**Original Article**

# Children's and Parents' Experiences from The Provided Emergency Care in a Pediatric Hospital: A Scoping Review

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**Abstract**

**Background:** Paediatric emergency departments are critical points of access for children and families during urgent, stressful and uncertain health events. The quality of emergency care is influenced not only by clinical outcomes, but also by how children, adolescents and parents experience communication, waiting, privacy, pain management, emotional support and involvement in care.

**Objective:** This scoping review aimed to map the available evidence on children's, adolescents' and parents' experiences of care provided in paediatric emergency settings and to identify the main factors influencing these experiences.

**Methodology:** A scoping review was conducted and reported according to PRISMA-ScR guidance. PubMed and Scopus were searched for peer-reviewed original research articles published in English from January 2010 to December 2025. Eligible studies included children or adolescents aged 0–18 years and/or their parents or caregivers and reported experiences, satisfaction, perceptions or needs related to paediatric emergency care. Data were extracted using a structured form and synthesised narratively because of heterogeneity in study designs, populations, tools and outcomes.

**Results:** Forty studies were included: 27 cross-sectional studies, nine qualitative studies and four mixed-method studies. Overall satisfaction was often high; however, recurrent gaps were identified in waiting time, information provision, privacy, age-appropriate communication, child participation, pain management, emotional support and discharge preparedness. Communication was the most consistent determinant of positive experience. Several studies showed differences between children's and parents' reports, highlighting the need to collect children's views directly. Vulnerable groups, including children with neurodevelopmental disorders, medical complexity, language barriers or mental health concerns, reported additional challenges.

**Conclusions:** Children's and parents' experiences of paediatric emergency care are multidimensional. Quality improvement should combine child-reported measures, caregiver feedback and process indicators to support timely, compassionate, developmentally appropriate and family-centred emergency care.

**Keywords:** children, emergency department, patient experience, satisfaction, quality improvement

## Introduction

Emergency departments (EDs) provide substantial opportunities for accessing health care outside the schedule, most frequently during periods when the child or family feels an emergency or experiences symptoms of pain, discomfort, anxiety, or confusion. The decision of parents to access emergency services is driven by several factors, including parents' perception of the urgency of the illness, parents' desire for reassurance, time considerations, lack of an appointment with a regular provider, geographical issues, and prior relationship with healthcare professionals (Nicholson et al., 2020).

As opposed to the notion of the quality of pediatric emergency care being solely related to the provision of clinically effective care and adherence to protocols, there is also the issue of patient experience of the care provided, which is defined by both relational and functional factors. Relational aspects include respect, comfort, communication, information sharing, and collaboration. Functional aspects include assessment, treatment, safety, coordination, and continuity (Janerka, Leslie & Gill, 2024).

In pediatric settings, care experience is closely related to the principles of patient- and family-centered care. In pediatrics we usually access health care services through parents or other guardians. However, children are also active participants in care and their views should be considered directly. Evidence suggests that children's and parents' assessments of ED care may be similar overall, but children may report lower levels of participation in care and fewer opportunities for private discussions with healthcare staff (Janhunen, Kankkunen & Kvist, 2019). This suggests that reliance on proxy reporting from parents may not sufficiently account for children's feelings, needs, or preferences. Patient-reported experience measures (PREMs) have been widely implemented in pediatrics to measure the perceptions of patients and families regarding the quality of care and to ensure the patient- and family-centred nature of services (Bele et al., 2021).

Existing evidence identifies several factors that shape children's and parents' experiences in pediatric EDs and the quality of the care provided. Triage becomes significant due to its likely status as the patient's first interaction and impact on their overall experience. Waiting times, information provided, the beginning of the assessment process and treatment procedures, and interactions with triage personnel become major factors in determining the experience of the patient in an ED (Janerka, Leslie & Gill, 2024). In addition, thorough examination, the organization of triage, qualified personnel, appropriate equipment, and aftercare instructions become essential components of quality care in the pediatric population as stated by parents and carers (Lacey, West & Craig, 2021).

Moreover, environmental issues also play a role in shaping the experience as noise, lack of privacy, overstimulation, and poor levels of comfort can cause distress, while appropriate designs, positive distractions, social support, and comfortable places suitable for children can enhance experience (Gripko, Joseph & MohammadiGorji, 2023). For children with intellectual and/or developmental disorders, an additional challenge lies in communication problems, sensory sensitivities, and behavioral difficulties during visits to the ED, and parents highlight communication issues, environment adjustment, and orientation aids (Elliott et al., 2024).

