions. • Orienting CFCC care toward equity- CFCC aims to reframe the relationships in paediatric health care in recognition of families & children being 'essential allies'. • EQUIP (a research and implementation program that involves health equity interventions implemented in a range of healthcare settings) offers a potential evidence-based approach to orient CFCC toward equity that has the potential to clarify its conceptualization, implementation, measurement, and evaluation.
Aim: To examine dominant discourses on CFCC in the context of families and children who are at greater risk of health inequities in wealthy countries.						
Gibson et al. (2018)	Canada	Original study	Qualitative (social constructionist) Interviews	Three Canadian urban centres-outpatient clinics	31 children with cerebral palsy, aged 8 to 18 years, and one parent/caregiver per child (62 participants)	• Three themes were generated: Investments in doing well; I know my child/myself; and caregivers' interpretations of the child's performance. • Themes were then integrated with principles of CFCC care to develop the challenge engagement guidelines directed at reducing test anxiety and enhancing shared decision-making.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To produce child-centred guidelines for the administration of a measure of children's advanced gross motor skills.						
Grahn et al. (2016)	Sweden	Original study	Sem-structured interviews Qualitative content analysis	Paediatric emergency department	7 Registered Nurses Range of experience (5–40 years)	• Three key themes and 9 subthemes. • The fundamentals for being able to create a good meeting were underpinned by the nurse's professionalism, knowledge and experience as well as the parent's role. • Nurses' adaptations when encountering children included adjusting to the environment, the child's participation and encountering the child. • Limitations associated with CFCC in the emergency department included communication barriers, time constraints, resource limitations and ethical approach.
Aim: To describe nurses' methods when interacting with children aged three to six at a paediatric emergency department and to identify aspects in need of further investigation.						
• Malcolm and Knighting (2021)	• Scotland	• Original article	• Qualitative descriptive study In-depth semi-structured interviews	• Community/ home setting	• 13 bereaved parents (male = 4, female = 9)	• Parents reported effective aspects of end-of-life care provided at home to include: (1) ability to facilitate changes in preferred place of death; (2) trusted relationships with care providers who really know the child and family; (3) provision of CFCC (4) specialist care and support provided by the service as and when needed; and (5) quality and compassionate death and bereavement care. • Parents proposed recommendations for future home-based end-of-life care including shared learning, improving access to home-based care for other families and dispelling hospice myths.
Aim: To explore the value and assess the effectiveness of an innovative model of care providing home-based, end-of-life care as perceived by families who accessed the service.						
• Massie (2020)	• Australia	• Letter to the editor	• Letter to the editor	• Not applicable	• Not applicable	• The author recommends tightening the language of family centred care to CFCC as this anchors the child as the focal point of care. • Emphasises the importance of not letting children get lost among the priorities of the family.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To tighten the language of Family Centred Care and to use the term Child and Family Centred Care.						
Morelius et al. (2020)	United States of America, Australia, New Zealand, Ireland, Europe	Literature review	Scoping review	Not applicable	Studies focused on nursing research.Priorities for hospitalised infant, child, or adolescent.	• 234 research priorities were identified. The synthesis generated 119 codes, 14 sub-themes and four themes: evidenced-based practice, paediatric context, CFCC and Paediatrics Nursing. • CFCC includes the sub-themes 'involvement in care', 'psychological health', and 'comfort and 'communication'. • Family Centred Care and CFCC combined, further research is needed to inform how to implement measure and evaluate CFCC interventions.
Aim: To systematically identify and synthesise the nature, range and extent of published paediatric nursing research priorities.						
Moynihan et al. (2021)	Global evidence- United States of America, Taiwan, Sweden, Turkey, Finland, Japan, Korea	Literature review	Comprehensive literature review	Not applicable	23 studies that included ethical climate definition or concept	• Propose a Paediatric Intensive Care Ethical Climate Conceptual framework and four measurable domains to be captured by an assessment tool. • Paediatric Intensive Care Ethical Climate encompasses four, core inter-related domains representing drivers of Ethical Climate including: (1) organisational culture and leadership;(2) interdisciplinary team relationships and dynamics; (3) integrated CFCC; and (4) ethics literacy.
Aim: To review existing ethical climate (EC) definitions, tools and areas where EC has been studied; ethical challenges and relevance of EC in contemporary paediatric intensive cases and relevant ethical theories.						
Nicholas, Zwaigenbaum, Muskat, Craig, Newton, Kilmer, et al., (2016)	Canada	Original Study	Grounded theory	Emergency department	Children with Autism Spectrum Disorder are treated in the emergency department (within 1 month) and their parent(s). The children were aged 3 to 17 years old. The parents were 31–51 years old.	• Participants identified issues that negatively affect care experiences, including care processes, communication issues, insufficient staff knowledge about autism spectrum disorder, and inadequate partnership with parents. • Elements contributing to an improved emergency department experience were also cited, including staff knowledge about Autism Spectrum Disorder, CFCC, and clarity of communication.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To examine emergency department care delivery from the perspective of children with autism spectrum disorder and their parents.						
Perers et al. 2022	United States of America Australia Canada, and New Zealand	Literature review	Review of literature	Psychiatric inpatient units	18 articles with a focus on children and adolescents' psychiatric units	• Interventions were evaluated: trauma-informed care, six core strategies, CFCC, collaborative & proactive solutions, strength-based care, modified positive behavioural interventions and supports, behavioural modification program, autism spectrum disorder care pathway dialectical behaviour therapy, sensory rooms, mindfulness-based stress reduction training of staff, and milieu nurse-client shift assignment. • Most interventions reduced the use of seclusions and/or restraints with collaborative and proactive solutions showing the most prominent results.
Aim: To summarise the last 10 years of literature regarding methods and strategies currently used for reducing seclusions and restraints in child and adolescent psychiatric inpatient units.						
Piggott et al. (2021)	Australia	Original study	Randomised controlled trial/ interviews	Clinical setting	Parents and carers of children who attended follow-up dental care within the randomised controlled trial. The children were Aboriginal preschoolers aged 0–6 years old. 25 communities, 12 of these were test communities ($n = 177$). 13 were control communities ($n = 161$).	• Three main themes (and subthemes) were identified: (1) access to care (barriers, service availability, impact on family due to lack of access); (2) experience of care (cultural safety, child-centred care, comprehensiveness of care); (3) community engagement (service information, engagement, oral health education). • Participants placed value on comprehensive care delivered within the community, underpinned by CFCC.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To elicit views of parents and carers to enable the evaluation of a model of care for dental treatment in young Aboriginal children with a view to its implementation in Western Australia and, potentially, other remote communities.						
Pilon et al. (2020)	The Netherlands	Original article	Randomised controlled trial	Clinical setting	Children 4–12 years 70 children	• Children, generally, anticipated greater discomfort than what they experienced during the administration of eye drops. • For most children, the booklet had a positive effect on their distress levels, but not for all. A large majority of parents noticed the added value of the booklet for their child. • Parents felt the booklet gave their children a sense of control during the administration of eye drops.
Aim: To describe the amount of distress children, experience when they are receiving eye drops.						
Poles and Bousso (2009)	Brazil (details of included articles not provided)	Concept analysis	Concept analysis	Articles on death in children-including ICU.	40 articles 26 research articles, four literature reviews, three expert opinions, four clinical guidelines and three case reports.	• The attributes of the dignified death concept include quality of life, CFCC, specific knowledge about palliative care, shared decisions, relieving the child's suffering, clear communication, helpful relations and a welcoming environment.
Aim: To describe the background, attributes, and consequences of the concept of dignified death for children.						
Regan et al. (2006)	United States of America	Review of literature and case study	Not described	A case study in child psychiatric unit.	13-bed psychiatric unit (child assessment unit)	• The use of restrictive practices reduced significantly since the inception of CFCC. • Since instituting CFCC, staff turnover has stabilised. • Unit working to create a CFCC model of care demonstrating how the concepts of CFCC can be operationalised.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: To describe the elements of child- and family entered care and how this model of care may be implemented on inpatient child psychiatric units.						
Tume et al. (2014)	United Kingdom	Original study	A modified three-round electronic Delphi technique Questionnaires were translated into seven different languages	Paediatrics ICU	90 nurses working in the PICU or ICU that cared for paediatric patients.	• Identified research priorities which included statements surrounding child and family centred care. The participants identified key priorities in this area to be: (1) Strategies to support parents and siblings of critically ill children, (2) The role and involvement of parents in the care of child in paediatric intensive care unit, (3) Psychosocial outcome and quality of life of child and family after paediatric intensive unit admission, (4) Therapeutic communication between paediatric intensive unit nurses and children, (5) Identifying best practices to improve family-centred care, (6) Improving physical outcomes of children after paediatric intensive unit admission, (7) Improving parental presence and visitation in the paediatric intensive care unit, (8) Identifying needs and experiences of child, parents, and family and (9) Identifying the needs of chronically ill children in paediatric intensive care unit.
Aim: To identify and establish research priorities for paediatric intensive care nursing science across Europe.						
Van Veelen et al. (2017)	The Netherlands	Original research	Case study Qualitative interviews and focus group discussions that occurred in three phases.	Case managers from working in child welfare/child protection agencies in the community	$N = 30$ (4 Focus group discussions with each team comprising 5–7 case managers, 1 psychologist and 1 team member). $N = 13$ interviews with managers not involved in the program.	• Key values-safety for all children, a permanent safe setting to grow up, and a child surrounded by family, relatives, and friends. • Delving into the family system- Investing in a relationship with the family and developing a more holistic perspective.

