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| **Language Translation** | |
| In-Person interpreter services are a necessity | |
| Need for in-person interpreters for multiple languages | *"Language barriers too- if we had on-site human interpreters to call if needed, teaching and education would benefit dramatically. I recently had an assignment where teaching was not complete because of language barrier I believe. [Interpreter phone] wasn’t working and if it was- it was still difficult to translate and parents reported that the interpreter “didn’t make sense” the translater phones were also difficult to use because of the background noise." (RN, 5-10 years experience)*  *"Well baby teaching takes a minimum of 1-2 hrs with an English speaking family that reads/writes/and has completed at least high school. Teaching a family that does not speak English and do not read or write well in their own language can take a minimum of 3-6 hours. Plus, you have to consider that the R.N. is always paired up with a 2nd baby."* *(RN, 26-30 years experience)* |
| Phone interpretation is a poor substitute | *" The interpreter phone is a poor and inefficient substitute." (RN, unspecified experience)*  *"Having more in-house interpreters available not just for Spanish but for other languages. Using the phone interpreter is not always ideal when trying to teach families. Teaching has to ultimately be held if there are no interpreters available in per person verses on the phone. " (RN, 26-30 years experience)* |
| Inadequate interpreter staffing | *”This hospital does not have enough Spanish translators. It is unacceptable.” (RN, unspecified experience)* |
| Tools to facilitate translation (with or without interpreters) | |
| All materials available in multiple languages | *”Educational materials (written, video, in person classes) in multiple languages are needed.” (RN, 10-15 years experience)*  *"Spanish translation for all materials; Multi-language translation for all materials," (RN, 26-30 years experience)*  *"More admission paperwork needs to be available in Spanish." (RN, 26-30 years experience)* |

**Appendix 1. Themes, subthemes and quotes (role, years of experience)**

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| **Communication Between Staff and Families** | |
| Inconsistent team communication of plan of care and updates is difficult for families | *“Continue to update family regularly on infant's status and have bedside RN verify with MD/NNP if parents have been updated on plan of care. Example: some parents do not realize infant is scheduled for surgery or has had a blood transfusion.” (RN, < 5 years experience)*  *"Doctors and nurses to make more of an effort to communicate changes in the plan of care with parents. It is important that any testing that is done on the infant is communicated as soon as it is resulted on to the parents.” (RN, 5-10 years experience)*  *"Set guidelines on what parents are expected to help dictate and what are going to be the care providers roles of what we believe is the best course of action for the patient.” (RN, 26-30 years experience)*  *"I don't think a lot of the actual staff nurses don't even know about all the resources [hospital] has to offer to families. Also, nurses get so busy that there isn't always time to orient families to things. There should be a dedicated person that does this." (RN, <5 years experience)*  *“I believe we do a pretty good job welcoming families. However, our communication with families could be improved. I think things become lost in translation with shift changes, staff changes and weekly provider changes. The difference in opinion amongst providers and changes to care with chronic kids can cause more stress on parents when plans of care are changed after a set plan was made."* (RN, 5-10 *years experience)*  *“Primary nursing at YY is great. I believe we do a great job. We need to involve parents more in care but it can be hard with 3 baby assignment because if they are late your entire flow as a nurse is off."*(RN, 5-10 *years experience)*  *“Primary nurses AND physicians (attendings) to follow challenging patients throughout hospitalization.” (RN, <5 years experience)*  "Primary care nursing- specifically in micropreemies so families can build higher trust." *(RN, <5 years experience)*  *“I think many of these questions vary nurse to nurse, while I may be comfortable directing a family member to comfort and infant through a procedure another RN may not. Same for educating them.” (RN, 16-20 years experience)*  *"I believe that we provide poor information about diagnosis, treatment plan and prognosis. For example “your baby needs a G tube”.we describe, what it does and what it looks like. Most parent translate this procedure to gaining weight. Parents are missing other components such as aspiration (what does this mean), if we don’t get the G tube what can happen to my baby? Dehydration, oral eversion and other sequela.” (RN, 5-10 years experience)* |
| Scheduling/communication tools | *”Written bath schedule that meets baby/parent needs rather than nurse preference." (RN, <5 years experience)*  *“Parents appreciate the scheduled times for hands on. This isn't always possible but nurses try hard to keep the baby on a schedule so parents can be there for hands on." (RN, 5-10 years experience)*  *”Regularly scheduled family meetings with team/family for updates.” (RN, 5-10 years experience)* |

