Abstract

Family-centered care encourages patients and families to participate in the planning and delivery of care based on personal preferences and individual needs. For pediatric patients and families, family-centered rounds (FCRs) represent a standard of care that involves patients and families partnering with the healthcare team to share information and make decisions about care. Our healthcare team strongly believes that FCRs are critical to providing excellence in care. Our initial attempt to implement and then sustain FCRs presented challenges that required changing the culture to one that consistently partners with patients and families and appreciates the role they play in the care of their children. Incorporation of observations and feedback from family advisors, a consistent process for rounding, and education for team members about expectations for participation were needed to revive and sustain FCRs. Through continued evaluation and collaboration, our unit worked to establish a standard approach to FCRs that benefits the patient and family as well as to the healthcare team.

Key words: Family; Family-centered rounds; Parental satisfaction; Supportive environment.

CE **2.0 ANCC Contact Hours**

Kara Nichols, BSN, RN, CPN, Karen Crow, MSEd, and Karen Balakas, PhD, RN, CNE

BEYOND IMPLEMENTATION: SUSTAINING Family-Centered ROUNDS

St. Louis Children's Hospital has long embraced the philosophy of family-centered care, an approach to care in which patients, families, and the healthcare team are partners. Family-centered care encourages patients and families to participate in the planning and delivery of care based on personal preferences and individual needs. Families are not considered "visitors" but essential nurturers, caregivers, and participants in the care and decisions that affect the physical, emotional, spiritual, and developmental healing of their child. For several years now, the philosophy of patient- and family-centered care has been widely adopted by pediatric hospitals where family-centered rounds (FCRs) have become a commonly accepted standard of practice. Family-centered rounds are a model of communication in "which the patient and family share in the control of the management plan as well as in the evaluation of the process itself" (Sisterhen, Blaszak, Woods, & Smith, 2007, p. 320). Family-centered rounds occur in the presence of the child and family and incorporate their viewpoint in clinical decision making (Cypress, 2012). For pediatric patients and families, FCRs represent a key element of patient- and family-centered care that involves patients and families partnering with the healthcare team to share information and make decisions about care (Rappaport, Ketterer, Nilforoshan, & Sharif, 2012). Our healthcare team strongly believes that implementation of FCRs is critical to providing excellence in care. Through continued evaluation and collaboration, our unit has worked to establish a standard approach to FCRs that benefits the patient and family as well as to the healthcare team. The purpose of this article is to share our experiences and processes used on a pediatric medical unit to implement, revise, and sustain FCRs.

Evidence for FCRs

Over a decade ago, the American Academy of Pediatrics issued a joint statement with the Institute for Family-Centered Care emphasizing the importance of the family's perspective in clinical decision making and advocated

for FCRs as standard practice (American Academy of Pediatrics [AAP], 2003). They continue to advocate this approach (AAP, 2012). Mittal et al. (2010) surveyed U.S. and Canadian participants of the Pediatric Research in Inpatient Settings Network (n = 265) and found that FCRs were the most common types of rounds conducted and academic hospitals are more likely to use FCRs than nonacademic hospitals. Respondents reported enhanced family participation in care and planning for discharge as well as improved team communication and workflow (Mittal et al.). Several recent studies have consistently reported that families believe their involvement in rounding will improve their children's care and are more satisfied with the hospital experience (Aronson, Yau, Helfaer, & Morrison, 2009; Drago, Aronson, Madrigal, Yau, & Morrison, 2013; Latta, Dick, Parry, & Tamura, 2008; Rappaport et al., 2012; Schleien, Brandwein, & Stasiuk, 2013).

The philosophy of patient- and family-centered care has been widely adopted by pediatric hospitals where family-centered rounds have become a commonly accepted standard of practice.

Family-centered rounds help foster involvement of patients and families and therefore are one way to improve the quality and safety of care (Kelly et al., 2013; Muething, Kotagal, Schoettker, Gonzalez del Rey, & DeWitt, 2007). This daily process offers an opportunity for open and unbiased information sharing and communications resulting in improved family confidence and trust with the healthcare team. Healthcare providers develop better understanding of family dynamics and establish a collaborative partnership for shared decision making throughout the child's stay (Sisterhen et al., 2007). Orders and care plans are clearly communicated so that families and healthcare team members leave rounds knowing confidently what to expect. Throughout the day, there is less need for bedside nurses to page resident physicians or attending physicians for clarification of plans or orders, and families are less likely to question the plan of care because they were part of the conversation and decision-making process during rounds (Mittal et al., 2010). Families are more clearly aware of the discharge goals and are included in necessary steps and decisions to help them make strides to

get there. Discussion about discharge includes what the family will need to have in place to confidently care for their child at home, including care supplies, follow-up appointments, and means for travel home. Families are more satisfied with the discharge process as a result of knowing how and when these necessary milestones will be arranged (Mittal et al.; Subramony, Schwartz, & Hametz, 2012).