Therefore, the aim of this scoping review is to describe the experiences of pediatric patients and their parents regarding care provided in the ED and to determine the main factors that influence these experiences.

## Methods

**Design:** This scoping review was designed and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews, PRISMA-ScR (Tricco et al., 2018). A scoping review is appropriate for this topic because the available literature is broad and heterogeneous, including studies on quality of care, satisfaction, PREMs, triage, waiting, communication, physical environment, pain, family-centered care, and specific pediatric populations. The purpose is not to estimate a single intervention effect, but to map the extent and nature of existing evidence, clarify the main concepts, identify the factors influencing children's and parents'

experiences, and highlight gaps in knowledge. This approach is consistent with the use of scoping review methodology in pediatric ED research, particularly where the aim is to identify, map, and describe evidence across a complex and diverse field using a Population–Concept–Context approach (Kammerer et al., 2024).

**Search protocol and information sources:** A structured literature search was performed in PubMed and Scopus. The search covered articles published from January 2010 to December 2025. The search strategy was developed using keywords related to the population, context, and concept of the review. The keywords used were: "children", "emergency department", "patient experience", "satisfaction", and "quality improvement".

The following indicative search strategy was applied and adapted according to the requirements of each database: (children OR child OR adolescent OR paediatric OR pediatric) AND (emergency department OR emergency care OR paediatric emergency department OR pediatric emergency department) AND (patient experience OR parent experience OR parental experience OR satisfaction OR quality of care OR quality improvement). Reference lists of eligible articles were also screened to identify additional relevant studies. Figure 1 illustrates the search strategy via a flowchart.

**Inclusion and exclusion criteria:** Original research articles published in peer-reviewed journals were included if they were quantitative, qualitative, or mixed-methods studies; were published in English; involved children or adolescents aged 0–18 years and/or their parents or caregivers; and described children's, adolescents', parents', or caregivers' experiences, satisfaction, perceptions, or needs in relation to care received in a pediatric ED.

Studies were excluded if they were reviews, scoping reviews, systematic reviews, protocols, editorials, comments, letters, opinion papers, or conference abstracts; were published in languages other than English; focused on adult populations; were conducted outside the ED setting; or did not report children's, adolescents', parents', or caregivers' experiences of emergency care. Studies focusing only on healthcare professionals' perspectives were also excluded unless they included findings directly related to children's or parents' experiences. In Table 1 are presented the specific inclusion and exclusion criteria.

**Study selection:** All retrieved records were screened independently by two reviewers. First, titles and abstracts were assessed according to the eligibility criteria. Articles considered potentially relevant were then retrieved and assessed in full text. Disagreements between reviewers were resolved through discussion and consensus. The study selection process was documented according to PRISMA-ScR recommendations (Tricco et al., 2018).

**Critical appraisal of the studies:** The methodological quality of the included studies was appraised using the Critical Appraisal Skills Programme (CASP) checklists (https://casp-uk.net/casp-tools-checklists).

The appropriate CASP tool was selected according to each study design, with qualitative studies assessed using the CASP Qualitative Studies Checklist and quantitative observational studies assessed using the CASP checklist for cross-sectional studies. For mixed-methods studies, the relevant CASP criteria were applied to both qualitative and quantitative components where applicable. The appraisal focused on the clarity of study aims, appropriateness of methodology, sampling, data collection, consideration of bias and ethical issues, rigour of analysis, clarity of findings, and relevance of the results to the review question. The CASP appraisal was used to support transparent interpretation of the evidence rather than to exclude studies from the scoping review. In Table 2 is presented the critical assessment of the selected studies using CASP checklists.

**Data extraction:** Data extraction was performed after full-text analysis of the included studies. A structured data extraction form was used to collect the following information: author and year of publication, country, study design, study duration, sample and sampling method, aim of the study, data collection tools, experience indicators, main findings, interventions where applicable, and main conclusions. Data extraction was independently checked by two reviewers, and any disagreements were resolved by consensus.

**Data synthesis:** Due to the expected heterogeneity of study designs, populations, tools, and reported outcomes, findings were synthesized narratively. The included studies were grouped according to study design and main experience-related themes. The synthesis focused on identifying the main factors influencing children's and parents' experiences of pediatric emergency care, including communication, waiting time, information provision, participation in care, privacy, pain management, emotional support, staff attitudes, physical environment, safety, and discharge or follow-up planning.

