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Nurse leaders' perceptions of organisational policies, guidelines, and practices that enact children and young people's involvement in hospitals

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Abstract

There is limited literature on nurse leaders' perceptions of organisational policies, guidelines, and practices that enact children and young people's (CYP) involvement in hospitals. Nurse leaders within what were the four District Health Board providers of children's tertiary health services in New Zealand (Auckland, Counties Manukau, Wellington, and Canterbury) were invited to respond to an online survey during November 2022 through to January 2023. The survey was developed by the researchers in accordance with the literature and included 11 open-ended questions. The open-ended questions were analysed iteratively through inductive thematic analysis. Eight out of 24 invited nurse leaders responded to the survey. Thematic analysis of the findings resulted in four key themes that highlighted how nurse leaders perceived their organisations provided a platform for children and young people's involvement in hospital: Policy and Guidelines; Diversity, Equity, and Inclusion; Models of Care; and CYP's Voices. Nurse leaders described various means and methods utilised to enact CYP's participation within paediatric settings in New Zealand. A multi-tiered collaborative approach with government, industry, leaders, healthcare professionals, family and CYP is required to enhance CYP's agency/voice in New Zealand hospitals as in alignment with the United Nation Convention of the Rights of the Child.

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Introduction

Children and young people (CYP) are individuals aged from birth to 18 years, as per the United Nations Convention of the Rights of the Child (UNCRC) (1989) and United Nations (2013) (United Nations, 2013; United Nations Human Rights Office of the High Commissioner, 1989). There are approximately 1.6 million CYP in New Zealand, representing 33% of the total population (Child and Youth Wellbeing, 2019). New Zealand continues to face significant challenges in child health, with over two decades of elevated paediatric hospital admissions and pronounced physical and mental health inequities existing for Māori, Pasifika and CYP living in socioeconomically deprived areas (Cure Kids, 2023). Approximately 40,000 CYP are admitted to New Zealand hospitals each year because of serious, potentially preventable, diseases (Asher & St John, 2016).

The UNCRC (1989) is a human rights treaty that outlines the civil, political, economic, social, health, and cultural rights of children worldwide (United Nations Human Rights Office of the High Commissioner, 1989). The UNCRC places an emphasis on amplifying children's voices and participation in processes affecting their lives (Lundy, 2018). New Zealand formally ratified the UNCRC in 1993, signifying the commitment of the New Zealand government to prioritise the interests of children in matters that concern them (Ministry of Social Development, n.d). New Zealand's commitment to the UNCRC (1989) outlined the role CYP can have in their own healthcare, recognising their agency as active reliable participants in shared decision-making where their voices are heard, valued and respected (Scheibmair, 2016). CYP's participation in healthcare spans across a macro-level (health policy and research) and micro-level (personal health choices), encompassing their right to developmentally appropriate information and opportunities to provide direction on care, practices, treatment, service delivery, and policy (Davies and Randall, 2015). In New Zealand, the Children's Convention Monitoring Group, Deputy Chief Executives, and Human Rights Commission collaborate to ensure that the rights of CYP outlined in the UNCRC are respected, protected, and fulfilled in various aspects of society, including healthcare, education, and social services (Ministry of Social Development, 2018b).

CYP's participation in shared decision-making is important to not only honour the rights of CYP under the UNCRC, the Convention on the Rights of Persons with Disabilities, the Children's Act, and Te Tiriti o Waitangi founding document but meaningful genuine involvement with CYP will lead to more appropriate and responsive interventions, services, and policies (Child and Youth Wellbeing, 2022; Parliamentary Counsel Office, 2023). Te Tiriti o Waitangi is the founding document signed between British Crown settlers and Māori in 1840, to outline a partnership between Māori and the British Crown. Incorporating CYP into shared decision-making processes paves the way for a holistic Child-Centred-Care approach associated with improved health outcomes and quality of life (Jacobs et al., 2023). Targeted policies/guidelines have been developed in New Zealand to support and advocate for the rights of CYP (Child and Youth Wellbeing, 2019, 2022; Parliamentary Counsel Office, 2023). Child and Youth Wellbeing (2022) released the *Engaging with Children and Young People* guidelines designed to support individuals '*to hear and empower the views and voices of CYP*" (p. 3). Child and Youth Wellbeing (2019) introduced a strategy emphasising collaboration, involvement, and engagement of CYP in shaping policies and services that affect them. The Children's Act (2014) focuses on the wellbeing and protection of

CYP, outlining the legal framework for various matters related to the care, protection, and rights of children.