There have been concerns that family-centered rounding may take longer, and that in an academic hospital, some aspects of teaching may be compromised (Muething et al., 2007). Traditionally, teaching during rounds occurred in a hallway outside the patient's room or in a conference room and encompassed developing a care plan and reporting medical information significant to the patient's condition. More recent research has found that medical students and residents prefer bedside rounds and value the role modeling for communication with families (Mittal et al., 2010; Rappaport et al., 2012; Sisterhen et al., 2007).

Our Experience in Implementing FCRs

Prior to 2010, our rounding process was similar to the traditional model, taking place in a conference room, and attended by the healthcare team and the unit charge nurse. Communication between the healthcare team and the nursing staff occurred through orders, notes, and charge nurse discussions after rounds were completed. Families and direct care nurses did not witness decision-making processes nor have ability to make clarifications or present their point of view. This led to questions and concerns being addressed after rounds and on a reactive basis, often leading to interruptions in workflow for the healthcare team. There were feelings of frustration from patients, families, and nursing staff related to lack of information, unclear expectations, and miscommunication. Rounds in the conference room were lengthy (at times up to 3 hours) and still required the healthcare team to communicate the plan with families after they were completed. This had negative effects on patient and employee satisfaction and patient throughput.

Following an off-site workshop regarding the benefits of FCRs that was attended by several members of our Unit Based Joint Practice Team, we made the decision to implement a similar practice on our general medical unit. We searched the literature and sought information from other pediatric hospitals that were already using FCRs on a daily basis. We developed roles for the direct care nurse, charge nurse, and senior resident and created an educational plan for all healthcare team members. The senior resident physician provides leadership and role modeling for interns during rounds; the charge nurse invites the family to rounds and provides additional leadership in presenting the patient as needed; the direct care nurse advocates for the family and is able to later reinforce or clarify the discussion while role modeling for nursing students; and other healthcare team members provide pertinent patient information as needed. We knew it was important to communicate with medical staff prior to their 4-week rotation on the unit so they knew what to expect and how to participate. An e-mail communication was created to share our process and goals with interns and resident physicians that could be sent at intervals throughout the year as the rotations changed.

Through family-centered rounds, healthcare providers develop better understanding of family dynamics and establish a collaborative partnership for shared decision making throughout the patient's stay.

Shortly after implementation, observation data were collected to determine how long the FCR process took, participation rate of nursing staff, and attention given to the discharge plan. Average time per child was 4.5 minutes, families were present 85.3% of the time, the bedside nurse was present 74.8% of the time, and the discharge plan was discussed 76.7% of the time. We developed a survey to collect data from families eliciting information about their satisfaction with the care and their perception of teamwork among members of the healthcare team. In the first 9 months following implementation, there was a notable increase in the patient/family perception of overall teamwork among physicians, nurses, and staff from 59.9% to 70% as well as an increase in patient satisfaction scores about the quality of care from 65% to 72.7%.

Identifying Challenges and Taking Action

Family-centered rounds continued over subsequent months and we continued to gather feedback from individual interviews with families conducted by the family advisor to improve the process. As a teaching institution, the physician team rotated frequently and that eventually became a greater challenge. We enlisted charge nurses to provide instruction to the senior resident physician at the beginning of each rotation about how to lead FCRs, and unit leaders "welcomed" the interns on their first day with a brief explanation of importance and value of FCRs. As time progressed, the process became very dependent upon the healthcare team and their appreciation of their role in conducting FCRs. Changes in physician team members led to challenges with consistency in practice and eventual frustration. Direct care nurse attendance decreased as the perceived value decreased (from 80% participation to 30% participation), the family participation decreased, and our patient satisfaction scores remained flat. Family-centered rounds continued to be valued with a potential for great success, but we were not moving ahead.

Family-centered rounds occur in the presence of the child and family and incorporate the patient's and family's viewpoint in clinical decision making.