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| **Staffing and Workflow** | | |
| More nursing staff needed to support FCC | | |
| Increase RN staffing/ Lower nurse-patient ratios | | *“MORE staff!” (RN, 5-10 years experience)*  *“We very rarely have adequate and appropriate staffing to give our babies and families the best possible care.” (RN, 11-15 years experience)*  *“Providing appropriate staffing ratios based on pt. needs and family needs. Teaching families takes more time than management realizes. Example: Well baby teaching takes a minimum of 1-2 hrs with an English speaking family that reads/writes/and has completed at least high school. Teaching a family that does not speak English and do not read or write well in their own language can take a minimum of 3-6 hours. Plus, you have to consider that the R.N. is always paired up with a 2nd baby.”* *(RN, 26-30 years experience)*  *“These goals are altruistic, and wonderful in theory, but they take TIME. Building rapport, establishing trust, meeting the needs of the family to this degree, requires more time than we currently have in a 12 hour shift. Most RN's struggle just to meet the minimum requirements of HR, admin, JCAHO, etc. If we want to be successful at achieving the above mentioned goals, we either need additional ancillary staff to facilitate it or the RN to patient ratio would need to be lowered to allow the necessary extra time to fulfill these expectations.” (RN, 11-15 years experience)*  *"Management support of staffing that supports family centered care...case in point the new Eat Sleep Console should have babies paired 1:1 when family is not present.”**(RN, 16-20 years experience)*  *“No 3 baby assignments (seriously). I know this would never happen but I usually hope the family doesn’t come in when I have a super busy 3- baby assignment because it makes it more stressful for me and I have difficulty staying afloat with tasks/duties/teaching.” (RN, 5-10 years experience)*  *“Lower ratios for families that need extra care and teaching.” (RN, 11-15 years experience)*  *“As a bedside nurse the time needed for some of extra support is time consuming and takes away from the care of the infant.” (RN, 26-30 years experience)*  *“Providing break relief nurses-we love to teach but this can be an extremely exhausting process while taking care of 2 patients and teaching all day. I've heard the statement "I'm fried at the end of the day" so many times that I completely understand what that means. The hours spent on teaching are not reflected in staffing.” (RN, 26-30 years experience)* |
| More support from interdisciplinary staff (social work, child life, lactation, etc.) | | |
| Increased availability | | *"More access to child life specialists to come help with our older long-term babies and help families transition to discharge. Possibly a music therapist or other specialties that are available strictly to help with parent/infant bonding and family coping (I believe [hospital] has this).” (RN,11-15 years experience)*  *“The unit would benefit greatly from Childlife Services, not only at the bedside to work with families but to educate staff.”*  *(RN, 16-20 years experience)*  *“24 hour social work coverage. Coverage cannot only be on “A” shift.” (RN, 26-30 years experience)*  *“[Hospital] needs Child-Life Specialists!” (RN, 5-10 years experience)*  *“When I have had palliative care services involved, they do a great job in assessing the family members for how to help them understand the difference between parents coordinating care vs, being involved with care providers coordinating care." (RN, 26-30 years experience)*  *“We need more help from other team members for helping parents with finding the support services that are available in the hospital. The idea of a guideline for an emergency or unknown admission would be helpful if it where being carried out by someone other than the bedside nurse." (RN, 26-30 years experience)*  *“A dedicated NICU Lactation Consultant.” (RN, 30-35 years experience)* |
| Nights and weekend support | | *“There is very little support for the staff to assist families in the XX NICU in the evening, at night or on weekends. We frequently have to tell families that they will have to wait until Monday to get the assistance they need, the referral done, see a certain specialist or have testing done. The families, and staff, get frustrated by this.” (RN, 26-30 years experience)*  *“Increased lactation consult availability for the evening.” (RN, 5-10 years experience)*  *“More social workers available, esp on admissions and weekends.” (RN, 16-20 years experience)* |
| Establish a NICU family support role | | *“Parents need support. A lot of it. I think as charge nurses start their shift they should visit each bed side with parent and introduce themselves and how they are? What their needs are? And state of they need anything to verbalize it directly to them. If there is an emergency or difficult admission a charge nurse should be there to address questions and concerns of what is happening with their baby.” (RN, 5-10 years experience)*  *“Not enough time during the shift to adequately orient families, nursing are routine interfering with family education, need a dedicated staff member to do this.” (RN, <5 years experience)*  *“The idea of a guideline for an emergency or unknown admission would be helpful if it where being carried out by someone other than the bedside nurse.” (RN, 26-30 years experience)*  *“More of a structured approach to designate a point person to communicate during admission / emergent procedures. Nothing seems more stressful than a family member standing to the side and watching what is happening without being able to ask questions or just have someone there to support them.” (RN, <5 years experience)*  *“Formal questioning of each family about their own ideas to improve family involvement.”* (MD*, 26-30 years experience)* |