There are a range of techniques described within the literature to involve CYP in discussions about healthcare priorities, for example, the creation of CYP committees where CYP worked with key-stakeholders and healthcare services that influenced strategies/initiatives and increased CYP's satisfaction, empowerment, and changes to practice (Cioana et al., 2019; Groot et al., 2021; Yamaji et al., 2020). Other practical strategies/initiatives include the creation of digital platforms to allow CYP with mental health issues the opportunity to feedback and make decisions about sensitive issues within a confidential safe environment (Martinez-Martin et al., 2020). Digital platforms have the added advantage of increased accessibility for CYP who are physically disabled, who live in remote areas or are without transport (United Nations, 2023).

Various approaches of care have been developed to optimise CYP's and parents/guardians shared decision-making in hospitals. These include a Child-Centred-Care, Family-Centred-Care or Child-and-Family-Centred-Care approach. Child-Centred-Care places the needs of the child at the heart of care provision, valuing their voices, lived contexts, dynamic bodies, and social relations by fostering therapeutic nurse-CYP relationships (Spray, 2020). Family-Centred-Care acknowledges the influence of family on the child, therefore prioritising family perspectives, partnerships, and collaboration with family during the care of their child (Ford et al., 2018). However, Family-Centred-Care can result in passive involvement of CYP, whose participation is often placed secondary to that of caregivers (Ford et al., 2018).

Child-Centred-Care is limited in that children are never truly independent of their parents or family, whilst Family-Centred-Care presents the risk of CYP's voices being silenced (Ford et al., 2018; Spray, 2020). Child-and-Family-Centred-Care has been developed and embedded into current health policy to reflect this, defined as '*a philosophical approach and a set of principles to guide the planning, delivery, evaluation and continuous improvement of healthcare* that is *grounded in active partnership between healthcare providers, children and families, at a level that reflects the child's competence and of the family's choosing*' (Queensland Health, 2021: p. 4). There is strong evidence in favour of genuine partnerships in paediatric healthcare, where the needs, participation, and shared decision-making of CYP and their families are embraced by healthcare professionals (Queensland Health, 2021).

The concept of health and wellbeing for Indigenous Māori is holistic, interwoven, and inherently relational, and therefore, family collaboration is considered an ethical and cultural imperative (Wilson et al., 2021). Rasmussen et al. (2017) reported CYP and family in New Zealand perceived hospital experiences differently, where the ability for CYP to assert themselves and maintain their identity in hospital depended on guidance/support from adult family members, parents or healthcare professionals (Rasmussen et al., 2017). This paper is part 2 of a two-armed study. In part 1 a critical review of the literature was undertaken to describe how New Zealand CYP participate in discussions and shared decision-making within health care organisations (Foster et al., 2024). '*It was evident within this review that there is a discourse between what expert opinion are stating is required to promote children and young people's participation in discussions and decision-making processes within healthcare settings and what is occurring in practice*' (Foster et al., 2024, pg. 1-2). There is presently a gap in the literature on nurse leaders' perceptions of organisational policies, guidelines, and practices that enact CYP's involvement in hospitals. Nurse leaders' insights hold significance in genuinely enhancing CYP's participation and shared decision-making in healthcare.

Aim

To explore nurse leaders' perceptions of organisational policies, guidelines, and practices that enact CYP's involvement in hospital care.

Method

Sample

The sample included twenty-four purposively sampled nurse leaders within what were the four District Health Board providers of children's tertiary health services in New Zealand (Auckland, Counties Manukau, Wellington, and Canterbury). Nurse leaders were identified through their key role within the organisation and the likelihood of being responsible for policy/practices/quality assurance activities that direct/inform the planning, implementation, and evaluation of service delivery for CYP.

Survey

The survey was developed by the researchers in accordance with the literature and included 11 open-ended questions. The survey was pilot tested amongst the research team, and no changes were made. No demographical characteristics other than years of experience were collected to ensure anonymity and confidentiality, and the survey remained open for 3 months. Participants were asked to comment on organisational policies, guidelines, and practices that enact CYP's involvement in hospitals.

