Practices and Provisions for Parents Sleeping Overnight with a Hospitalized Child

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Objective To describe practices affecting parents’ overnight stays, provisions for parents sleeping overnight and parents’ involvement in overnight care of their hospitalized child. Methods A cross-sectional telephone survey of Canadian and American hospitals with more or equal to 50 acute pediatric beds and more or equal to two pediatric wards was conducted. Results Surveys were completed by 135 hospitals (77% response rate). All general pediatric units allowed parents to sleep at the bedside overnight; higher acuity units limited parental stays. The majority of hospitals limited overnight visitors at the bedside to one parent, and few hospitals routinely allowed siblings to sleep overnight. One hundred and thirty-three (99%) hospitals reported parental involvement in their child’s care at night, with 52 (39%) stating this was an expectation. Conclusions In general, parents are given the opportunity to stay at the bedside overnight, but barriers exist that limit opportunities for sleep during their child’s hospitalization, and serve to separate families who have a hospitalized child.

Key words hospitalization; parents; sleep.

With the introduction of family-centered care, parents are encouraged to be at the bedside with their hospitalized child. The subsequent increase in parents’ overnight stays with their hospitalized child raises concerns about parents’ ability to achieve adequate and restful sleep. Given the effects of sleep loss on psychological health and emotional well-being, health care professionals, including pediatric psychologists, need to better understand how to prevent sleep loss for parents. Sleep restriction and fragmentation results in difficulty modulating emotions, decreases in cognitive function, and difficulties with decision-making (Bonnet, 2005; Dinges et al., 1997; Harrison & Horne, 2000; Stepanski, 2002); clearly, adequate sleep for parents is crucial to their psychological functioning and their ability to support their child and participate in and determine the course of their child’s care.

Little is known regarding variation in existing North American hospital practices related to overnight stays for parents or parental involvement in nighttime care of the hospitalized child. There may be great variation between and within hospitals, in terms of factors that influence whether parents are allowed to sleep overnight with their child. Regardless of the factors leading to parental stays at night, in order to facilitate parents’ overnight stays provision of physical and emotional support is needed; the range of what is available to families is largely unknown. Ultimately, it will be important to develop and evaluate interventions to maximize benefit of overnight stays for both parents and hospitalized children. First, it is important to establish the existence and prevalence of common practices related to supports for parents sleeping overnight with their child in hospital.

Parents staying for extended periods at the bedside of their hospitalized child, including at night, found that self-care was not easy during this major life transition and that the physical surroundings of the hospital, such as uncomfortable furniture, unavailable private rooms, and overcrowding in rooms did not promote comfort (Dudley & Carr, 2004). Changes in daily rhythm and lifestyle were also identified as challenging and included alterations in work schedules and daily routines. In particular,
parents noted that sleep was easily disrupted when staying overnight with their sick child. In addition to the physical and daily schedule disruptions, parents also described emotional upheaval including anxiety, shock, uncertainty, and loss of control when their child was hospitalized. Given the distress experienced by parents, they too require emotional support and can also be conceived of as patients who need support from the health care team, in order to continue to be with their sick child (Callery, 1997).

Research suggests which supports might be important to provide to parents staying overnight with their hospitalized child. Findings from the Press Ganey Pediatric Inpatient National database suggested priorities for improving pediatric care according to the parent’s perspective (Miceli & Clark, 2005). Identified priorities included improving accommodations and comfort for visiting family members, and improving staff concern related to achievement of rest for the hospitalized child. Recommended strategies included ensuring parents could stay with their child in hospital, altering the physical environment to encourage sleep, and timing interventions during the night to maximize rest opportunities. Other strategies to meet identified priorities could be delivered by pediatric psychologists, including assessments of parent and child sleep disturbance and implementation of strategies to improve sleep such as relaxation techniques.

Finally, it is unknown to what extent hospitals involve parents in provision of care, especially during the night. Given evidence that parents participate in their child’s care in hospital due to feelings of responsibility for their child’s care, a perceived lack of support from staff, and sensitivity to overworked staff (Ygge & Arnetz, 2004), the potential physical and emotional burden of parental involvement in nighttime care merits examination by psychologists working with families in the hospital setting.