| **Strenghtening Team Culture and Leadership** | | |
| Family-centerd care values | | *“We are excellent advocates for our infants and their families. Our staff is well trained and are compassionate. We have a new staff of well trained new grads that add to our care.” (RN, 36-40 years experience)*  *“I hope we could have a different scrub in our unit like more friendlier scrub - just the top.. it makes more friendlier.” (RN, 11-16 years experience)*  *“I do not feel that our unit currently sees the family as "a member of the healthcare team". Hopefully we an move in that direction better in the near future. Furthermore, I do not see our parents being empowered with decision making as much as they could be for day to day changes in their child's course. Our culture feels much more of a culture that makes choices for the patient and informs the family later (unless a consent is required). I also believe that in our unit it is difficult to assist in "identify, plan & evaluate new programs, policies & procedures to improve the quality of patient & family care". That does not feel like the case as a bedside staff." (RN, 5-10 years experience)*  *“As a bedside RN, I am not routinely involved in encouraging parents to attend parent-help groups. The ICN does not have a strong parent-to-parent relationship presence. I am also not aware of how to help parents financially, though SW and case managers are involved in that aspect of care. We do a poor job of encouraging parents to advocate for their baby (we do not often let them make medical decisions).”* *(RN, <5 years experience)*  *"The medical staff needs to view the parent/family as an equal party in the team and not be threatened by their presence/knowledge/questions and they need to involve families in hands on care/collaboration accordingly.” (RN, 11-15 years experience)*  *“But, I don't think we're as good at family centered care as we could be. We occasionally have issues with family-led care, which is not as appropriate I think, but centered is a great goal."**(RN, 5-10 years experience)* | |
| Views in opposition to family-centerd care principles | | *“Having no visitors, including parents at the bedside during shift change/report will allow for better handoff communication between nurses as so often pertinent information about a baby is missed when one feels awkward about verbally disclosing sensitive information while the parents are sitting at the bedside. So often parents ask for updates, have questions and comments when report handoff is occurring. I feel this is a disservice to the cares of the baby as well as to the parents when adequate time cannot be spent with them. It would greatly encourage bonding if parents feel comfortable with the nurses and not so out of the loop as to what is occurring with their baby when the nurses are not able to adequately spend the needed time with them due to shift change. This does not feel like patient centered care if the parents are not able to relax at the bedside.” (RN, 11-15 years experience)*  *"It is incredibly vital and important to practice family-centered care and incorporate families in the decision making process. However, there are times when the medical team makes a care plan decision that is not in the best interest of the infant due to parent request in spite of evidence-based best practice." (RN, 11-15 years experience)*  *“Set guidelines on what parents are expected to help dictate and what are going to be the care providers’ roles of what we believe is the best course of action for the patient.**When I have had palliative care services involved, they do a great job in assessing the family members for how to help them understand the difference between parents coordinating care vs, being involved with care providers coordinating care.” (RN, 26-30 years experience)*  *“For the past couple of years I noticed an increase in very demanding and almost abusive parents toward nursing staff and the sad part of it is, it is becoming the norm.**From day one, parents need clear boundaries and expectations explained to them and if they will deviate that should not be tolerated. We should not be abused at work.” (RN, 16-20 years experience)* | |
| Leadership and staff buy-in of family-centered care model | | *“For Family Centered Care to be a success the Staff have to buy into it and support the program. The staff must feel a part of the development of the program and be personally invested in it for it to be a success.” (RN, 36-40 years experience)*  *“Nurse managers / educators should visit units such as in Northern Europe where family involvement is a much more practiced concept. This as much for inspiration as well as to see how participation ""policies"" were developed , what kind of hurdles had to be overcome, what kind of teaching the personnel, incl. nurses, RTs, SWs, physicians etc received." (MD, 36-40 years experience)*  *"Nurses often encourage family interaction and involvement in care." (RN, <5 years experience)* |