To address the need to revive FCRs, we created a committee on the unit focused on enhancing our ability to provide family-centered care and to restructure and sustain FCRs. The committee publicized FCRs for families with signs in rooms, developed a brochure to give to families upon admission, and continued education of staff members on the value of partnering with patients and families in decision making. The Family-Centered Care committee was dedicated to supporting a culture on our unit that consistently partners with patients and families and appreciates the role they play in the care of their children. The committee was active in seeking feedback from the front-line nurses to identify opportunities to continually improve the rounding process. As a busy pediatric medical unit with a short average length of stay and varying degrees of acuity among patients, nurses were having difficulty incorporating FCRs into their morning work. Nurse participation in rounds was felt to contribute to a superior patient and family experience. Based on feedback from nurses, one barrier to participation was the inconsistency in the rounding order that led to inability to anticipate when the team would round on their patients. As a result, a consistent rounding order was established and a rounding list was created by the charge nurse. This allows the nurses to prioritize morning tasks to be present for rounds. It also helped nurses to communicate with families about when the team would be at their room. Increased nurse participation was seen as a result of a consistent process to identify the rounding order. The committee then sought additional opportunities to standardize the process to achieve similar successes.

Although the chief resident physicians had been involved in the early implementation plan for FCRs, and the unit-based Family-Centered Care committee had worked on rounds as a project, it became clear there was not an identified owner or standard for FCRs. Variances remained in the process and content depending upon individual (direct care nurse, charge nurse, senior resident) participation and engagement. As a result, there was a somewhat undesirable impact on patients and families. The proposed need was brought to the Unit Based Joint Practice Team and accepted as a multidisciplinary project. In addition to the healthcare professionals on this practice team, a family advisor joined and her contribution was invaluable. Family advisors are parents of children who have been hospitalized at our institution and who have received a brief orientation program to be able to serve on committees and contribute insights into our delivery of family-centered care. The family advisor was able to provide understanding for the providers as to how families interpreted communication from the healthcare team during FCRs and how comfortable they felt participating in the process.

The team decided that more regular family feedback could provide insights into the benefits of including families and patients in rounds, as well as help to improve the process. To do this we enlisted the help of a family advisor to observe and provide feedback to the rounding team. The unit's daily patient care team consists of

medical students, resident physicians, interns, fellows, gastrointestinal and general medicine service attending physicians, nurse practitioners, direct care and charge nurses, a pharmacist, a care coordinator (responsible for assistance with discharge planning and follow-up appointments), a resident assistant, and a child life specialist. Observations by a family advisor using a checklist developed for this purpose and similar to the one created by Henneman, Kleppel, and Hinchey (2013) occur during the first, third, and last weeks of a monthly resident rotation. Feedback is focused on the following topics: consistency of team introductions to family members; consistency of order entry and read-back by the healthcare team; communication of daily and discharge plans; consistency of bedside nurse participation; amount and extent of family and patient participation; length and efficiency of rounding session; consistency of rounding roles; and how to optimize communication with families for better understanding and increased participation in the process.

Family advisors record their observations of team behaviors and conversations during daily rounds as well as the family reactions. A short huddle to summarize the feedback after each day's rounds provides team members with an opportunity to hear the family advisor's observations of the key elements of the rounding process and for the team to share their thoughts and reflections about how they felt rounds went that day. On 3 days each week, the family advisor informally collects comments and impressions from current families that participated in the daily rounds and shares that anecdotal feedback with the care team the next day. Most comments reinforce the families' desire to participate in rounds to help in decision making and developing a plan of care for their child. They welcome seeing and hearing from the care team together, which enhances their confidence that everyone on their child's care team participates and agrees with the care plan. Families feel confident that they can ask questions and share information with the care team when they are asked their opinion or to add anything else they feel is important. This feedback is in agreement with the literature that using common terminology in addition to medical jargon is important to family confidence in understanding and feeling comfortable participating in rounds (Latta et al., 2008). To be sure that all families knew about FCRs

FIGURE 1. Portion of the Pamphlet Provided for Families to Educate Them About Family-Centered Rounds and How to Participate.

Family-Centered Rounds
Patients and Families: Join the Team!

What Are Family-Centered Rounds?

The medical team meets every morning. Usually this happens between 8:30 and 10:30. They talk about each child on the unit and make a plan for that day. This is also called "Family-Centered Rounds." It is family centered because we want your input! You can choose to meet at the bedside or outside the room

Please join us!

You know your child best. **You** play an important role in your child's care. We want to keep you involved in the decisions about your child.

Can't attend but would like an update? Ask your nurse to give you a call after rounds.