Information on North American pediatric hospital practices and provisions for parents sleeping overnight with their child and the supports given to them are major gaps in the literature. In order to develop and evaluate interventions to maximize benefit of parental overnight stays for both parents and hospitalized children, we must first establish the existence and prevalence of common practices and supports for parents sleeping overnight with their child. Potential future interventions include staff education regarding the importance of sleep for families and links between adequate sleep and psychological health, changes to patient–caregiver interactions, decreased sound and light in the physical environment, provision of materials to increase comfort and mask hospital noises, delineation of parents’ care responsibilities and promotion of cognitive-behavioral strategies to promote sleep for families. Therefore, the objective of this study was to survey North American pediatric hospitals to determine the nature of practices and support for parents sleeping overnight, and expectations of their involvement in overnight care of the hospitalized child.

**Methods**

A descriptive, cross-sectional design with telephone survey methods was used. A database of potentially eligible hospitals created and previously used by one of the investigators (Vandenberg, Hutchison, & Parshuram, 2007), provided contact information for North American acute care pediatric hospitals. This initial database was created by searching the American Hospital Directory (AHD, Inc) to identify freestanding pediatric hospitals and general hospitals with more than 450 acute care beds, searching the Internet for hospitals by province or state, and local knowledge of respondents in surveyed hospitals. From the initial database, a list of 265 Canadian and American hospitals offering pediatric services was available to use for the current telephone survey; 181 of these hospitals were identified as eligible in the initial study (Vandenberg, Hutchison, & Parshuram, 2007), the remaining hospitals were not able to be contacted in the initial study. Eligibility for all hospitals was reconfirmed at study entry.

Eligible participants were senior hospital administrative staff members who identified themselves as knowledgeable of the practices, policies, and provisions of the hospital, particularly regarding parents’ overnight stay with their hospitalized child. Included pediatric hospitals had more or equal to 50 acute care inpatient beds for patients aged ≤18 years of age and more or equal two pediatric wards (including neonatal units). Hospitals with only pediatric long-term care, psychiatric or rehabilitation beds were excluded, since those hospitalizations often involve extended stays, and practices around parental overnight stays are likely different from those units providing acute care.

The questionnaire was developed by two investigators (Wong and Stremler) based on a review of the literature and previous clinical experience and consisted of 37 questions. Design strategies used in developing the telephone survey included formatting, wording, and ordering of questions to facilitate the flow and efficiency
of completing and recording the survey (Dillman, 1978). Questions were asked to determine practices and provisions for parents staying overnight with their hospitalized child, including which units were amenable to overnight stays, limitations on who could sleep overnight, what was provided for parents (e.g., sleep surfaces, meals, and shower facilities), and what were the expectations and extent of parents’ participation in nighttime care (Table I). The survey was pretested and reviewed for content and face validity with three health care professionals familiar with providing care in hospital at night.

If the initial person contacted for participation was not eligible to complete the survey, or did not feel he or she was the most informed person to complete the survey, he or she was asked to provide contact information for a more appropriate respondent. If the staff member contacted did not wish to complete the telephone survey at that time, an appointment was made to call the participant back at a more convenient time. Three attempts were made to make contact and complete the survey. A record was kept for every call, in order to track all attempted contacts. Information about the background and purpose of the study, participant eligibility, study procedures, voluntary participation and early withdrawal, risks and benefits, privacy and confidentiality, and nonidentifying presentations of findings were discussed with the respondent. Opportunity was given for the potential participant to ask questions about the study and consent was implied when the participant agreed to take the survey. Questions were asked at the beginning of the phone call to ensure that the hospital was eligible.

Ethics approval was obtained from the University of Toronto. Data forms were coded with unique identification numbers and enrollment forms with identifying information were stored separately from the data forms, each in secure locations. Data were entered into Microsoft Access 2002 (Microsoft Corporation, Redmond, WA, USA) using double-data entry and analyzed with descriptive statistics using SAS Version 9.1 (SAS Institute Inc., Cary, NC, USA) statistical software. Chi-squared tests were used to determine if differences existed between hospitals with different country, funding, or patient-population characteristics.

Results

Telephone surveys were conducted from July to September, 2006. Of the 176 eligible hospitals contacted with an eligible participant identified, 135 completed the survey giving a response rate of 77% (Table II). Of the 135 respondents, 105 (79%) were senior staff such as unit managers, nursing directors, clinical nurse specialists, or nurse educators, 23 (17%) were registered nurses, social workers, or patient representatives, and 6 (4%) were unit clerks or secretaries.