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TABLE 2 | (Continued)

Authors	Country	Type of article	Method	Setting e.g., community	Sample details e.g., age & No	Comments
Aim: How can the emergent organisational vision of the new child and family-centred case management approach intensive family case management be understood at the organisational levels of artefacts (operations and structures), espoused values (strategy) and basic underlying assumptions (organisational culture)?						
Van Veelen et al. (2018)	The Netherlands	Original research	Case study Reflexive monitoring in action approach	Case managers who work with intensive family case management at Child and Youth Protection Services in the Amsterdam area in the Netherlands	$N=14$ Interviews with a case manager. $N=28$ more interviews with the case manager in the second phase of the study. $N=3$ interviews. $N=4$ focus groups comprising 6–8 case managers, a psychologist, and a team manager. 36 dynamic learning agenda workshops consisting of 6–8 case managers, a psychologist, and a team manager. 3 reflection sessions with Directors of Child and Youth Protection Services in the Amsterdam area.	• Transformation toward child and family centred care and post-bureaucratic practices demand that professionals adopt a new mindset. • Rather than being a clinical expert or executor of procedures, legal guardian professionals are expected to act as facilitators of change.
Aim: To better understand the challenges perceived and coping strategies employed by child welfare professionals in a post-bureaucratic organisation.						
Zheng and Pansier (2022)	Georgia	Literature review	Not described	The focus was on short- and long-term effects of Family Centred Care interventions	25 articles reviewed.	• Various interventions have been designed to foster and tailor Family Centred Care implementation. • Key facilitators to the adoption of Family Centred Care principles are staff motivation to change, commitment across hierarchies, experiential learning, and effective mentors. • Mentorship between countries was a key theme helpful to the implementation of Family Centred Care.
Aim: To evaluate and synthesise existing literature on psychosocial and FCC mentorship for paediatric healthcare professionals in four parts: ongoing need, effects on healthcare professionals, effects on children and their families and/or caregivers, and in cross-country healthcare settings.						

Abbreviations: CFCC, Child and Family Centred Care; COVID-19, coronavirus disease 2019; EC, ethical climate; ICU, intensive care unit; PICU, paediatric intensive care unit.

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TABLE 3 | Quality scoring for articles.