What happens in Family-Centered Rounds?

The team talks about your child's current condition and progress. They also discuss:
- Changes and what happened overnight
- New lab and test results
- A plan for the day
- Goals for discharge

This is an important time to make sure everyone knows what each patient needs to get well.

What is the Patient and Family Role at Rounds?

Write down questions and notes before and during rounds. Tell us what YOU think will help your child. Listen and join in the discussion. Your ideas and questions are important, be sure to share them during rounds. Working together to provide the best care for your child is part of the Superior Patient Experience at St. Louis Children's Hospital.

Who Attends Family-Centered Rounds?

Many people make up the medical team. Each person has a special role to play. Here are some of the members of the medical team:
- Care Providers: attending Doctors, Nurse Practitioner, Fellow, Resident, Intern, Medical students
- Charge Nurse, Bedside Nurse
- Therapists: Respiratory, Physical, Occupational, and Speech
- Pharmacists, Care Coordinators, Child Life Specialists, Dietitian, Social Workers, House Staff Assistant

Why Are There So Many People on Rounds?

St. Louis Children's Hospital is a teaching hospital. The team has one doctor who is in charge. This is the "attending doctor." During rounds, the attending doctor teaches other team members about the best ways to:
- Diagnose and treat medical conditions
- Speak to families about their child's health

FIGURE 2. Process for Family-Centered Rounds.

Family-Centered Rounds

The goal for family-centered rounds is to effectively and efficiently complete the key components below while promoting the development of leadership skills. The senior resident physician is strongly encouraged to lead rounds by ensuring the key components are met. The charge nurse group is willing and able to ensure the key components are met when needed. Communication between the charge nurse and senior resident physician to establish a plan and mutual expectations for the rotation is expected.

- Before Rounds: Charge RN and Senior Resident Physician Collaborate on Rounding list/plan for rounds
  - Charge RN makes list based on planning with senior resident
- Begin at 0830 in the Conference Room for:
  - Sensitive issues (social issues)
  - Overnight events (sickest patients, any use of the Rapid Response Team)
  - Big events (unit activity/concerns)
  - Identification of primary and backup intern to write orders during FCR
- Key Component: Senior Resident Leads Introductions
  - Specifically introduces the attending physician and fellow, senior resident, and charge nurse (may be done by the charge nurse if needed).
  - Provider presents patient information
  - Introductory statement to explain and invite parent participation: "I'm going to give a brief presentation about your child. Feel free to add anything you think of or clarify something I say."
  - Using layman's terms and pertinent positives is encouraged.
- Key Component: Senior Resident Physician summarizes/restates the plan for the family and team
- Key Component: Senior Resident Physician asks for questions from the team
  - Any question from RN or other team members?
- Key Component: Entering intern reads off orders as written. Presenting intern confirms accuracy (Senior Resident physician or Charge nurse initiates if Intern does not initiate)
- Key Component: Senior Resident Physician asks family
  - What questions do you have?
  - Discharge goals clearly stated
  - Wrap up/thank family for participating.
- After Rounds: Closing Huddle led by Charge RN and Senior Resident Physician.
  - Overall picture of the floor for the day
  - Any known events for the day

and how they could participate, we created a brochure that is distributed upon admission to the unit (Figure 1). Families are reminded that we value their input and guidance in our efforts to provide a superior patient experience.

Resident physicians and medical students have been open to hearing observations and recommendations from the family perspective and are eager to implement changes throughout the remainder of their rotation. At the end of each month, resident physicians have confirmed benefits of implementing these small changes and importance of the experience on their future rounding and communication practices with patients and families. They have expressed increased confidence in their ability to connect and build trust with more of their families and patients. They have also expressed appreciation for bedside nurse participation and contributions to care decisions, stating this greatly decreases need for clarification of orders later in the day as well as need to restate or clarify plans to patient and families. Although concerns arise as to increased length of the total rounding process, feedback from residents has shown that efficiency and amount of daily work completed during rounds has provided a much smoother workflow for the remainder of the shift.

Our next step was to establish a reliable process for FCRs on a daily basis using input from all involved disciplines. This consistency has been a key factor in achieving success and sustainment of FCRs for every patient, and every family, during every rounding experience. With support of the charge nurse and other team members, FCRs are led by a senior resident physician. If any of the key components are not discussed, the charge nurse prompts the team for the missing information. A pharmacist and care coordinator round with the team each day and help to ensure order read-backs have been completed and a clear plan for the day and discharge has been discussed. Figure 2 presents our standardized approach for daily FCRs.