| Support to prevent nursing burnout | | *"More support to deal with difficult parents."**(RN, 16-20 years experience)*  *“Currently, our concern is our patient. While our patient is not just the baby we are caring for, it seems almost overwhelming to provide for the entire family at all times.” (RN, 26-30 years experience)*  *“Staff may express concerns related to patient care issues, but rarely hear back on action taken. Frustrating to communicate in an effort to provide quality care when not receiving any feedback.”(RN, 31-35 years experience)* |
| Hospital resources to support family-centered care | | Immediate families (parents, siblings, maybe grandparents) of infants hospitalized should have free access to parking - the hospitalization fee is so high already that an additional $ 10 - 20 /day doesn't make much of a difference for the "system", but can make a huge difference for a family . One could start with a "study" to see if free parking makes a significant difference in visitation pattern (frequency, length ...)? And how would that influence parent participation in care and efficacy of discharge training etc.”*(MD, 36-40 years experience)*  *"FCC is a very ideal concept but how can this FCC be implemented to those that are less privileged,who probably lacks economics, education, language support? Like the concept but will it be workable." (RN, 25-30 years experience)* |

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| New policies/policy change to define and support family-centered care | | |
| Family presence | | *“In the ICN, I feel visiting is too restrictive. Parents/grandparents/guardians should never be viewed as “visitors”, they are the parent, and therefore, they belong with the baby. I think the fact that only two visitors are ever allowed at the bedside (excepting end-of-life care) means that both parents can never show their new infant to their parents, in-laws, or other family members. Especially considering we have private rooms for most infants, it is unnecessarily restrictive.* *Obviously if a particular family is causing a problem or inhibiting care, address that, but on the whole, it would be great if parents and grandparents were able to visit baby together. ”* *(NNP, 5-10 years experience)*  *“Additionally, I feel we don't have enough support for non-parental shared decision makers/alternative families. For single parents, whether it is a friend, sibling, parent, doula or whatever, they should be able to designate them as someone to be treated as a parent. Or if there are no grandparents, but they have friends that stand in that stead, that should be allowed and encouraged. In essence, perhaps allowing each family to designate two people as ""parental"" roles, and four people as ""grandparent"" roles. It would be fine if those can't be switched around (pending something extreme happening) and should be counseled that this is a "permanent" decision, not something to get a friend in after hours etc****.”*** *(NNP, 5-10 years experience)*  *“Incorporate some type of policy for sibling visitation--i.e., why aren't they allowed at the bedside 24/7 like the parents since they are immediate family? Sometimes the older sibling is the one who will also help in providing the child's care at home. Rooming-in rooms when preparing infants for discharge would be helpful to ensure that parents feel confident when sending patient's home to families.” (RN, 5-10 years experience)* |
| Defining family-centered care standards | | *“No policies exist on how parents can help comfort their children during painful procedures or what they can do during these times.” (RN, 5-10 years experience)*  *“I think that some people do this better/more effectively than others because there are not a lot of standards or policies to govern family centered care. Better guidelines to help create a clearer standard of care instead of everyone doing things their own way.” (RN, <5 years experience)*  *“Nurse managers / educators should visit units such as in Northern Europe where family involvement is a much more practiced concept. This as much for inspiration as well as to see how participation "policies" were developed , what kind of hurdles had to be overcome, what kind of teaching the personnel, incl. nurses, RTs, SWs, physicians etc received."*(MD*, 36-40 years experience)*  *“A uniform system for orienting families to the unit/hospital and involving them in each aspect of their child's care is needed. Having a true expectation of family to be present and participate in care would help family-centered care." (RN, 11-15 years experience)* |
| Ethical guidelines | | *“An ethical decision-making model that includes consideration of the impact of medical decision-making on the the entire family (not just the infant), and includes socio-economic concerns.” (NNP, 36-40 years experience)* |
| **Education for Staff and Parents** | | |