## Results

### Characteristics of the included studies

Forty study records were charted. The evidence was mainly quantitative, with 27 cross-sectional studies, followed by nine qualitative studies and four mixed-method studies. The publication years ranged from 2011 to 2025, with a clear increase in publications from 2020 onward. The studies were conducted in diverse international settings, including Canada, the United States of America, Australia, Spain, Sweden, Finland, the United Kingdom, Germany, Korea, China, Tanzania, Malta, France and Turkey. Most studies focused on paediatric emergency department encounters, whereas a smaller number addressed broader paediatric hospital experience measures or the development and validation of instruments relevant to assessing children's and families' care experiences.

The participants included parents, caregivers, children, adolescents, paediatric patients, nurses and physicians. Several studies collected paired child-parent data, which enabled direct comparison between children's and parents' views of the same care context. Sample sizes varied widely, from small qualitative interview samples of fewer than 20 participants to large cross-sectional surveys involving several thousand caregivers, patients or patient visits. Across the studies, the main outcomes were satisfaction, perceived quality of care, communication, privacy, waiting time, family involvement, emotional support, safety, pain management, and unmet informational or practical needs. The analytic characteristics of the included studies are presented in Table 3.

### Overall experiences and satisfaction with care

Overall, the studies showed that children, adolescents and parents often reported positive experiences of paediatric emergency or hospital care. High satisfaction was commonly associated with professional and empathetic staff, clear communication, respectful treatment, and confidence that the child was receiving appropriate care. Positive ratings were reported in studies examining parental satisfaction, adolescent satisfaction, child-parent evaluations of care quality, and national surveys of children's ED experiences (Weissenstein et al. 2011; Shefrin, Milner & Goldman 2012; Parra et al, 2028; Janhunen, Kankkunen & Kvist 2019; Parra et al. 2020; Ma et al. 2024).

However, high overall satisfaction did not mean that all aspects of care were experienced as optimal. Several studies identified specific areas requiring improvement, including long waiting times, insufficient explanations, limited privacy, lack of age-appropriate information, inadequate distraction during waiting, and incomplete involvement of children in decisions about their care. In caregiver-focused studies, unmet needs were most often related to prompt medical attention, practical support, pain control and communication about the child's condition and care plan (Parra et al. 2017; Bal et al. 2020; Ali et al. 2025).

### Communication, information and family partnership

Communication was the most consistent factor associated with positive or negative care experiences. Parents and caregivers valued understandable explanations, timely updates, opportunities to ask questions, and clinicians who listened and responded respectfully. In one study, structured communication practices and post-discharge telephone contact improved caregiver satisfaction and strengthened perceptions of professionalism and empathy in the paediatric ED (Locke et al. 2011). Qualitative studies also showed that families valued compassionate communication, emotional support, respect, and partnership in care decisions (Byczkowski et al. 2016; Barbarian et al. 2021; Peeler et al. 2019).

Communication needs were particularly evident among parents of children with medical complexity. These parents often described themselves as key coordinators of care and reported difficulties when ED staff did not recognise their expertise, when essential clinical information was not transferred efficiently, or when treatment plans were not explained clearly. Studies involving parents and clinicians identified treatment time, data exchange, and communication as recurring challenges in emergency care for children with complex medical needs (Pulcini et al. 2021; Lysak et al. 2024; Ciurria et al. 2025).

**Waiting time, environment and care processes**

Waiting time and the ED environment were repeatedly identified as important elements of experience. Adolescents' satisfaction decreased when waiting time exceeded two hours, while children reported problems related to waiting, lack of entertainment, discomfort, privacy, and insufficient information during the visit (Shefrin, Milner & Goldman 2012; Parra et al. 2017; Parra et al. 2020). Parents' perceptions of waiting time were influenced not only by the length of the wait but also by how well triage decisions and expected delays were explained. In one Australian study, caregivers of semi-urgent patients were less likely to view waiting times as appropriate compared with caregivers in other triage categories (Fitzpatrick et al. 2014).

Several studies highlighted the importance of care process indicators in addition to global satisfaction measures. These indicators included time to triage, documentation, safety-netting practices, procedures performed, triage level, care pathway, and length of ED stay. Length of stay alone did not predict satisfaction, but process factors such as triage level, number of procedures and paediatrician care track were associated with child-parent evaluations of care quality (Janhunen, Kankkunen & Kvist 2021). Quality indicator work also identified incomplete documentation and the need for locally relevant indicators that support continuous improvement in paediatric emergency care (Borg et al. 2021).