Recruitment online survey

Nurse leaders from each of the four Children's Hospitals were invited to participate in an online Qualtrics survey via a publicly available email address. The email outlined the purpose of the study, included the participant information sheet, and a link to the online survey. The first page of the online survey provided a clear explanation of the project and the participant information sheet. Nurse leaders provided informed voluntary consent by ticking an online consent box. The survey would only commence once the consent box was ticked, and nurse leaders had the option to download the participant information sheet. Participants were informed that by submitting the survey they were consenting to take part in the project.

Analysis

The open-ended questions were analysed iteratively through inductive thematic analysis. This qualitative research method is used to identify, analyse, and report patterns and is suitable for different types of qualitative data including qualitative surveys (Braun and Clarke, 2023). Authors one and two began by familiarising themselves with the data by reading through all survey responses, treating the data as one cohesive data set and noting initial ideas and patterns (Clarke and Braun, 2021). Next, they discussed these initial impressions and then moved on to generate codes from reading the data, reflecting on, and noting personal/clinical experience and the scholarly review of the literature as part of phase 1 of this study (Foster et al., 2024). These main codes were then sorted into potential themes and relevant excerpts from participants were collated. The process of coding, re-coding and discussions between the authors continued until the final themes were agreed upon. Although Braun and Clarke (2023) does not encourage consensus among multiple coders, this analytic process was undertaken given the aim to develop meaningful interpretation of the data and due to the differing philosophical positioning of the authors where one holds a more positivist position and the other post-positivist (Braun and Clarke, 2023). Themes were then aligned to answer the original research question.

Ethics

Approval was obtained from the institution's ethical committee to which the researchers were affiliated (Auckland University of Technology Number 21/402) where the principles of informed consent, respect, beneficence, integrity, confidentiality, and justice were upheld. Data were stored on a password protected document and only members of the research team had access to the data. Nurse leaders were informed that they could withdraw at any time and that pseudonyms (Emma, Lucy, Sophie, Grace, Olivia, Emily, Ruby and Sarah) would be used in any publications/outputs. (Table 1).

Results

The online survey was sent to 24 people via email. Eight nurse leaders responded who had experience ranging from five to 40 years in working with CYP. The nurse leaders' roles included

Table 1. Survey questions.

	Questions
1	Could you please describe the role you undertake in your organisation and years of experience in work?
2	What policies, guidelines or practices do you have in your hospital or services for children and young people to assist them as consumers to participate in practice, policy, and healthcare delivery?
3	How is the United Nations convention on the rights of the child being implemented in your hospital or services?
4	What current practices of child and young person's self-reporting measures do you use in your hospital or services?
5	How do children and young people participate in shared decision-making on matters that concern them in your hospital or service?
6	Do you have any specific practices/initiatives to include Māori, Pacific or other ethnicities and vulnerable groups of children and young people to participate in shared decision-making on matters that concern them in your hospital or services?
7	Do you have any specific practices/initiatives taking into consideration the social determinants of health to increase Māori, Pacific or vulnerable populations access and ability to participate in shared decision-making on matters that concern them in your hospital or services?
8	Do you have a child and young person's advisory group at your hospital or services?
9	Do you think that children and young people should be included in child and young person's health advisory groups?
10	What are your thoughts on gaining feedback from children and young people in relation to their experience within healthcare services?
11	What is the guiding philosophical model used in your health service, for example, person-centred care, family-centred care, child-centred care or other?

leading project managers and hospital play specialists. The hospital plays specialists work closely with the nurses and use play as a medium to minimise stress and anxiety, and create opportunities for CYP to participate in their health cares. Thematic analysis of the findings resulted in four key themes that highlighted how nurse leaders perceived their organisations provided a platform for children and young people's involvement in hospitals: Policy and Guidelines; Diversity, Equity, and Inclusion; Models of Care; and Children and Young People's Voices (Figure 1).

Policy and guidelines

Nurse leaders described key policies, guidelines and/or practices they believed positively impacted on CYP's involvement in hospital. Two key documents being the Ministry of New Zealand Education Curriculum and Early Childhood Curriculum played an important role ensuring a strong focus on children's wellbeing, belonging, exploration, communication, contribution and were deemed foundational in the way of working with CYP.