Authors		Epistemological			Pragmatic			Linguistic			Logic		
		E1	E2	Total	P1	P2	Total	L1	L2	Total	Lo 1	Total	Total score
(Al-Motlaq et al. 2021)	Yes (2)	—	—	0	✓	—	2	✓	✓	4		0	
	Partly (1)	✓	✓	2	—	—	0	—	—	0	✓	1	
	No (0)	—	—	0	—	✓	0	—	—	0		0	
	Total Score			2			2			4		1	9
(Chung and Chae 2023)	Yes (2)	✓	✓	4	✓		2	✓	✓	4	—	—	
	Partly (1)	—	—	0	—	✓	1	—	—	0	✓	1	
	No (0)	—	—	0	—	—	0	—	—	0	—	0	
	Total Score			4			3			4		1	12
(Ferreira et al. 2022)	Yes (2)	—	—	0	—	—	0	—		0	—	—	
	Partly (1)	✓	—	1	—	—	0	—	✓	1	—	—	
	No (0)	—	✓	0	✓	✓	0	✓	—	0	✓	0	
	Total Score			1			0			1			2
(Foster and Blamires 2023)	Yes (2)	✓	✓	4	—	—	0	✓		2		0	
	Partly (1)	—	—	0	✓	—	1		✓	1		0	
	No (0)	—	—	0		✓	0			0	✓	0	
	Total score			4			1			3		0	9
(Foster et al. 2019)	Yes (2)	✓	✓	4	—	—	0	✓	✓	4	—	0	
	Partly (1)	—	—	0	✓	—	1	—	—	0	✓	1	
	No (0)	—	—	0	—	✓	0	—	—	0	—	0	
	Total score			4			1			4		1	10
(Foster and Shields 2020)	Yes (2)	✓	✓	4	✓	—	2	✓	✓	4	✓	2	
	Partly (1)	—	—	0	—	—	0	—	—	0	—	0	
	No (0)	—	—	0	—	✓	0	—	—	0	—	0	
	Total score			4			2			4		2	12

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TABLE 3 | (Continued)

Authors		Epistemological			Pragmatic			Linguistic			Logic		Total score
		E1	E2	Total	P1	P2	Total	L1	L2	Total	Lo 1	Total	
(Gerlach and Varcoe 2021)	Yes (2)	✓		2	✓	—	2	✓	✓	4	—	0	
	Partly (1)	—	✓	1	—	—	0	—	—	0	✓	1	
	No (0)	—	—	0	—	✓	1	—	—	0	—	0	
	Total score	—	—	3	—	—	2	—	—	4	—	1	10
(Gibson et al. 2018)	Yes (2)	—	—	0	—	—	0	—	—	0	—	0	
	Partly (1)	—	—	0	✓	✓	2	✓	✓	2	—	0	
	No (0)	✓	✓	0	—	—	0	—	—	0	✓	0	
	Total score			0			2			2		0	4
(Grahn et al. 2016)	Yes (2)	—	—	0	—	—	0	✓	✓	4	—	0	
	Partly (1)	—	✓	1	✓	—	1	—	—	0	—	0	
	No (0)	✓		0		✓	0	—	—	0	✓	0	
	Total score			1			1			4		0	6
(Malcolm and Knighting 2021)	Yes (2)	—	—	0	✓		2	—	—	0	—	0	
	Partly (1)	✓	—	1									
	✓	1	✓	✓	2	✓	1						
	No (0)	—	✓	0	—	—	0	—	—	0	—	0	
	Total score			1			3			2		1	7
(Massie 2020)	Yes (2)	—	—	0	—	—	0	✓		2	—	0	
	Partly (1)	✓	✓	2	—	—	0	—	✓	1	✓	1	
	No (0)	—	—	0	✓	✓	0	—	—	0	—	0	
	Total score			2			0			0		1	3
(Morelius et al. 2020)	Yes (2)	—	—	0	—	—	0	✓		2	✓	2	
	Partly (1)	✓		1	✓	✓	2	—	✓	1	—	0	
	No (0)	—	✓	0	—	—	0	—		0	—	0	
	Total score			1			2			3		2	8

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TABLE 3 | (Continued)

Authors		Epistemological			Pragmatic			Linguistic			Logic		Total score
		E1	E2	Total	P1	P2	Total	L1	L2	Total	Lo 1	Total	
(Moynihan et al. 2021)	Yes (2)	—	—	0	—	—	0		✓	2		0	
	Partly (1)	✓											
	—	1	✓	✓	2	✓	—	1	✓				
	1												
	No (0)	—	✓	0	—	—	0	—	—	0	—	0	
	Total score			1			2			3		1	7
(Nicholas et al. 2016)	Yes (2)	—	—	0	—	—	0	—	—	0	—	0	
	Partly (1)	✓		1	✓	✓	2	✓	✓	2	—	0	
	No (0)	—	✓	0	—	—	0	—	—	0	✓	0	
	Total score			1			2			2		0	5
(Perers et al. 2022)	Yes (2)	✓		2	—	—	0	✓	✓	4		0	
	Partly (1)	—	✓	1	✓	✓	2	—	—	0	✓		
	1												
	No (0)	—		0	—	—	0	—	—	0	—	0	
	Total score			3			2			4		1	10
(Piggott et al. 2021)	Yes (2)	✓		2	—	—	0	—	—	0	—	0	
	Partly (1)	—	✓	1	✓	✓	2	✓	✓	2	✓	1	
	No (0)	—	—	0	—	—	0	—	—	0	—	0	
	Total score			3			2			2		1	8
(Pilon et al. 2020)	Yes (2)	✓	—	2	—	—	0	✓	✓	4	—	0	
	Partly (1)	—	—	0	✓	✓	2	—	—	0	✓	1	
	No (0)	—	✓	0	—	—	0	—	—	0	—	0	
	Total score			2			2			4		1	9

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TABLE 3 | (Continued)

Authors		Epistemological			Pragmatic			Linguistic			Logic		Total score
		E1	E2	Total	P1	P2	Total	L1	L2	Total	Lo 1	Total	
(Poles and Bousso 2009)	Yes (2)	✓		2	✓	—	2	—	—	0	—	0	
	Partly (1)	—	—	0	—	✓	1	✓	✓	2	✓	1	
	No (0)	—	✓	0	—	—	0	—	—	0	—	0	
	Total score			2			3			2		1	8
(Regan et al. 2006)	Yes (2)	✓	—	2	✓	—	2	✓	✓	4	—	0	
	Partly (1)	—	✓	1	—	✓	1	—	—	0	✓	1	
	No (0)	—	—	0	—	—	0	—	—	0	—	0	
	Total score			3			3			4		1	11
(Tume et al. 2014)	Yes (2)	—	—	0	✓	—	2	✓	✓	4	—	0	
	Partly (1)	—	—	0	—	✓	1	—	—	0	—	0	
	No (0)	✓	✓	0	—		0	—	—	0	✓	0	
	Total score			0			3			4		0	7
(Van Veelen et al. 2017)	Yes (2)	✓	✓	4	✓	✓	4	✓	✓	4	✓	2	
	Partly (1)	—	—	0	—	—	0	—	—	0	—	0	
	No (0)	—	—	0	—	—	0	—	—	0	—	0	
	Total score			4			4			4		2	14
(Van Veelen et al. 2018)	Yes (2)	✓	✓	4	✓	✓	4	✓	✓	4	✓	2	
	Partly (1)	—	—	0	—	—	0	—	—	0	—	0	
	No (0)	—	—	0	—	—	0	—	—	0	—	0	
	Total score			4			4			4		2	14
(Zheng and Pansier 2022)	Yes (2)	—	—	0	✓	—	2	—	—	0	—	0	
	Partly (1)	—	—	0	—	✓	1	—	—	0	✓	1	
	No (0)	✓	✓	0	—	—	0	✓	✓	0	—	0	
	Total score			0			3			0		1	4