**Children's and adolescents' perspectives**

A major finding was that children's and adolescents' experiences should be assessed directly and not inferred solely from parent or caregiver reports. Studies comparing child and parent responses found differences in perceptions of communication, privacy, involvement and waiting. Children often reported more problems than parents, particularly regarding privacy during examinations, the opportunity to speak privately with clinicians, pain management, and whether explanations were clear and age-appropriate (Parra et al. 2017; Janhunen, Kankkunen & Kvist 2019; Bal et al. 2020).

Adolescents valued being seen quickly, receiving clear explanations, being treated in a clean and comfortable environment, and having respectful communication with staff. For young people attending emergency departments after self-harm or with mental health concerns, satisfaction was linked to confidentiality, respect, emotional safety, perceived help received and whether the encounter addressed their actual needs (Bryans et al. 2018; Keating et al. 2023; Lategan et al. 2023). These findings indicate that child- and adolescent-centred assessment tools are necessary to identify areas of care that may not be visible through caregiver-reported measures alone.

**Equity, vulnerability and specialised needs**

The charted studies also demonstrated that experiences of care differed across populations with specific communication, developmental or social needs. Families with limited local language proficiency or unfamiliarity with the healthcare system experienced uncertainty and stress, while access to in-person interpretation improved understanding and emotional comfort (Ellbrant et al. 2018; Zamor et al. 2022). Caregivers of children with neurodevelopmental disorders reported lower satisfaction than caregivers of children without such disorders, mainly due to prolonged waiting, communication difficulties and sensory challenges in the ED environment (Heyming et al. 2023).

Targeted adaptations were reported as beneficial for children with specialised needs. A sensory kit designed for children with

autism spectrum disorder was well received and was associated with reduced distress and improved experience in the ED (Litwin & Sellen 2023). Studies of children with medical complexity showed that repeated emergency visits, repeated painful procedures, poor information transfer and insufficient acknowledgement of parent expertise contributed to challenging experiences for families (Pulcini et al. 2021; Lysak et al. 2024; Ciurria et al. 2025).

**Experience measures and quality indicators**

The included studies used a wide range of instruments and indicators to assess experience and quality of care. These included structured satisfaction questionnaires, Press Ganey surveys, Picker Patient Experience Questionnaire adaptations, Child Hospital Consumer Assessment of Healthcare Providers and Systems, Consumer Emergency Care Satisfaction Scale adaptations, patient-reported experience measures, service satisfaction scales, and locally developed quality indicators. Several studies focused on developing, validating, translating or adapting instruments for paediatric, adolescent, parent or caregiver populations (Byczkowski et al. 2013; Toomey et al. 2015; Wennick et al. 2021; Hu et al. 2021; Buclin et al. 2024).

Across these measures, the recurring quality domains were communication, respect, emotional support, family involvement, privacy, perceived safety, pain management, waiting environment, involvement in decisions, discharge information and preparedness for care after discharge. The evidence therefore indicates that care experience is multidimensional and cannot be adequately captured by a single global satisfaction score. Direct child-reported measures, caregiver-reported measures and process indicators are all required to identify gaps in paediatric emergency care and to guide patient- and family-centred quality improvement.

**Figure 1. Search Flow diagram**

**Identification of studies via databases (PubMed & Scopus)**

| | | |
|---|---|---|
| **Identification** | **Articles identified*:**<br>Databases: PubMed and Scopus (n = 3528 articles) | **Articles removed before screening:**<br>Duplicate records removed (n = 743)<br>Records removed for other reasons (n = 46) |
| ↓ | | |
| **Screening** | **Articles screened by title**<br>(n = 2739)<br>**Articles screened by abstract**<br>(n=1788) | **Records excluded by title**<br>(n = 851)<br>**Records excluded by abstract**<br>(n = 1441) |
| ↓ | | |
| **Retrieval** | **Articles selected for retrieval**<br>(n =347) | **Articles not retrieved**<br>(n = 5) |
| ↓ | | |
| **Eligibility** | **Articles assessed for eligibility**<br>(n = 342) | **Articles excluded after full text review:**<br>Population, non-ED setting, or no child/parent emergency-care experience outcome, or no outcome related to the scope of the review<br>(n = 302) |
| **Included** | **Studies included in the scoping review**<br>(n = 40) | Final number of articles that were included after title, abstract, and full-text review and met the stated inclusion/exclusion criteria. |

*Exclusion/Inclusion criteria were assessed during the initial search.