The median number of beds in the surveyed hospitals was 107 [interquartile range (IQR) 74–155] and the median number of units was 4 (IQR 3–6). Hospitals surveyed included 65 (48%) free-standing pediatric hospitals and 70 (52%) adult hospitals with pediatric units. Fifteen (11%) hospitals were Canadian and 120 (89%) were American; funding was private for 50 (37%) hospitals and public for 85 (63%) hospitals. No statistically significant differences between Canadian and American or private and publicly funded hospitals were found on any of the survey responses.
Factors Affecting Parents’ Overnight Stay

Hospitals allowing one, two, and three or more family members to sleep overnight at the bedside and elsewhere in the hospital (e.g., lounge, waiting room) are displayed in Table III. One-hundred and seventeen (87%) hospitals had access to no cost accommodations for parents; these may have been in the hospital in a shared or private parent sleeping room, or outside the hospital in a Ronald MacDonald House or other residence. One hundred and twenty-five (93%) hospitals had reduced cost accommodation for parents, either within or outside the hospital. Unfortunately, demand for both free and low-cost accommodations usually outweighed supply, so that if available, use of was typically short-term, with availability not guaranteed over the hospital stay.

Types of units allowing parents to sleep overnight at the bedside are shown in Table IV. Adult hospitals with pediatric units were more likely than free-standing pediatric hospitals to allow parents to sleep in the PICU overnight (77% vs. 53%, \( \chi^2 = 8.62, p \leq .01 \)); there were no other differences between adult and free-standing hospitals.

Limitations on ability to stay overnight at the child’s bedside based on relationship to the child are presented in Table V. Further limits on sleep at the bedside included the acuity of the child’s condition in 26 hospitals (19%). In 18 (69%) of these 26 hospitals, parents were not allowed to stay if the child’s condition was deemed too unstable, and in 4 (15%) hospitals parents could not stay if the child’s condition worsened as this was likely to result in crowding due to extra equipment in the room. In 5 (19%) of the 26 hospitals, more people than usually were allowed to sleep by the bedside if the child’s condition was deteriorating.

Another limit on bedside stays was the number of beds in the room; 24 hospitals (18%) responded that as the number of patient beds in a room increased, fewer parents were allowed to sleep overnight. Seventy-eight hospitals (58%) did not allow parents to bed-share with their child; reasons given for this restriction included concerns related to the acuity of the child, interference with provision of care, and increased risk of sudden infant death syndrome due to bed-sharing.

Provisions and Supports Available for Parents

Provisions and supports available for parents staying overnight with their hospitalized child are represented in Table VI. Few hospitals routinely provided free meals for parents (19, 14%); some (52, 39%) hospitals provided free meals to parents under certain circumstances such as demonstrated financial need, or to breastfeeding mothers.

Parents’ Involvement in Overnight Care

Parental involvement in overnight care, hospital expectations of parental involvement, and hospital understandings of parents as co-patients (i.e., parents are also patients who require care from the health care team in addition to the hospitalized child) are found in Table VII.

Discussion

This survey is the first to provide a cross-sectional description of practices related to parents’ overnight stays, provisions for parents sleeping overnight, and parents’ involvement in overnight care of their hospitalized child in medium and large-sized pediatric hospitals in Canada and the United States. Significant factors affecting parents’ ability to sleep overnight with their hospitalized child were the type of unit and the acuity of the child’s condition, where increased acuity meant more
limits on parents’ overnight stay. Paradoxically, parents of children in higher acuity units or with increased severity of illness may be very anxious and especially want to be with their child overnight. Future exploration of potential benefits of parental overnight stays, such as decreased stress and anxiety for both hospitalized children and their parents, is needed in light of the common occurrence of restrictions on such stays, and may provide justification for alterations to current standards. Given the common experience of restrictions on parental overnight stays, it is important for pediatric psychologists to explore where and how well family members are sleeping at night and to investigate if sleep disruption may be a contributing factor to excessive family stress or difficulty coping with the child’s hospitalization.