Note: Interpreting scores:
- Total maximum score = 14
- 12–14: Provides significant information to advance understanding of CFCC
- 9–11: Provides good information to advance understanding of CFCC
- 5–8: Provides some useful information to advance understanding of CFCC
- 0–4: Provides minimal information to advance understanding of CFCC.

Abbreviations: E = Epistemology, P = Pragmatic, L = Linguistic, Lo = Logic.

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duplicates left 122 articles, with 21 identified as relevant. The reasons for excluding articles were different outcomes, discussing different approaches to care, and being non-peer reviewed. Two additional articles were removed due to a lack of extractable data to code to the four principles. To update the search findings, a further search was conducted at the start of 2024 to check for relevant articles published since the initial search performed in 2022 to December 2023. Two more articles that met the inclusion criteria were identified. This resulted in a final sample size of 23 articles (Figure 1).

The characteristics of the 23 included articles are presented in Table 2. The articles were published between 2006 and 2023 with the majority (83%) being published after 2016. Four articles originated from Australia (Foster and Shields 2020; Foster et al. 2019; Massie 2020; Piggott et al. 2021), three were from the Netherlands (Pilon et al. 2020; Van Veelen et al. 2018, 2017), three came from Canada (Gerlach and Varcoe 2021; Gibson et al. 2018; Nicholas et al. 2016), four articles were global evidence that included multiple countries (Al-Motlaq et al. 2021; Morelius et al. 2020; Moynihan et al. 2021; Perers et al. 2022), two from the United Kingdom (Malcolm and Knighting 2021; Tume et al. 2014) and two from the USA (Regan et al. 2006; Zheng and Pansier 2022), there was one each from Portugal (Ferreira et al. 2022), New Zealand (Foster and Blamires 2023), Brazil (Poles and Bousso 2009), Sweden (Grahn et al. 2016) and the Republic of Korea (Chung and Chae 2023).

A variety of methodologies were noted, with qualitative studies being the most common type of original research (Chung and Chae 2023; Grahn et al. 2016; Malcolm and Knighting 2021; Nicholas et al. 2016; Van Veelen et al. 2018, 2017). In these articles, thematic analysis was often used to analyse data from interviews and focus groups, highlighting CFCC as a field of in-depth exploration around complex experiences and social contexts. No meta-analyses or systematic literature reviews were identified, however, there was a scoping review (Morelius et al. 2020), a concept analysis of dignified death with a child focus (Poles and Bousso 2009) and narrative reviews (Regan et al. 2006; Zheng and Pansier 2022); one of which featured systematic searching (Perers et al. 2022). Three quantitative studies were identified; two randomised controlled trials (Piggott et al. 2021; Pilon et al. 2020); and one development and validation of an instrument (Foster et al. 2019). The remaining articles were expert opinion pieces, including two letters to the editor (Foster and Blamires 2023; Massie 2020), a position statement (Al-Motlaq et al. 2021) and a Delphi study (Tume et al. 2014) (Table 2).

2.4.1 | Phase 3, Stage 1: Quality Appraisal of the Articles

Four articles were rated at the highest possible ranking, providing significant information (Chung and Chae 2023; Foster and Shields 2020; Van Veelen et al. 2018, 2017). A further seven provided good information (Al-Motlaq et al. 2021; Foster and Blamires 2023; Foster et al. 2019; Gerlach and Varcoe 2021; Perers et al. 2022; Pilon et al. 2020; Regan et al. 2006), eight provided useful information (Grahn et al. 2016; Malcolm and Knighting 2021; Morelius et al. 2020; Moynihan et al. 2021; Nicholas et al. 2016; Piggott et al. 2021; Poles and Bousso 2009; Tume et al. 2014) and four articles were rated at lowest possible ranking, providing the minimal information to advance the understanding of CFCC (Ferreira et al. 2022; Gibson et al. 2018; Massie 2020; Zheng and Pansier 2022) (Table 3). No article was excluded based on low quality appraisal rating.

TABLE 4 | Principles and sub-themes.

Principle	Sub-theme
Epistemological	CFCC nuances
	Position of child and family in CFCC
Pragmatic	Practical application
	Research gaps
	Future areas for improvement Outcomes
Linguistic	Collaboration
	Participation
	Communication Dignity and respect
Logical	Distinguishing CFCC
	Connections with other concepts, theories, and models

Abbreviation: CFCC, Child and Family Centred Care.

2.4.2 | Phase 3, Stage 2: Summative Conclusions of the Four Principles

The summative conclusions from the deductive thematic analysis are based on the four guiding principles of epistemological, pragmatic, linguistic, and logical (see Table 4).

2.4.2.1 | Epistemological. This principle examines whether the concept of CFCC has been clearly defined in the literature and differentiated from the competing concepts. Some articles did not define CFCC (Gerlach and Varcoe 2021; Malcolm and Knighting 2021; Moynihan et al. 2021). Of those that did, some had unclear definitions (Piggott et al. 2021; Tume et al. 2014; Zheng and Pansier 2022), while others depicted it with a diagram rather than a definition (Massie 2020). Despite this, the articles provided several clarifications and primitive definitions that could be used to differentiate CFCC from other concepts. The following is a dissection of the concept based on its explicit or implicit use in the identified literature.

2.4.2.1.1 | Child and Family Centred Care Nuances. Multiple nuances regarding the concept of CFCC are apparent in the identified literature. Some authors have described CFCC as an approach to care and service delivery established around the collaborative presence of the healthcare team, the affected child, and their family (Chung and Chae 2023; Foster and Shields 2020). Others described CFCC as a fundamental approach to the design, delivery, and evaluation of children's services (Gerlach and Varcoe 2021) that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families (Regan et al. 2006). Further, Al-Motlaq

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et al. (2021) and Malcolm and Knighting (2021) identify CFCC as an approach without a description of the context.