**Table 1. Inclusion and exclusion criteria**

| Characteristics | Inclusion criteria | Exclusion criteria |
|---|---|---|
| Study design | Original research<br>Quantitative, Qualitative or Mixed study design | Reviews and overviews<br>Opinion pieces (i.e., comments, editorials, letters) |
| Publication date | Articles published from January 2010 to present | Articles published prior January 2010 |
| Language | Articles published in English | Articles published in any language other than English |
| Population | Paediatric patients (Infants, children or adolescents aged 0 to 18 years)<br>Parents of paediatric patients | Populations other than infants, children or youth aged 0 to 18 years or other than parents of infants, children or youth aged 0 to 18 years |
| Procedures | Children or adolescents receiving care in paediatric ED settings | Receiving care less common to the emergency medicine setting (e.g., vaccinations, outpatient clinics visit etc) |
| Outcomes | Articles describing children or parental experiences in relevance to the care received in the ED setting | N/A |

## Table 2. Critical assessment of the selected studies using CASP checklists

### Cross-sectional studies

| No | Source and design | CASP checklist applied | Methodological strengths | Main limitations / unknowns | Applicability and value for this review | Overall CASP summary judgement |
|---|---|---|---|---|---|---|
| 1 | Weissenstein A. et al., 2011 Cross-sectional study; Germany; 67 parents | CASP descriptive/cross-sectional | Clear satisfaction-focused aim; parent-reported questionnaire captured communication, waiting time and environment. | Small single-setting sample | Useful for communication and waiting-time domains, but applicability to paediatric ED care is limited if the setting was primarily paediatric practice. | Moderate |
| 2 | Locke R. et al., 2011 Cross-sectional/pre-post quality-improvement survey; USA; 456 parents | CASP descriptive/cross-sectional | Clear focus on structured communication; Press Ganey survey and a defined communication intervention with post-discharge call. | Non-randomised before/after design; temporal effects and other service changes may confound results | Highly relevant to ED communication improvement, but causal inference should be cautious. | High |
| 3 | Shefrin A.E. et al., 2012 Cross-sectional survey; Canada; 282 adolescents | CASP descriptive/cross-sectional | Direct adolescent reporting; clear focus on satisfaction and waiting time; structured 33-item survey. | Sampling frame, response rate, psychometric detail and adjustment for confounders not shown; cross-sectional design cannot establish causation. | Relevant for adolescent-centred ED care, privacy and waiting-area planning. | Moderate |
| 4 | Fitzpatrick N. et al., 2014 Cross-sectional survey; Australia; 133 parents | CASP descriptive/cross-sectional | Parent perceptions were assessed across care, triage and waiting-time domains; directly relevant to ED flow. | modest sample; questionnaire validation, recruitment and missing-data handling not stated. | Useful for triage communication and expectation-setting, especially for semi-urgent patients. | Moderate |
| 5 | Jang H.Y. et al., 2015 Cross-sectional study; Korea; 1000 parents | CASP descriptive/cross-sectional | Large national parent sample; identifies staff professionalism, explanations and child-friendly environment as key drivers. | Self-report satisfaction | Relevant to parent satisfaction and staff communication across paediatric EDs. | High |
| 6 | Parra C. et al., 2017 Cross-sectional study; Spain; 257 children aged 8-17 | CASP descriptive/cross-sectional | Direct child and parent comparison; modified Picker Patient Experience Questionnaire; identifies child-specific problems. | Likely single-centre; adaptation/validation detail and sampling strategy not fully stated; self-report recall/response bias possible. | Strong relevance for collecting children's own ED experience rather than relying on proxy reports. | High |
| 7 | Bryans A. et al., 2018 Cross-sectional study; UK; 254 adolescents aged 12-16 | CASP descriptive/cross-sectional | Direct adolescent perspective; clear focus on priorities such as promptness, cleanliness, comfort and explanations. | Tool validation, representativeness and non-response not stated; preference data may not reflect actual care outcomes. | Relevant for adolescent- friendly ED service design. | Moderate |
| 8 | Ellbrant J. et al., 2018 Cross-sectional study; Sweden; 962 patient visits | CASP descriptive/cross-sectional | Large visit-level dataset; addresses language, social characteristics, triage and ED-use equity. | Measurement of appropriateness and self-reported language/social factors may be prone to bias | Important for equity, interpreter access and access-pathway planning. | High |
| 9 | Kemp K.A. et al., 2018 Cross-sectional study; Canada; 3389 parents/guardians | CASP descriptive/cross-sectional | Large sample and standardized Child HCAHPS measure; benchmarking potential across hospitals. | Primarily inpatient/family experience rather than ED-specific evidence | Useful for standardized paediatric experience measurement, with indirect applicability to ED domains. | Moderate |
| 10 | Parra C. et al., 2018 Cross-sectional study; Spain; 50 parents | CASP descriptive/cross-sectional | Addresses a specific high-acuity setting: parent presence in the resuscitation room; clear patient/family-centred outcome. | Small sample; no comparator; questionnaire validation, recruitment and response rate not stated. | Useful for resuscitation-room accompaniment and information policies, but transferability is limited. | High |
| 11 | Janhunen K. et al., 2019 Cross-sectional study; Finland; 98 child-parent pairs | CASP descriptive/cross-sectional | Direct child-parent paired reporting; adapted humane caring scale; highlights participation and private communication gaps. | Small convenience sample | Highly relevant to child participation, privacy and direct child PREM use. | High |
| 12 | Bal C. et al., 2020 Cross-sectional study; Canada; 237 parents and 109 children | CASP descriptive/cross-sectional | Uses a paediatric urgent/emergency PREM and compares child-parent experience discrepancies. | Recruitment strategy, response rate and psychometric performance not fully stated | Useful for routine child-reported experience measurement in ED settings. | High |
| 13 | Parra C. et al., 2020 Cross-sectional study; Spain; 170 children aged 8-17 | CASP descriptive/cross-sectional | Direct child experience survey; adapted Picker instrument; focuses on waiting, privacy and age-appropriate information. | Single-centre and self-reported | Relevant for child-centred quality improvement in paediatric EDs. | Moderate |
| 14 | Janhunen K., Kankkunen P. & Kvist T., 2021 Cross-sectional survey Finland; 89 child-parent pairs | CASP descriptive/cross-sectional | Combines survey and register/process data; links triage, procedures and care track with satisfaction. | Small convenience sample; observational associations cannot establish causality; potential unmeasured confounding. | Useful for pairing process indicators with experience outcomes. | High |
| 15 | Borg et al., 2021 Cross-sectional survey/quality-indicator review; Malta; 1834 paediatric ED cases | CASP descriptive/cross-sectional | Large case review and local quality indicators; identifies documentation, triage timing and safety-netting gaps. | Patient experience component appears limited; indicator validity/reliability and feedback-form response details are not fully described. | Valuable for local quality -monitoring infrastructure and process indicators. | Moderate |
| 16 | Wennick A. et al., 2021 Cross-sectional psychometric study; Sweden; 203 children | CASP descriptive/cross-sectional | Translation, cultural adaptation and testing of p-CECSS-S; valid/reliable tool reported. | Sample limited to non-urgent paediatric ED care | Strong relevance for measuring children's emergency-care satisfaction. | High |