| Empathy training/  How to support families | *“Teaching nurses how to gauge parent emotional distress when they are comforting their baby.”* *(RN, 16-20 years experience)*  *"Staff continuing education to learn more about how to more effectively support and help families (based on personal accounts of positive and negative experiences shared by families who have had a child in the NICU)." (RN, 30-35 years experience)*  “... remembering no matter how much we love our job and get excited about what we do ...it is so hard for the family members. We need to stay sensitive to that and keep them involved. It's not our baby...it's theirs." *(RN, 5-10 years experience)*  *"A better understanding and appreciation for the varied life experiences, challenges, and socio-economic dynamics in play with most of our families. I often find that bedside nurses are frustrated that families don't act like THEY would act, and that acts as a deterrent to providing more family-centered care."(RN, <5 years experience)*  *"We are excellent advocates for our infants and their families. Our staff is well trained and are compassionate. We have a new staff of well trained new grads that add to our care." (RN, 36-40 years experience)*  *“Parts of new employee orientation to stress the importance of family centered care and focus on how to prevent becoming 'callused' to what we do.” (RN, 6-10 years experience)* | |
| Family-centerd care education | *“More education on how to support family-centered care in the NICU. Maybe provide a half day conference, or all day conference to teach staff how to do so.” (RN, 6-10 years experience)*  *"Care training to help staff understand what can be done here at [hospital] and what is expected." (RN, 31-35 years experience)*  *“I hope that the staff (Nurses, NNPs, Neonatologists, Fellows, Residents, SW, OT/PT) will be given lots of education about family-centered care prior to the start. Don't forget about float pool nurses." (RN, 21-25 years experience)*  *"Education for staff on involving families in care and how to educate families." (RN, 6-10 years experience)*  *"24 hour social work coverage. Coverage cannot only be on A shift. More education is needed for nurses. Currently, our concern is our patient. While our patient is not just the baby we are caring for, it seems almost overwhelming to provide for the entire family at all times." (RN, 26-30 years experience)*  *"A strong theme I felt throughout the survey is that more education for staff and parents will help solidify a patient-family centered experience. The earlier we establish trust and educate parents, the more helpful they will be to the infants care. The more they know early, and if trust is established early, Parents can be invaluable tools to the infant’s care. This also will help in difficult situations such as palliative/comfort care needs." (RN, <5 years experience)*  *"I think it is important to train staff on how to support the families through rough times. Communicating and gaining their trust is key. It helps staff advocate for their patients and families." (RN,<5 years experience)*  *"As a new staff member, I do not feel that there was any emphasis on how and where to find resources that support family centered care. I would recommend gathering an introductory packet with all of the available paper work be provided to new staff so they can take the time to review before starting. Adding list of all available support groups and resources at the hospital would be helpful." (RN, <5 years experience)*  *"Educate staff on how to assess sibling needs." (RN, 16-20 years experience)*  *"Provider education around what parents could actually be the decision makers on. A better way to introduce parents to each other (other than sending them up to the peds floors)." (RN, <5 years experience)*  *“Continued staff development and informational trainings.” (RN, 11-15 years experience)*  *"Consistency in teachings given"* (RN, 16-20 years experience) | |
| Education on other related topics | *"We very rarely have adequate and appropriate staffing to give our babies and families the best possible care. With such a large influx of new, inexperienced staff, the problem is exacerbated and there is no follow up with recent hires and no common knowledge regarding what newer RNs know, how they are teaching, and updating families and their comfort level with involving families. Most importantly, there is a massive lack of developmental teaching at ZZ. Even some senior staff are unaware of optimum positioning, handling, environment, and family involvement for preemies."* (RN, 11-15 years experience)  *"Primary care. Better education for all nurses "who are interested", in complex care."*(RN, 6-10 years experience)  *"I think we need more programs that address how to care for families and how to interact with families, certainly with situations that are critical or in end-of life situations."* (RN, 36-40 years experience) | |
| Education for parents | *“More parent classes"* (RN, 31-35 years experience)  *“A uniform system for orienting families to the unit/hospital and involving them in each aspect of their child's care is needed.”*(RN, 11-15 years experience)  *"Daily log with educational tools that can be accessed from home. Handout of what family centered car means. An informal contract for parents to sign so they know ahead of time what it means to participate."* (RN, <5 years experience)  *"Provider education around what parents could actually be the decision makers on. A better way to introduce parents to each other (other than sending them up to the peds floors)."* (RN, <5 years experience)  *"A strong theme I felt throughout the survey is that more education for staff and parents**will help solidify a patient-family centered experience. The earlier we establish trust and educate parents, the more helpful they will be to the infants care. The more they know early, and if trust is established early, Parents can be invaluable tools to the infant’s care. This also will help in difficult situations such as palliative/comfort care needs."* (RN, <5 years experience) | |