While an approach is the way of doing things, a philosophy is a system of beliefs. Other authors describe CFCC as a philosophy (Chung and Chae 2023; Foster and Blamires 2023; Foster and Shields 2020; Gerlach and Varcoe 2021; Perers et al. 2022; Van Veelen et al. 2017) that is based on principles (Regan et al. 2006) that reflects the vision of paediatric care. CFCC is guided by past experiences of a child, family, and health providers, and it is inspired by the other philosophies underpinning paediatric care (Ferreira et al. 2022; Foster and Shields 2020). Others referred to CFCC as a model that explains the phenomenon and representation of the idea that shapes the process of caring for children (Foster and Shields 2020). CFCC is further referred to as an adaptable and effective model (Zheng and Pansier 2022).

2.4.2.1.2 | Position of Child and Family in CFCC. Acting in the best interests of the child, the concept of CFCC uniquely strives to place the child (rather than their illness) at the centre of holistic care (Foster and Shields 2020; Piggott et al. 2021; Van Veelen et al. 2018). Working in partnership with the child and the parents/caregivers, CFCC consistently considers the contextual wishes of the child, the family, and the community (Foster and Blamires 2023; Foster et al. 2019; Malcolm and Knighting 2021; Massie 2020; Piggott et al. 2021). These partnerships help to develop relationships that engender trust between the child, their parents/caregivers, and the healthcare providers. This in turn increases the efficacy of care (Gerlach and Varcoe 2021; Malcolm and Knighting 2021). In these partnerships, children are active partners alongside their families in all areas that impact their health, including direct healthcare, research, and administration. Establishing these partnerships requires actively listening to and involving the child and their family in all aspects of care, and supporting them physically, socially, and emotionally (Gerlach and Varcoe 2021; Pilon et al. 2020).

While acknowledging the centrality of the child, two articles assert that the child can neither be placed before nor be completely separated from the family; rather the child and family are viewed as an interdependent entity (Foster and Shields 2020; Van Veelen et al. 2018). Parents/caregivers are considered to know their children best and are seen to be crucial in both providing information about their child and in guiding care decisions that align with family values (Moynihan et al. 2021). However, the key to CFCC is that the prevailing needs of the child override the needs of the parents/caregivers (Foster and Shields 2020).

2.4.2.2 | Pragmatic. This principle assesses whether the concept has been operationalised and applied in practice disciplines. CFCC is applied in both practice and research, which further demonstrates its usefulness. Incorporation of CFCC in the care of the child results in positive physical, psychological, and social outcomes. However, several barriers to the implementation of CFCC research gaps and future areas for improvement are highlighted in the paragraphs below.

2.4.2.2.1 | Practical Application. Numerous practical applications of CFCC have been identified across diverse settings such as outpatient clinics, emergency departments, inpatient units, community settings, child and family centres, hospitals, the welfare system, and palliative care. Notably, healthcare providers trained in CFCC have positively embraced the approach (Zheng and Pansier 2022). Further, Malcolm and Knighting (2021) noted that CFCC is regarded by experts as beneficial to and is valued by parents (Malcolm and Knighting 2021). The ability to access, interpret, and apply the best available evidence is key to the practical application of CFCC (Morelius et al. 2020), as is the importance of fostering collaborations and relationships between families and health professionals (Malcolm and Knighting 2021).

However, several barriers exist in the translation of CFCC into practice, particularly where its complexity demands the need for greater clarity (Gerlach and Varcoe 2021). For example: (a) perceptions, assessments, and interventions can vary both within practice settings and between healthcare practitioners (Foster and Blamires 2023; Foster and Shields 2020); (b) discrepancies in priorities may exist between healthcare practitioners and patients (Zheng and Pansier 2022); and (c) knowledge and organisational support may also vary with practice settings and between healthcare practitioners (Regan et al. 2006). Thus, communication barriers, time constraints, resource limitations, and the challenge of maintaining an ethical approach (Grahn et al. 2016), can make operationalising CFCC difficult.

2.4.2.2.2 | Research Gaps. While CFCC has been applied in both clinical settings and research, most of the articles agreed on the need for further research on the concept (Foster and Blamires 2023; Foster and Shields 2020; Gerlach and Varcoe 2021; Gibson et al. 2018; Morelius et al. 2020; Regan et al. 2006; Zheng and Pansier 2022). Authors proposed CFCC interventional studies (Foster and Blamires 2023; Foster and Shields 2020; Morelius et al. 2020) that can focus on the success of CFCC (Regan et al. 2006; Zheng and Pansier 2022); parent/caregiver satisfaction with CFCC (Regan et al. 2006); application of CFCC in caring for families at greater risk of healthcare inequalities including those with disabilities (Gerlach and Varcoe 2021; Gibson et al. 2018; Zheng and Pansier 2022); and the impact of CFCC on clinical outcomes (Regan et al. 2006). Notably, Tume et al. (2014) highlighted CFCC as a research priority.

2.4.2.2.3 | Future Areas for Improvement. Recommendations made for moving forward to improve CFCC application in practice included the need to identify best practices for enhancing collaboration (Al-Motlaq et al. 2021; Gerlach and Varcoe 2021; Tume et al. 2014). Gerlach and Varcoe (2021) emphasised the necessity of applying CFCC to manage stigma associated with parental substance use, to subsequently facilitate access to care and quality of care in such families. Three articles further discussed the need for professional development of healthcare providers to enhance their knowledge of CFCC (Al-Motlaq et al. 2021; Grahn et al. 2016; Zheng and Pansier 2022). This included suggestions to raise awareness of how CFCC can be effectively implemented and ensure that all principles are applied during its implementation (Al-Motlaq et al. 2021). In this context, Grahn et al. (2016) recommended staff development in communication with paediatric patients, while Zheng and Pansier (2022) emphasised using mentorship

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programs for peer psychological support and improving the quality of care.

2.4.2.2.4 | Outcomes. Twelve articles (Al-Motlaq et al. 2021; Ferreira et al. 2022; Foster and Shields 2020; Gerlach and Varcoe 2021; Grahn et al. 2016; Malcolm and Knighting 2021; Nicholas et al. 2016; Piggott et al. 2021; Pilon et al. 2020; Poles and Bousso 2009; Regan et al. 2006; Zheng and Pansier 2022) identified three areas in which applying CFCC produced positive outcomes. These areas encompassed the physical, psychological, and social aspects of caring for sick children and their families. Specific outcomes are discussed below under the consequences section and are also outlined in the coding tree (File S1).