Nurse leaders highlighted how these key documents supported CYP's right to education in hospital and included guidance for schools in regional health facilities, which were important for CYP who had long inpatient stays. Some nurse leaders were involved with condition specific networks, for example, the Adolescent and Young Adult Cancer Network Aotearoa (New Zealand), where key policy documents and standards of care were deemed sound examples of policy in which young people's voices were embedded and thus helped direct, govern and inform practice, policy and health care delivery. One of the key threads evident within this theme was the connection to UNCRC, where nurse leaders referred to how this could be better implemented.

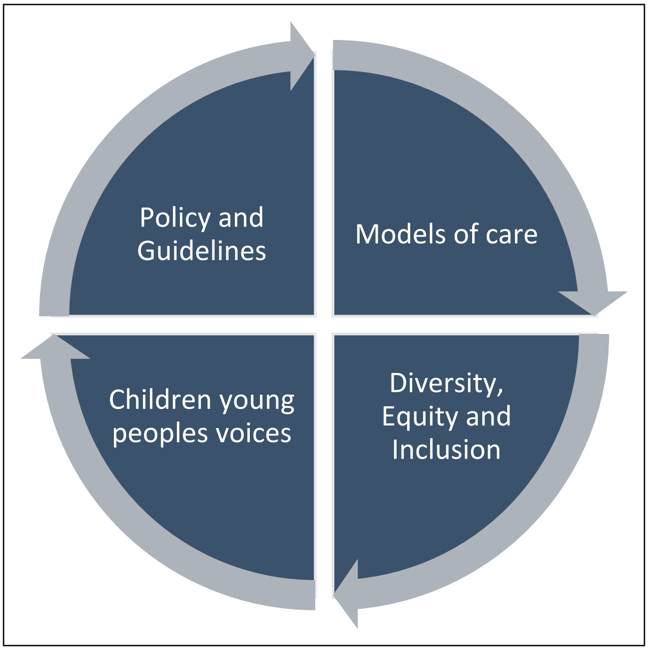

Figure 1. Key themes Providing a Platform for Children and Young People's Involvement.

> '*The United Nations convention on the rights of the child is being implemented in our service in the following ways: We advocate for children – we ensure that their views, opinions and thoughts are heard by all and taken on board but also that they can do this in a way that makes sense to them. We also ensure that children have access to information in a way that they can understand. This is through a range of different ways depending on a child's age, ability and interests but could be better implemented*' (Sophie).

CYP's rights were at the forefront of interactions in practice and policy within clinical settings. One specific example was the design of developmentally appropriate patient information documents and consent forms that were developed in alignment with the UNCRC. The integration of age-appropriate information, education sessions, or external supports were considered essential components of quality service that supported CYP to either consent themselves or nominate a person that could act on their behalf.

Nurse leaders described numerous examples demonstrating a commitment to creating a place and space for CYP's participation and voice in shared decision-making. Examples included ensuring consistency of care across the trajectory of treatments for long term conditions and to allow development of rapport to help support and build therapeutic relationships.

> This was deemed '*integral to enabling autonomy for young people, allowing them to govern and determine what is important for them and their nominated support people*' (Ruby).

Additionally, youth focused approaches to care which included: risk screening, HEADSSS assessment, and management planning in collaboration with youth, as well as surveillance, planning and protection of youth's future pathways (including protecting future fertility). Hospital play services were cited as an exemplar of how services provide support for CYP to cope with hospitalisation and uphold children's right to have a voice through play. Play specialists empowered CYP to learn about their health or illness, supported them to understand interventions/treatment and ensured their developmental and emotional needs are met.

Diversity, equity, and inclusion

There was a clear message that regardless of ethnicity, gender identity, cultural background, or level of vulnerability care was tailored around the needs of the adolescent and family, so their voices remained central to all decision making. Examples of services providing care for vulnerable populations included community youth health services who worked with youth living with a chronic health issue, those involved in alternative education, and those undergoing gender affirming care. One participant provided an example from practice where information around gender diversity was provided by young people to youth advisory council on use of pronouns directing changes to patient information forms.