Further restrictions on the number of visitors, sibling and friend visitation creates an environment that separates families who have a hospitalized child. Restrictions on overnight stays may result in partners who must separate at nighttime and parents with other children who are forced to choose between staying with children at home or the hospitalized child. Given that 99% of hospitals surveyed held a family-centered care philosophy, practices that serve to separate families and that most often allow only one family member, usually a parent, to sleep with the child overnight, seem incongruous and may contribute to stress, anxiety and depression in families with an ill child.

Most respondents (99%) noted that parents took part in the care of their child at night, and in fact, 39% of hospitals expected this parental contribution to care. If parents are expected to care for their child at night, this may be viewed as a means of distributing staff workload and merits further exploration along with determination of health care professionals’ views of provision of care at night and relationships with parents who stay. Establishment of standards of practice related to parental contributions toward care, including at night, are recommended (Berman, 1991; Ygge & Arnetz, 2004).

Most hospitals surveyed provided amenities for self-care; future research should examine parents’ perceptions of whether their self-care needs are being met in the hospital environment. Surprisingly, most hospitals responded that they provided aids for better sleep. Understanding of the impact of noise, light, and interruptions due to care on sleep for hospitalized children and evidence of sleep disruption for family members of hospitalized patients suggests use of strategies to improve sleep is limited (Al-Samsam & Cullen, 2005; Cureton-Lane & Fontaine, 1997; Halm et al., 1993). In future, families’ experiences of sleep in hospital should be elicited to determine if interventions could be developed to improve sleep in hospital. For example, if worry is a significant contributor to insomnia, pediatric psychologists could offer cognitive-behavioral strategies to parents and children to promote transition to sleep.

Traditionally, telephone surveys with health care professionals have low response rates; the high response rate (77%) for this survey is a strength and indicates significant respondent interest in the area of inquiry. There are several limitations to this survey. The survey was administered to voluntary respondents over the telephone; respondents did not have time to confirm the data they provided, and the investigators did not confirm the accuracy of their responses. Furthermore, potential for social desirability bias in responses merits confirmation of experiences from children and parents. However, since the large majority of informants were senior clinical administrators, primarily with nursing backgrounds, we believe that the information is likely to be representative of each institution. This cross-sectional survey provides an overall snapshot of practices in North American hospitals but cannot determine specific cases; individual and unit interpretation of practices and provisions related to parents’ overnight stays may vary. The findings also may not be generalizable to other types of hospitals or to hospitals in other geographic locations.

Restrictions on overnight stays create an environment that separates families who have a hospitalized child; this systematic disruption of usual family supports and

### Table VI. Provisions and Supports Available for Parents (n and %)

<table>
<thead>
<tr>
<th>Provisions and supports</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surface intended for sleeping in child’s room</td>
<td>134</td>
<td>(99%)</td>
</tr>
<tr>
<td>Surface intended for sleeping in waiting room</td>
<td>44</td>
<td>(33%)</td>
</tr>
<tr>
<td>Aids for better sleep (e.g. music, reduced light)</td>
<td>133</td>
<td>(99%)</td>
</tr>
<tr>
<td>Showering facilities</td>
<td>131</td>
<td>(97%)</td>
</tr>
<tr>
<td>Towels, bed linen, pillow</td>
<td>133</td>
<td>(99%)</td>
</tr>
<tr>
<td>Toiletries</td>
<td>104</td>
<td>(77%)</td>
</tr>
<tr>
<td>Laundry facilities</td>
<td>80</td>
<td>(59%)</td>
</tr>
<tr>
<td>Computer access</td>
<td>112</td>
<td>(83%)</td>
</tr>
<tr>
<td>Some food/beverages</td>
<td>90</td>
<td>(67%)</td>
</tr>
</tbody>
</table>

### Table VII. Parents’ Involvement in Overnight Care (n and %)

| Parents involved in child’s care during the night | 133 | (99%) |
| Staff expect parents to provide care at night    | 52  | (39%) |
| Parents considered co-patients                   |     |       |
| Formally                                          | 48  | (36%) |
| Informally                                        | 69  | (51%) |

Most hospitals expected this parental contribution to care.
routine may contribute to psychological distress. In future, parents’ experiences of sleeping in hospital with their child, and children’s and parents’ views on barriers and facilitators of sleep in hospital should be explored. As we learn more about families’ experiences sleeping overnight with a hospitalized child, we will be better able to design environments that support sleep for all family members and psychosocial interventions to assist families to achieve adequate sleep.

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References