| No | Source and design | CASP checklist applied | Methodological strengths | Main limitations / unknowns | Applicability and value for this review | Overall CASP summary judgement |
|---|---|---|---|---|---|---|
| 17 | Donaldson C.D. et al., 2021 Cross-sectional study; USA; 15,895 paediatric patients/parents | CASP descriptive/cross-sectional | Very large dataset linking satisfaction, pain scores, age and opioid administration; objective medication records add value. | Observational design; satisfaction may be confounded by acuity, expectations and diagnosis; no causal inference. | Useful for pain-management and satisfaction analyses, especially age/pain- tailored approaches. | High |
| 18 | Hu G. et al., 2021 Cross-sectional validation study; China; 2258 children/caregivers | CASP descriptive/cross-sectional | Large sample; culturally adapted Child HCAHPS with validity/reliability testing. | Inpatient rather than ED-specific; applicability to emergency settings is indirect | Useful for paediatric experience measurement, less directly for ED care. | Moderate |
| 19 | Zaigham M. et al., 2022 Cross-sectional study; Sweden; 5003 mothers | CASP descriptive/cross-sectional | Large sample and WHO-based quality-of-care indicators; captures experience during a system stressor. | Maternal/pandemic childbirth context is outside paediatric ED care; direct relevance to child/parent ED experience is weak. | Low direct applicability to this scoping review, except for general respectful-care measurement. | Limited |
| 20 | Keating L. et al., 2023 Cross-sectional study; UK; 104 adolescents | CASP descriptive/cross-sectional | Direct young-person data; compares self-harm with suspected fracture attendances; includes emotional safety and involvement. | Small pilot sample; measures partly new; potential selection and response bias; limited power. | Important for youth mental-health presentations and trauma-informed ED care. | Moderate |
| 21 | Heyming T.W. et al., 2023 Cross-sectional matched study; USA; 2324 caregivers | CASP descriptive/cross-sectional | Matched comparison of NDD and non-NDD visits; validated NRC questionnaire; equity-relevant findings. | Caregiver-only report; residual confounding and self-report bias possible; Table 3 gives limited missing-data detail. | Highly relevant to sensory, communication and equity adaptations for NDD populations. | High |
| 22 | Yeung M. et al., 2023 Cross-sectional study; Canada; adolescents and parents at paediatric/adult trauma centres | CASP descriptive/cross-sectional | Uses QTTAC-PREM; compares adolescent and caregiver experience across trauma-centre models. | Small subgroup sizes; trauma/inpatient setting only partly overlaps with ED; selection bias possible. | Useful for older adolescents in traumasystems, with limited general ED transferability. | Moderate contribution |
| 23 | Lategan et al., 2023 Cross-sectional survey; Canada; 646 children/adolescents with mental-health concerns | CASP descriptive/cross-sectional | Large vulnerable-population sample; Service Satisfaction Scale plus qualitative feedback; confidentiality and respect captured. | COVID-period context may affect wait/access; symptom-resolution outcomes may reflect system capacity beyond ED encounter. | Highly relevant to mental-health ED presentations and perceived help received. | High |
| 24 | Buclin C.P. et al., 2024 Cross-sectional validation study; France; adults, adolescents and parents | CASP descriptive/cross-sectional | Large validation/adaptation of French PPE-15 versions; allows age-group comparisons. | Mostly inpatient and partly adult population; direct paediatric ED applicability is limited; Table 3 does not provide response details. | Useful as measurement evidence, not as direct ED-experience evidence. | Moderate |
| 25 | Ma K. et al., 2024 Cross-sectional study; Canada; 514 children/caregivers across 10 paediatric EDs | CASP descriptive/cross-sectional | Multicentre child-reported national survey; directly measures privacy, fear, understanding and satisfaction. | Cross-sectional self-report; satisfaction may not equal understanding; caregiver-child differences require careful interpretation. | Highly applicable to direct child PREM collection in paediatric EDs. | High |
| 26 | Dinç F., Kurt A. & Yıldız D., 2025 Cross-sectional survey; Turkey; 596 parents with 72-hour return visits | CASP descriptive/cross-sectional | Clear focus on parents' experiences during unplanned return visits; sizeable sample. | Restricted to return visits, limiting representativeness; causation between nursing experience and return visits cannot be inferred. | Useful for communication reassurance and discharge-preparedness improvement. | Moderate |
| 27 | Ali S. et al., 2025 Cross-sectional survey; Canada; 2005 caregivers across 10 paediatric EDs | CASP descriptive/cross-sectional | Large multicentre caregiver survey; identifies unmet needs in timeliness, practical support, pain and communication. | Caregiver report only; cross-sectional self-report and unmet-need measurement may be influenced by expectations and acuity. | Highly applicable to family-centred paediatric ED quality improvement. | High |