There was a strong thread to provide spaces and places for a bicultural approach to CYP's care and the enablement of Māori and Pacifica voices. Examples included using bicultural liaison services to help integrate and provide appropriate cultural support including Māori health support workers and Māori and Pacifica Health to ensure that children and family who identified as Māori felt comfortable their cultural needs were advocated for. One participant acknowledged that there was still a lot of work to do to create an environment that truly supported the voice of CYP; however, there was a strong intention to ensure Māori and Pacifica CYP have a voice.

> '*As an organisation we have a commitment to reducing health inequality for Māori and Pasifika and ensuring these young people have a voice and are able to raise awareness relating to issues around their care*' (Grace).

Community services and initiatives were particularly important in addressing issues of inequity such as, provision of clinics and health appointments in schools or community centres locally to make access easier for families; providing dental hygiene packs for children having oral surgery; involving Pacifica nursing services who help address barriers such as transport or health literacy; and culturally appropriate community nursing services. Models of service initiatives to address inequity included the Lungs4Life initiative which focused on reducing inequity in respiratory conditions. This initiative identified children at admission to hospital with a respiratory infection and referral to the Lungs4Life team for follow up in the community and clinic until the age of 5 years.

One nurse leader described project work being undertaken to address implicit bias within their organisation, enabling their service to reflect on themselves as individuals. The findings from this initiative provided foundation to build stronger systems and processes to reduce health inequities. Although nurse leaders described an acute awareness of social determinants of health for Māori, Pacific and other vulnerable populations, concern was raised with those services for other ethnicities or cultures such as Chinese or Somalian immigrants.

Models of care

Within this theme there were a range of models, philosophical positions, and approaches to care that were described as supportive in facilitating CYP's voice. These included Family-Centred Care, also referred to as a Whanau-Centred-Model which embraced a Māori Model, as well as Child-Centred-Care, and Child-and-Family-Centred-Care further referred to as Child-and-Whanau-Centred-Care and finally Youth-Led-Care. The strong message with these approaches was clear, what is happening for a family affects the child, and what happens to the child affects the family. Child-centred care approaches ensured that CYP lead all decision making, allowing autonomy, informed consent and integration of support people. The intention of a Child-Centred-Care approach was to provide a platform for involvement where their needs/feelings/choices would be identified, respected, and taken into consideration in developing their healthcare plan.

Family-Centred-Care was the predominant model of care described by nurse leaders who aimed to work in partnership with children and their family respecting their positions as key decision makers and recipients of care. Examples included the development of nursing care plans that were described as founded on family-centred care with a pro-active approach to involving a child/young person in this process. Strategies such as checking in with the child and family, ensuring buy in of CYP and family before proceeding with a plan as well as ensuring they were invited to create, participate and collaborate with care planning in any way they wished.

Other ways nurse leaders described Family-Centred-Care approaches included collaborative processes between the medical/nursing and play specialists who worked with the family and child to ensure care needs were agreed.

> '*This is all about empowering children, ensuring we support them holistically, that family and community is an integral part of what we do (family centred care) and the importance of understanding that children learn through responsive and reciprocal relationships with people places and things*' (Sophie).

Children and young people's voices

There was a clear message of good intentions regarding CYP's voices as consumers of healthcare; however, there were several barriers to this occurring in practice. Children's age played a role where nurse leaders described if the child was under 6 years of age interactions, feedback, and input were always sought from parents on behalf of the child. Other surveys focused on areas such as communication, partnership, co-ordination of care, physical and emotional needs and included space for both parent/caregiver and children's voices; however, nurse leaders stated it was not clear how many responses were collected from CYP.

Youth health specific initiatives and action related to CYP's voices were noteworthy and largely associated with the Adolescent and Young Adult Cancer Network in New Zealand. Nurse leaders who worked with youth using a youth development model highlighted some of the work being done to give voice to and address issues and concerns relevant to young people living with cancer so they could work together to advocate for positive outcomes. The Adolescent and Young Adult Cancer Network utilises feedback from young people through a Patient Experience Survey that directly informed action plans, key projects and working groups. One nurse leader articulated how the voice of the young person governed every move of the network. Other examples of places in the community where youth advisory groups had a strong presence were Youth Line and outpatient clinics within children's hospitals in the North Island.