2.4.2.3 | Linguistic. This principle evaluates the consistency of use and meaning of the concept and considers if the meaning is context-bound or if it is constrained by context (Smith and Mörelius 2021). The analysis of this principle identified several key attributes and characteristics of CFCC with some consistency in the implied meaning of the concept across the articles. The associated terms identified have been grouped into four key areas representing the fundamental language used that is, collaboration, participation, communication, and dignity and respect.

2.4.2.3.1 | Collaboration. Collaboration and collaborative settings were associated terms that were not well defined but were universally related to working in partnership with children and families (Al-Motlaq et al. 2021; Foster and Shields 2020; Malcolm and Knighting 2021; Moynihan et al. 2021; Nicholas et al. 2016) where authors described this as a core principle of CFCC. The term partnership was widely used but there was some inconsistency or lack of clarity about what partnership entailed. For example, this could include working with children, parents, and families (Al-Motlaq et al. 2021; Foster et al. 2019; Morelius et al. 2020), or only include 'parents as partners' or parents/caregivers with no mention of the child (Moynihan et al. 2021; Perers et al. 2022). While the degree of collaboration within the articles was broad, collaboration with families and children was the strongest.

2.4.2.3.2 | Participation. Although widely used, participation was not well defined; however, it was a term described to suggest a key concept of CFCC (Al-Motlaq et al. 2021; Foster and Shields 2020; Foster et al. 2019). Participation was also described in the context of the involvement of the child and family in care and decision-making, allowing family presence (Al-Motlaq et al. 2021; Gerlach and Varcoe 2021), easing bureaucracy (Poles and Bousso 2009), and including, involving, and respecting parents (Al-Motlaq et al. 2021; Ferreira et al. 2022; Foster et al. 2019; Malcolm and Knighting 2021).

2.4.2.3.3 | Communication. Communication and information sharing were key associated terms that illustrated attributes of CFCC used across a variety of clinical contexts and settings (Al-Motlaq et al. 2021; Ferreira et al. 2022; Foster and Shields 2020; Foster et al. 2019; Gerlach and Varcoe 2021; Moynihan et al. 2021; Nicholas et al. 2016; Perers et al. 2022; Regan et al. 2006; Tume et al. 2014). These terms were often found together and represented an action within the concept of CFCC where healthcare providers listened to and engaged in conversations with children and families to honour their role as partners in care (Grahn et al. 2016; Malcolm and Knighting 2021; Pilon et al. 2020; Zheng and Pansier 2022). Important qualities of information sharing included being unbiased (Al-Motlaq et al. 2021; Regan et al. 2006), timely and accessible (Al-Motlaq et al. 2021; Gerlach and Varcoe 2021; Nicholas et al. 2016), clear (Foster and Shields 2020; Tume et al. 2014), and as therapeutic communication (Perers et al. 2022). Therapeutic communication was described as a key instrument for the nursing care of children, young people, and their families (Ferreira et al. 2022; Foster and Shields 2020).

2.4.2.3.4 | Dignity and Respect. Dignity and respect were often used concurrently across multiple contexts (Foster and Shields 2020; Foster et al. 2019; Malcolm and Knighting 2021; Nicholas et al. 2016; Perers et al. 2022; Piggott et al. 2021; Poles and Bousso 2009; Regan et al. 2006). The terms were not defined, however, they seemed to be associated with a way of being with, interacting with, or honouring the views and choices of patients, children, parents/caregivers and/or families (Gerlach and Varcoe 2021). The features associated with these terms included being non-discriminatory, non-judgmental, and incorporating care beliefs (Foster and Shields 2020; Foster et al. 2019; Gerlach and Varcoe 2021; Perers et al. 2022). Furthermore, the goal of dignity and respect was linked to building strength and independence in parents/caregivers and families (Perers et al. 2022; Regan et al. 2006).

2.4.2.4 | Logical. This principle is usually used to explore the dimensions and characteristics of a concept, with a focus on its fluidity and rigidity in the context of holding boundaries when integrated with related concepts. The identified concepts that are related to CFCC are Family Centred Care, Child Centred Care, Family Integrated Care, and Patient and Family Centred Care. However, other non-relatable concepts or theories were identified in the review and are discussed as well.

2.4.2.4.1 | Distinguishing CFCC. Four articles used CFCC interchangeably with the concepts of Family Centred Care and/or Child Centred Care (Moynihan et al. 2021; Nicholas et al. 2016; Piggott et al. 2021; Zheng and Pansier 2022). A further four discussed multiple related concepts, but the difference between these concepts was unclear (Al-Motlaq et al. 2021; Nicholas et al. 2016; Regan et al. 2006; Van Veelen et al. 2017). The common core terms of dignity and respect, information sharing, child participation and collaboration terms were associated with the concepts of CFCC, Family Integrated Care, Patient and Family Centred Care, Child Centred Care, and FCC (Foster et al. 2019). While Foster et al. (2019) linked dignity and respect, information sharing, partnership, and collaboration with Child Centred Care and Family Centred Care, in 2020 the same authors associated these concepts with respect, communication, partnership, optimal health, patient safety, health equity, and patient and family experiences (Foster and Shields 2020). Communication is also mentioned in describing characteristics of Patient Oriented Care, Child Centred Care, and Family Centred Care (Van Veelen et al. 2017). One article did not distinguish the concept of CFCC from other concepts (Perers et al. 2022).

Only three articles clearly distinguished CFCC from Family Centred Care, Family Integrated Care, Child Focused Care, and

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Patient and Family Centred Care (Foster and Blamires 2023; Foster and Shields 2020; Nicholas et al. 2016). The distinction is based on the position of the child in care delivery. CFCC places the child at the centre of care delivery within the context of family and community, emphasising shared decision-making (Foster and Shields 2020). Other authors have regarded Child Centred Care as an integral component of CFCC, and that CFCC is founded to address the shortcomings of Family Centred Care, which does not place the child at the centre of care (Gerlach and Varcoe 2021; Massie 2020; Van Veelen et al. 2017). CFCC aims to find a balance between 'child-centredness and family-centredness' (Van Veelen et al. 2017). Gerlach and Varcoe (2021) further stated that CFCC is yet to address the shortcomings of Family Centred Care. While none of the articles discussed the centredness of the patient or the family in the Patient and Family Centred Care approach, Foster and Shields (2020) note that this approach aims at developing and nurturing mutually beneficial relationships among the family, the patient and the healthcare provider.