As a result of our efforts to fully implement FCRs, we have achieved our mutual goals of increased patient and family involvement in clinical discussion and decision making; improved communication and coordination of care including a shared mental model among the patient, family, and all key members of the care team; establishing and communicating a clear plan for the day and for discharge; and efficiency and effectiveness to support safety and excellence in care. Work is completed during rounding (orders entered and read-back for accuracy) and educational opportunities are optimized.

TABLE 1. Patient Satisfaction Scores Over Time Achieving a Rating of Excellent*

Specific Question	Jan to Dec 2008	Jan to Dec 2009	Jan 2010 to June 2011	July 2011 to June 2012	July 2012 to June 2013	July 2013 to June 2014
Nurse communication with you or your family	58	53.4	64	71	67.7	71.3
Nurse instructions or explanations of you/your family members treatment or tests	61	51.5	60	70	67	73.5
Overall teamwork between the doctors, nurses, and staff	59.9	52.3	70	61	65.8	65
Overall quality of care	65	65.5	72.7	69	77.5	79.3

*% Rated excellent

During this period, data reporting time frames changed from Jan to Dec moving to July to June.

Concerns still remain that medical teaching, in the traditional sense, is often diminished during FCRs. Teaching methods for physicians continue to be adapted to FCR with short conferences following rounding if needed. However, many team members, including nurses and other ancillary staff, have identified educational benefits with FCRs. Families have also expressed satisfaction in hearing some of these "teaching points" to better understand the rationale for care plans and illness or disease processes, and they frequently welcome these opportunities to share specifics of their child's illness with the team in an effort to educate them. In situations where the senior resident physicians and attending physician help to model appropriate behaviors, such as asking open-ended questions, making eye contact with the family, reading nonverbal cues, and inviting families and patients to share in the discussion, resident physicians and medical students develop confidence and expertise in providing family-centered care (Muething et al., 2007).

Regular feedback from our families and staff regarding FCR has allowed us to recognize excellence and identify opportunities for improvement. Ongoing monitoring, education, and feedback continue with front-line staff to reinforce the value of their participation. Specified points for the nurse to address were introduced as we strive to increase their comfort level in advocating for patients and families and sharing up-to-date information. Feedback from nursing staff continues to affirm the efficiency and effectiveness of the new standardized rounding process. Average nurse participation in rounds has greatly improved and continues to be maintained between 85% and 90%.

Over time, feedback from families has been positive as demonstrated in the increased scores achieving an excellent response to survey questions (Table 1). Additionally, through informal conversations, discussion during feedback sessions, and patient surveys, families have shared their appreciation for our dedication to FCRs. Families of patients with chronic illnesses have been able to compare their hospital experience both pre- and post-FCRs. They reinforce that we are doing the right thing, for every patient and every family, with every rounding experience. ✣

Clinical Nursing Implications

- Family-centered rounds will continue to be successful on a unit only if all nurses and other healthcare team members embrace a culture that recognizes families as true partners in providing care for patients.
- Families continue to emphasize the importance of the direct care nurse during FCRs, and nurses on the unit have an opportunity to role model leadership for their peers and nursing students.
- The nurse is able to bring the family's questions and concerns to the group and advocate for family involvement in daily and discharge planning.
- Nurses can play a key role in sustaining FCRs and moving family-centered care forward so that families are consistently involved in decision making.

Kara Nichols is Manager, General Medicine I, St. Louis Children's Hospital, St. Louis, MO.

Karen Crow is Former Coordinator Family Care Initiatives, St. Louis Children's Hospital, St. Louis, MO.

Karen Balakas is Research Manager, St. Louis Children's Hospital, St. Louis, MO. She can be reached via e-mail at KaBalakas@bjc.org

The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.

DOI:10.1097/NMC.0000000000000123

References

American Academy of Pediatrics. (2003). Family-centered care and the pediatrician's role. *Pediatrics, 112*(3 Pt 1), 691-697.