Some nurse leaders indicated that their services did not have CYP present on advisory groups. However, did describe examples of inclusion such as ensuring children were involved in family meetings, expressing a desire to learn more about CYP's hospitalised lived experience, and practising in a way that ensured information was directed at CYP to enable CYP to make informed decisions about their care. Participants clearly saw the value and necessity of including CYP's voices as active participants within a healthcare service and saw how seeking feedback from them was crucial to shape care delivery.

> '*We should be open to the concept of "through the eyes of Child," to make necessary changes and improvements to what we offer*' (Lucy).

Discussion

We conducted a qualitative cross-sectional study to explore nurse leaders' perceptions of organisational policies, guidelines, and practices that enacted CYP's involvement in hospitals. Our study revealed that nurse leaders from four tertiary children's hospitals perceived that children needed to be provided with a platform to be involved in matters that concerned them. In this study, opportunities for children to exercise their rights to be heard and participate in decisions regarding their health as mandated in article 3, 12 and 13 of the UNCRC treaty were influenced by policies and guidelines, diversity and inclusion, models of care and CYP's agency (United Nations Human Rights Office of the High Commissioner, 1989).

Key educational and health documents including the Child and Youth Wellbeing Strategy and internationally ratified UNCRC in New Zealand state every opportunity should be undertaken by healthcare professionals to facilitate and promote children's rights; however, it is evident from the results of this study that this continues to remain elusive and challenging to enact. However, despite good intentions of these foundational documents and nurse leaders' perceptions on the importance of CYP's participation, there is little concrete or pragmatic evidence to reflect how CYP's participation is operationalised or measured in healthcare (Foster et al., 2024). Of interest the Child and Youth Wellbeing Strategy was reviewed in 2022 by the Department of the Prime Minister and Cabinet (2022) as part of the New Zealand Children's Act 2014 (Parliamentary Counsel Office, 2023). Carter et al. (2022) looked at 68 individual focus group participants that worked across public sectors, in which most who responded supported the strategies, principles and vision. They found that children wanted to be involved, listened to, and wanted their voices represented better; however, they also identified that inequity and under-representation of marginalised CYP within the Child and Youth Wellbeing Strategy required greater clarity as '*key groups, particularly Māori as well as Pasifika, disabled and migrant children and youth, were not accorded adequate priority within the Strategy*' (Carter et al., 2022) (p.5). Similarly, the literature reports marginalised, and minority ethnic groups globally are still not receiving equitable representedness and access to healthcare services (Shahidullah et al., 2023). Healthcare professionals working with marginalised, and minority ethnic groups need to take a multi-faceted and inclusive approach to address systemic barriers, and promote cultural competence, that actively include children and their families in decision-making processes (Cavet and Sloper, 2004; Clarke, 2021; Shahidullah et al., 2023). This approach will contribute to more equitable and responsive healthcare systems to prioritise the wellbeing of children, regardless of social or cultural background.

It is important and encouraging that nurse leaders in this study saw the interconnectedness of health and education, as they worked together to support both physical and mental wellbeing of CYP. Others have similarly highlighted the important role hospital school programs play in upholding social justice, equity and children's rights in education and health (Caggiano et al., 2021; Murphy and Ashman, 1995) as well as maintaining a sense of normalcy for CYP (American Academy of Pediatrics Committee on School Health, 2000; Ratnapalan et al., 2009).

There were various strategies reported by nurse leaders in this study to facilitate CYP's participation and voice such as inclusive practices, models of care, screening tools, multi-disciplinary input, child advisory groups, cultural sensitivity, and child or parent reporting tools. These practices are further reported in the wider literature as well as the importance of listening to CYP, providing time for questions, delineating misconceptions, offering age-appropriate information, providing choices and child-friendly space (Moore and Kirk, 2010; Srinivas et al., 2022; Vis et al., 2011; Wyatt et al., 2015). However, these practices are varied and dependent on multiple factors such as the child's illness typology, severity and age; healthcare professional's belief of a child's agency, discipline, years of experience, approaches to care, knowledge of the UNCRC, available resources, culture and country (Coyne et al., 2016; Ford et al., 2018; Moore and Kirk, 2010; Üstüner-Top and Cam, 2023). The participants in our study had an awareness of UNCRC and provided examples of good practice and intent to uphold these principles. In contrast, Georgousopoulou et al. (2023) found significant gaps in healthcare professionals' knowledge and practice surrounding the UNCRC, where half of the sample did not know about the UNCRC and almost 60% were unaware that there were rules and bioethical practices related to clinical work with children (Georgousopoulou et al., 2023). Building on the framework of children's rights highlighted in our study, Jorgensen recommended an additional two constructs be added to the UNCRC being power and preparation, thus making a total of five constructs (provision, protection, participation, power, preparation) in a study that explored children's rights during COVID-19 (Jörgensen et al., 2023).