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| **NICU Physical Environment** | |
| Environmental constraints on FCC | |
| Not enough space:  - to work with baby  - storage areas  -for teaching/ discharge prep | *“I strongly believe in family centered care but it will be a challenge in our present unit because of the limited space around the bedsides.” (RN, 41-45 years experience)*  *“Adequate room for all the equipment needed to care for a patient.” (RN, 41-45 years experience)*  *“There is not enough physical space between patients in rooms aa,bb,cc,dd and ee. Not conducive to a pleasant visit for families.” (RN, 26-30 years experience)*  *“More space in NICU.” (RN, 16-20 years experience)*  *“Additional storage outside of the unit, so the unit is not so congested. Working around families and equipment is extremely challenging.”- (RN, 31-35 years experience)*  *“More space per bedside and private areas to do teaching. Ability to have the other part of your assignment be covered while you teach in a quiet comfortable space.”* *(RN, 31-35 years experience)*  *“Rooming-in rooms when preparing infants for discharge would be helpful to ensure that parents feel confident when sending patient's home to families.” (RN, 5-10 years experience)*  *“It is difficult in our unit to round on each patient while at the same time, providing appropriate confidentiality for each patient.” (RN, 31-35 years experience)* |
| Environment designed to support family involvement in care | *“It would be awesome - [other hospital] had mentioned a facility that gives parents a badge so they can badge in and out of the units allowing better access to their children. What about baby monitor cameras? The hospital I worked at before had webcams that parents could access with a personal private log in to view their baby 24/7 with the except during cares the camera is paused. I think we're doing okay, but as always, there's room for improvement.” (RN, <5 years experience)*  *“Hoping our units will have more visuals/pictures of family (posted on our wall or outside the unit; ofcourse will ask permission from parents if its ok) e.g. father doing skin to skin with mother beside (i saw this in one of the nicu unit we visited and it says a lot by just seeing the photo.. it makes the unit fr families less scarier.” (RN, 11-15 years experience)* |
| Environment designed to support developmental care | *“The ability to dim lights and reduce noise for each patient.” (RN, 41-45 years experience)*  *“Decrease noise levels.”* *(RN, 31-35 years experience)*  *“Quieter environment.” (RN, 11-16 years experience)*  *“I feel the private rooms lack some development stim for the infants.”* *(RN, <5 years experience)* |
| Creating a comfortable space for parents | |
| Chairs | *“Dedicated chairs at bedside so that they dont disappear when families go to eat/restroom. Sleep chairs like in the ICU so parents can be encouraged to spend more time at the bedside especially nearing discharge.” (RN, <5 years experience)*  *“Better chairs to make being at beside more comfortable.” (RN, 16-20 years experience)*  *“\*Reclining chairs for proper positioning during skin to skin care (at least 2 per pod).” (RN, 31-35 years experience)* |
| Privacy | *“More private space in the NICU environment to sit down with families - rather than a special place far away from the NICU which often seems to give parents the sense of impending doom.” (MD, 31-35 years experience)*  *“For our particular unit, having more space around the infant's bed would be helpful...and curtains that actually work (we do the best we can but it can become frustrating for example trying to help with breastfeeding when there's no room to maneuver around the space).” (RN, 6-10 years experience)* |
| Sleep areas | *“Having parent sleep rooms allowing a safe and better area to sleep if breast feeding or having a baby in the NICU would be helpful.” (MD, 41-45 years experience)*  *“Parents should be able to sleep at bedside or have rooms close by.” (RN, 21-15 years experience)*  *“\*More overnight accommodations for parents who have difficulty getting to and from the hospital and for breastfeeding moms.” (RN, 31-35 years experience)* |
| Single family rooms | *“Private rooms, but hopefully that will be coming one day.” (RN, 31-35 years experience)*  *“Private rooms for the babies, at times very loud in the unit with admissions and the daily business.” (RN, 16-20 years experience)* |
| Family space/ refreshments/ bathroom access | *“A private, safe, relaxing, and comfortable place with a kitchen for parents away from the NICU but in-house.” (RN, 31-35 years experience)*  *“We need to create an easier way to access the bathrooms without having to check in and out of the NICU with the UA (this would decrease the calls to the unit of pods by est 20%).Also if we got couches similar to what L&D just placed in their waiting area I feel could be nice in our back hallway.We need a water filter or water fountain for breastfeeding moms by every pod if possible.” (RN, <5 years experience)*  *“Better waiting rooms.” (RN, 11-15 years experience)* |