2.4.2.4.2 | Connections With Other Concepts, Theories, and Models. CFCC is integrated with other concepts underpinning healthcare practice such as Child Centred Care, Family Integrated Care, Family Centred Care, and Patient and Family Centred Care (Foster and Shields 2020). The inclusion of 'child' and 'family' in the same concept is an important foundation to visualise the child within a family. In a scoping review, Family Centred Care and Child Centred Care were combined into a CFCC theme to better reflect a "contemporary thinking of terminology" (Morelius et al. 2020, e67). A philosophical shift to CFCC aligns with a growing recognition of children as social agents (Gerlach and Varcoe 2021) and "anchors the child as the focal point of care" (Massie 2020, 660). As proof of use, Van Veelen et al. (2018) showed that CFCC approaches in child welfare practice ensured that workers developed plans and delivered services that fulfilled the unique needs of children as well as their families.

Other theories and models were also mentioned in some of the included articles but were not directly linked to CFCC. Examples include Antonovsky's Sense of Coherence (Perers et al. 2022), social learning theory (Perers et al. 2022), comfort theory (Grahn et al. 2016), ethical culture (Moynihan et al. 2021), quality of life (Poles and Bousso 2009), and model of organisational culture (Van Veelen et al. 2017). The remaining articles did not mention other theories.

2.4.3 | Phase 3, Stage 3: Conceptual Components

Conceptual components were identified deductively during analysis by pinpointing key terms that contributed to understanding the CFCC concept and were grouped into preconditions, attributes, and consequences (Figure 2).

2.4.3.1 | Preconditions. These are the conditions that occur before the application of CFCC by the healthcare workforce. Preconditions of the CFCC must be guaranteed for its successful implementation. The preconditions of the concept CFCC include adequate knowledge and skills regarding implementation of CFCC and its principles (Al-Motlaq et al. 2021; Foster and Shields 2020; Grahn et al. 2016; Zheng and Pansier 2022); organisational support (Nicholas et al. 2016; Regan et al. 2006; Van Veelen et al. 2017); practice guidelines (Foster and Shields 2020; Nicholas et al. 2016); healthcare providers' perceptions and beliefs (Grahn et al. 2016; Regan et al. 2006; Zheng and Pansier 2022); adequate resources (Grahn et al. 2016); formation of therapeutic relationships between families, healthcare providers, children and their family members (Al-Motlaq et al. 2021; Foster and Shields 2020; Malcolm and Knighting 2021; Regan et al. 2006; Zheng and Pansier 2022); effective communication skills of healthcare providers (Grahn et al. 2016; Nicholas et al. 2016); commitment to the ethical standards of care (Al-Motlaq et al. 2021; Grahn et al. 2016; Nicholas et al. 2016); and the involvement of family members (Gerlach and Varcoe 2021).

2.4.3.1.1 | Attributes. Attributes or characteristics of CFCC were determined through examination and selection of the words or expressions most frequently used to describe CFCC (Smith and Mörelius 2021). From the analysis, four key attributes were determined, and these are collaboration, participation, communication, and dignity and respect.

The collaboration included the act of working together and with others that is, industry, organisations, healthcare practitioners, children, and families. To enable decisions, initiatives, treatment, and care planning to be made together, collaboration was seen as a process that required a willingness to learn to be responsive to the needs of the individual child and family (Al-Motlaq et al. 2021; Gibson et al. 2018; Grahn et al. 2016; Malcolm and Knighting 2021; Morelius et al. 2020; Moynihan et al. 2021; Nicholas et al. 2016; Perers et al. 2022; Piggott et al. 2021; Pilon et al. 2020; Regan et al. 2006; Tume et al. 2014; Van Veelen et al. 2018, 2017).

The term participation was predominantly used for parental participation or child in childcare (Al-Motlaq et al. 2021; Ferreira et al. 2022; Morelius et al. 2020; Tume et al. 2014), or conjointly including both parents and the child (Foster and Shields 2020; Gerlach and Varcoe 2021; Gibson et al. 2018; Poles and Bousso 2009; Van Veelen et al. 2017). Effective participation was linked to "timely accessible information sharing" (Gerlach and Varcoe 2021, 458) that enhanced involvement of child and family and was only possible when the cognitive development of the child allowed for it (Poles and Bousso 2009).

Communication in the context of CFCC includes respectful, honest and appropriate communication with the child and parents/caregivers, and it is key to building rapport, achieving shared decision-making, building therapeutic relationships and gaining trust (Ferreira et al. 2022; Foster and Shields 2020; Grahn et al. 2016; Morelius et al. 2020; Moynihan et al. 2021; Nicholas et al. 2016; Perers et al. 2022; Pilon et al. 2020; Poles and Bousso 2009; Regan et al. 2006; Tume et al. 2014). Underpinning quality communication in CFCC is the notion that conversations are honest, clear, impartial, delivered in an effective, timely, supportive manner, and in a developmentally age-appropriate manner to include all children in decision-making and care planning.

Dignity and respect go together, and while they are equally important there is an important distinction between the two. For children and families, dignity is upheld through encouraging

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FIGURE 2 | Conceptual Components of CFCC.

independent choices and decision-making, upholding privacy and child and family centred communication together without making assumptions about how the child and family want to be treated (Van Veelen et al. 2017). Respect includes listening to and accepting the unique entity that is the child and family (Van Veelen et al. 2017), and providing care that considers their knowledge, values, beliefs, desires, cultural understandings, autonomy, and justice (Grahn et al. 2016; Nicholas et al. 2016; Perers et al. 2022; Poles and Bousso 2009; Van Veelen et al. 2018). Respect requires non-judgement, non-discriminatory treatment, and care that is embedded in dignity and integrity (Foster and Shields 2020; Foster et al. 2019; Perers et al. 2022; Regan et al. 2006).