## Qualitative studies

| No | Source and design | CASP checklist applied | Methodological strengths | Main limitations / unknowns | Applicability and value for this review | Overall CASP summary judgement |
|---|---|---|---|---|---|---|
| 1 | Byczkowski T.L. et al., 2016 Qualitative study; USA; 68 parents/guardians | CASP qualitative | Clear aim and appropriate qualitative approach; parent-informed framework with six domains of family-centred ED care. | Researcher-participant relationship | High value for defining family-centred ED quality domains. | High |
| 2 | Barbarian M. et al., 2018 Qualitative study; Canada; 12 parents | CASP qualitative | Clear focus on what matters to parents; identifies interpersonal interaction, respect and communication as key domains. | Small sample | Useful for prioritizing empathic communication and family engagement. | Moderate |
| 3 | Peeler A. et al., 2019 Qualitative phenomenological inquiry; Australia; 18 parents/guardians | CASP qualitative | Appropriate design for lived experience; rich emotional themes around anxiety, trust and communication. | Sampling | Highly relevant for emotional support and family-centred ED care. | High |
| 4 | Lewis P. et al., 2019 Qualitative study; Australia; 8 paediatric nurses | CASP qualitative | Addresses care of children with intellectual disability and family advocacy; identifies communication and staff-support needs. | Participants are nurses rather than children/parents; acute ward context reduces direct ED relevance; small sample. | Indirectly useful for disability-sensitive paediatric emergency care and staff training. | Moderate |
| 5 | Pulcini C.D. et al., 2021 Qualitative study; Australia; 20 parents and 16 physicians | CASP qualitative | Includes parent and physician perspectives; clear focus on children with medical complexity; convergent themes strengthen credibility. | Analysis rigour, sampling rationale | Highly relevant to information transfer, treatment time and communication for medical complexity. | High |