American Academy of Pediatrics. (2012). Patient- and family-centered care and the pediatrician's role. *Pediatrics, 129*(2), 394-404. doi:10.1542/peds.2011-3084

Aronson, P. L., Yau, J., Helfaer, M. A., & Morrison, W. (2009). Impact of family presence during pediatric intensive care unit rounds on the family and medical team. *Pediatrics, 124*(2), 119-125. doi: 10.152/peds.2009-0369

Cypress, B. S. (2012). Family presence on rounds: A systematic review of literature. *Dimensions of Critical Care Nursing, 31*(1), 53-64. doi:10.1097/DCC.0b013e31824246dd

Drago, M. J., Aronson, P. L., Madrigal, V., Yau, J., & Morrison, W. (2013). Are family characteristics associated with attendance at family centered rounds in the PICU? *Pediatric Critical Care Medicine, 14*(2), e93-e97. doi:10.1097/PCC.0b013e31827129cc

Henneman, E. A., Kleppel, R., & Hinchey, K.T. (2013). Development of a checklist for documenting team and collaborative behaviors during multidisciplinary bedside rounds. *The Journal of Nursing Administration, 43*(5), 280-285. doi:10.1097/NNA.0b013e31828eebfb

Kelly, M. M., Xie, A., Carayon, P., DuBenske, L. L., Ehlenbach, M. L., & Cox, E. D. (2013). Strategies for improving family engagement during family-centered rounds. *Journal of Hospital Medicine, 8*(4), 201-207. doi:10.1002/jhm.2022

Latta, L. C., Dick, R., Parry, C., & Tamura, G. S. (2008). Parental responses to involvement in rounds on a pediatric inpatient unit at a teaching hospital: A qualitative study. *Academic Medicine, 83*(3), 292-297.

Mittal, V. S., Sigrest, T., Ottolini, M. C., Rauch, D., Lin, H., Kit, B., ..., Flores, G. (2010). Family-centered rounds on pediatric wards: A PRIS network survey of US and Canadian hospitalists. *Pediatrics, 126*(1), 37-43. doi:10.1542/peds.2009-2364

Muething, S. E., Kotagal, U. R., Schoettker, P. J., Gonzalez del Rey, J., & DeWitt, T. G. (2007). Family-centered bedside rounds: A new approach to patient care and teaching. *Pediatrics, 119*(4), 829-832. doi:10.1542/peds.2006-2528

Rappaport, D. I., Ketterer, T. A., Nilforoshan, V., & Sharif, I. (2012). Family-centered rounds: Views of families, nurses, trainees, and attending physicians. *Clinical Pediatrics, 51*(3), 260-266. doi:10.1177/0009922811421002

Schleien, C., Brandwein, A., & Stasiuk, L. (2013). Do families play a role in deciding on their own involvement in family centered rounds? *Pediatric Critical Care Medicine, 14*(2), 235-236. doi:10.1097/PCC.0b013e31827451d8

Sisterhen, L. L., Blaszak, R. T., Woods, M. B., & Smith, C. E. (2007). Defining family-centered rounds. *Teaching and Learning in Medicine, 19*(3), 319-322. doi:10.1080/10401330701366812

Subramony, A., Schwartz, T. & Hametz, P. (2012). Family-centered rounds and communication about discharge between families and inpatient medical teams. Clinical *Pediatrics, 51*(8), 730-738. doi: 10.1177/0009922812446012

ONLINE

Applying Patient- and Family-Centered Concepts to Bedside Rounds
www.ipfcc.org/advance/topics/PH_RD_Applying_PFCC_Rounds_012009.pdf

Navigating Patient- and Family-Centered Care Rounds: A Guide to Achieving Success
www.ipfcc.org/advance/topics/navigating-pfcc-rounds.pdf

For more than 150 additional continuing nursing education activities on pediatric topics, go to nursingcenter.com/ce.

Instructions for Taking the CE Test Online
Beyond Implementation: Sustaining Family-Centered Rounds

- Read the article. The test for this CE activity can be taken online at www.nursingcenter.com/ce/MCN. Tests can no longer be mailed or faxed.
- You will need to create a free login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Williams & Wilkins online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Williams & Wilkins: 1-800-787-8985.

Registration Deadline: June 30, 2017

Disclosure Statement:

The authors and planners have disclosed that they have no financial relationships related to this article.

Provider Accreditation:

Lippincott Williams & Wilkins, publisher of *MCN, The American Journal of Maternal/Child Nursing,* will award 2.0 contact hours for this continuing nursing education activity.

Lippincott Williams & Wilkins is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.0 contact hours. Lippincott Williams & Wilkins is also an approved provider of continuing nursing education by the District of Columbia and Florida CE Broker #50-1223. Your certificate is valid in all states.

Payment:

- The registration fee for this test is $21.95.

CE For additional continuing nursing education activities on neonatal topics, go to nursingcenter.com/ce.