2.4.3.1.2 | Consequences. Consequences were derived from findings that suggested an evaluation of CFCC applications to report outcomes. Physical outcomes included improved comfort, positive health outcomes, and enhanced rapid recovery (Grahn et al. 2016; Gerlach and Varcoe 2021; Regan et al. 2006). Psychological outcomes include the alleviation of separation anxiety (Chung and Chae 2023; Ferreira et al. 2022), emotional distress in both the sick child and their parents/caregivers (Chung and Chae 2023; Ferreira et al. 2022; Pilon et al. 2020), and procedural pain or discomfort (Grahn et al. 2016; Regan et al. 2006), an increased sense of self-determination for the child (Gerlach and Varcoe 2021), and a sense of belonging (Regan et al. 2006). Social outcomes included increased satisfaction with care for parents and staff (Gerlach and Varcoe 2021; Nicholas et al. 2016; Piggott et al. 2021; Zheng and Pansier 2022), the individual needs of the child being met (Nicholas et al. 2016; Zheng and Pansier 2022), the quality of life for the child and parents/caregivers being enhanced and healthcare costs decreased (Zheng and Pansier 2022), the potential for achieving health promotion and equity (Gerlach and Varcoe 2021), and the honouring of the rights of both the child and the parents (Al-Motlaq et al. 2021; Foster and Shields 2020; Gerlach and Varcoe 2021; Regan et al. 2006).

2.4.4 | Phase 3, Stage 4: Theoretical Definition

The theoretical definition of CFCC is deduced from this analysis under the epistemological, pragmatic, linguistic, and logical principles that underpin the principle-based concept analysis

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approach, along with the conceptual components. We propose defining CFCC as:

> A flexible approach to delivering holistic care to children and their families, while placing the child at the core of care. Children are acknowledged to have rights, preferences, and perspectives. CFCC is generally achieved through collaborative processes involving individualised partnerships with children and their families, guided by the principles of collaboration, participation, communication, and dignity/respect.

CFCC leads to positive physical, psychological, and social aspects of caring, through honouring the rights of the child and their family. Successful implementation of CFCC is enhanced by factors such as CFCC knowledge and skills, adequate resources such as time, and perceptions of the implementers, alignment with childcare organisational policies, availability of and adherence to CFCC practice guidelines and therapeutic relationships.

3 | Discussion

This study presents the first theoretical definition of CFCC based on current literature to facilitate further implementation in various healthcare settings and countries. A unified definition of CFCC is essential to provide clarity, consistency, and a shared understanding of CFCC principles among healthcare providers, educators, policymakers, and the broader community that promotes a shared commitment to the well-being of children and their families (Queensland Government 2021). Using a common language, the consistency and shared understanding of CFCC is crucial for the delivery of high-quality evidence-based care when working with children and their families, which can further enhance interprofessional collaboration, communication, coordination, policy development, advocacy, and development of educational programs (Fitzpatrick and McCarthy 2016).

Having a common CFCC language also contributes to establishing a unified international definition, facilitating its measurement in scientific research and the state of the science (Podsakoff et al. 2016). In addition, defining CFCC and identifying its associated terms lays the foundation for establishing distinct boundaries between CFCC and other competing concepts such as Family Centred Care, Child Centred Care, and Patient and Family Centred Care (Committee on Hospital Care and Institute for Patient and Family Centred Care, 2012; Coyne et al. 2018).

According to Morse et al. (1996), the maturity of a concept is reached when there are no competing concepts. Therefore, as a concept, CFCC is partially mature. We believe this is an advantageous time for a concept analysis because it helps clarify and refine the concept at an early stage. This early exploration also facilitates the identification of gaps in knowledge, setting the foundation for further research (van der Wiel et al. 2010). Innovative concepts such as CFCC are expected to be multidisciplinary, and their maturity can be acquired over time (Morse et al. 1996; van der Wiel et al. 2010).

However, there is still room for advancement with this CFCC concept analysis. For example, none of the included articles examined CFCC in neonatal settings. There is also a need for research into the inclusion of psychiatric, marginalised and/or migrant children, and children who have special developmental and/or communication needs across diverse healthcare settings. Further, we recommend more interventional and feasibility studies to evaluate how the child's age, cognitive functioning, capacity, illness typology and culture impact CFCC implementation, efficacy, quality of care, and health outcomes. The development of a CFCC framework and clear guidelines to assist implementation and evaluation of CFCC from a multi-tiered lens (organisational, healthcare provider, parent, child) will assist in measuring adherence to CFCC principles that will direct future research, practice, policy, and education.

The use of the principle-based concept analysis methodology was chosen for this study as it provides a rigorous, structured, systematic process for defining complex concepts such as CFCC. This approach has the advantage of being able to explore the concept of CFCC thoroughly and from multiple perspectives as they exist. It provides a structured framework for breaking down and analysing concepts as it relies on a set of core principles to dissect and evaluate concepts, getting to the essence of a concept compared to traditional methods. The principle-based concept analysis achieves a clearer and more precise understanding of CFCC as a complex concept because of the consistency and rigour in analysis with predefined principles. It is also acknowledged that this methodology is not in full maturity and therefore, there is a potential for misinterpretations or oversimplifications, however, we believe the advantages outweigh the potential disadvantages.

Despite CFCC being studied in different countries and settings, for this concept analysis most studies originated from Western countries. Therefore, the cultural competency and sensitivity reflected in the findings are limited to the included countries and settings. Further, this concept analysis was conducted systematically according to Smith and Mörelius (2021) which allowed a broader overview of the different definitions of the concept. Although the search and review processes undertaken for this concept analysis were rigorous, as with all database searches, there is the possibility that some articles may have been omitted (Nuopponen 2011).

4 | Conclusion

This concept analysis establishes CFCC as an approach that recognises the child as an individual and an active collaborator with healthcare providers and their families. The theoretical definition of CFCC, developed through this analysis, is grounded in the epistemological, pragmatic, linguistic, and logical principles that underpin the principle-based concept analysis framework. It is concluded from this analysis that the concept of CFCC is partially mature. Concepts evolve and their meanings can change with advances in research, technology, or societal shifts. Therefore, periodic concept analysis is required to ensure that the CFCC definition remains relevant, meaningful, and up to date, to help standardise the language around the CFCC concept. Nonetheless, this CFCC

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concept analysis provides insight into CFCC and assists in driving forward the scientific understanding and practice into a new phase of theory development.

Author Contributions

All authors made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content. All authors given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. All authors agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing does not apply to this article, as no datasets were created during this study.

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