Of interest in this study Family-Centred-Care was highly reported by nurse managers as the model of choice, yet recent research reports a shift from Family-Centred-Care to a more child centric approach in order to facilitate CYP's participation in care as prescribed by the UNCRC (Coyne et al., 2016; Foster and Blamires, 2023; O'Connor et al., 2019). Child-Centred-Care is often described as an alternative to Family-Centred-Care where the rights of the child to participate and make decisions about their care are forefront (Foster and Shields, 2020; Foster and Whitehead, 2019; Shields, 2015). A recent scoping review highlighted the potential that a Child-Centred-Care approach has in acknowledging and reaffirming the rights of children (Carter et al., 2024) (pg. 130) however drew attention to the need for further research focused on its effectiveness and impact on children and families.

Limitations and strengths

We applied a high level of rigour in this study by using an iterative process with the analysis. This process allowed members of our interdisciplinary research team to share ongoing feedback and rich discussions about the themes as they were developed. As an outcome, our study may deliver a timely contribution to our understanding of current practices of nurse leaders' perceptions of organisational policies, guidelines, and practices that enact CYP's involvement in hospitals. One of the limitations of this study consists of the average response rate ($N = 33\%$), and invitations were directed at four main Children's Hospitals, excluding other smaller hospitals that had CYP's wards.

Implications to practice

One potential way to promote CYP's participation in care would be the wider use of the Child Impact Assessment Tool that was developed by the Ministry of Social Development to support New Zealand's commitment to the UNCRC in policy-making processes (Ministry of Social Development, 2018a). This tool acknowledges Te Tiriti o Waitangi and UNCRC as a key source of rights for children living in New Zealand. It mandates that all policy proposals must adhere to the principles outlined in the treaty and strongly advises the inclusion of perspectives from a diverse array of CYP during the evaluation of policies being developed to improve the health and wellbeing of CYP (Ministry of Social Development, 2018a). In addition, nurse leaders and the multi-disciplinary team need to collaborate and elicit, promote, and model ways of beseeching child participation where CYP are included in shared decision-making with their parents.

Some strategies to promote a culturally responsive Child-and-Family-Centred-Care approach that supports multilingualism include cultural awareness and training workshops; the use of cultural liaison advisors/advocates; providing culturally appropriate spaces and non-traditional platforms for CYP with differing abilities to be involved; ensuring documents are translated into other languages; allowing traditional healing practices; involving community leaders and representatives when requested and ensuring the workforce is ethnically diverse.

Conclusion

The findings revealed that nurse leaders felt strongly that CYP must be provided a platform for involvement in relation to their health and healthcare and described the various means and methods utilised within paediatric settings in New Zealand. A multi-tiered collaborative approach with government, industry, leaders, healthcare professionals, family and CYP is required to enhance CYP's agency/voice in New Zealand hospitals as in alignment with the UNCRC. It is vitally important that we find effective culturally responsive and meaningful ways to mitigate socio-economic disadvantage and promote diversity, equity, and inclusion especially for Māori, Pacifica, and minority ethnic groups. CYP should be listened to in all matters concerning them and there should be policies in place to allow children to have a voice.

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Author contributions

MF, AD and JB conceived and designed the study; MF, JB, VJ, SK and CM provided key expert informants (email contacts); MF and JB contributed to development of survey post literature review; MF, JB, VJ, SK and CM pilot tested the survey; MF and JB undertook data extraction, analysis and synthesis; MF and JB completed the methodology and results sections; VJ critically reviewed and edited the results section; MF, JB and SK completed the discussion; MF and JB undertook numerous edits of indraft and completed/revised versions. AD did the final review of the completed manuscript and provided mentorship throughout.

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