| No | Source and design | CASP checklist applied | Methodological strengths | Main limitations / unknowns | Applicability and value for this review | Overall CASP summary judgement |
|---|---|---|---|---|---|---|
| 6 | Zamor R.L. et al., 2022<br>Qualitative study; Canada; 16 Latinx parents | CASP qualitative | Equity-focused design; captures language barriers, uncertainty and interpreter value from parent perspective. | Small purposive/specific group | Valuable for interpreter access and culturally responsive ED communication. | High |
| 7 | Lysak et al., 2024<br>Qualitative study; Canada; 9 parents of children with medical complexity | CASP qualitative | Purposive interviews of 60-90 minutes; directly addresses information needs and repeated ED experience. | Very small sample | Highly relevant to parent expertise, information transfer and repeated painful procedures. | High |
| 8 | Ciurria J.A. et al., 2025<br>Qualitative study; USA; 15 caregivers | CASP qualitative | Clear focus on communication experiences of caregivers of children with medical complexity. | Convenience sample from a complex-care clinic may not represent all ED users | Useful for caregiver-clinician communication frameworks in ED care. | Moderate |
| 9 | Gutman C.K. et al., 2025<br>Qualitative study; country not stated in Table 3; 19 parents | CASP qualitative | Important focus on marginalized racial/ethnic communities and inclusion/marginalization in clinician-parent communication. | Sampling | Highly relevant to equity, racism-informed communication and partnership-building. | High |

## Mixed-method studies

| No | Source and design | CASP checklist applied | Methodological strengths | Main limitations / unknowns | Applicability and value for this review | Overall CASP summary judgement |
|---|---|---|---|---|---|---|
| 1 | Byczkowski T.L. et al., 2013<br>Mixed-method study; USA; 68 focus-group parents and 4004 survey parents | CASP qualitative + descriptive/cross-sectional | Strong sequential development/validation of a parent-centred ED quality measure; large quantitative sample and qualitative grounding. | Survey response rate, sampling | High value for family-centred paediatric ED experience measurement. | High |
| 2 | Toomey S.L. et al., 2015<br>Mixed-method study; USA; 17,727 parents/guardians from 69 hospitals | CASP qualitative + descriptive/cross-sectional | Very large multicentre development of Child HCAHPS; rigorous standardized instrument development. | Inpatient rather than ED-specific; ED applicability is indirect | Excellent measurement resource for paediatric experience, with limited emergency-specific transferability. | High |
| 3 | Remtullah A.Z. et al., 2020<br>Mixed-method cross-sectional study; Tanzania; 107 caregivers/providers | CASP qualitative + descriptive/cross-sectional | Uses Donabedian structure-process-outcome model; includes caregiver satisfaction and clinical quality discrepancy in a lower-resource setting. | Small single-site sample; mixed-method integration, sampling, analysis rigour and confounding control not fully stated. | Useful for contrasting perceived and clinical quality and for non-high-income settings. | Moderate |
| 4 | Litwin S. & Sellen K., 2023<br>Mixed-method study; Canada; 14 interviews and 21 caregiver surveys | CASP qualitative + descriptive/cross-sectional | Co-designed practical sensory kit; combines interviews and satisfaction survey; directly targets ASD-related ED distress. | Small feasibility sample; no control group; durability, harms/costs, and broader implementation not established. | Highly relevant for sensory adaptations for autistic children in ED settings. | Moderate |

**Abbreviations:** ED, emergency department; PED, paediatric emergency department; PREM, patient-reported experience measure; NDD, neurodevelopmental disorder; ASD, autism spectrum disorder; CT, cannot tell from Table 3. **CASP sources used** Critical Appraisal Skills Programme (2024). CASP Checklist: For Descriptive/ Cross-Sectional Studies. Critical Appraisal Skills Programme (2024). CASP Checklist: For Qualitative Research. Critical Appraisal Skills Programme. CASP Tools & Checklists.

## Table 3. Summary Table of studies' characteristics and main outcomes

| N. | Source | Design | Period | Country; sample & sampling | Aim | Key findings | Intervention | Experience indicators | Main conclusion |
|---|---|---|---|---|---|---|---|---|---|
| **Cross-sectional studies** | | | | | | | | | |
| 1 | Weissenstein A. et al., 2011 | Cross-sectional | Oct-Nov 2010 | Germany; 67 parents. | Identify drivers of parental satisfaction and trust in pediatric practice. | High satisfaction; communication/empathy and short waits rated highest; concerns focused on waits and explanations. | None | 27-item parent experience questionnaire. | Communication, short waiting times and a welcoming environment drive satisfaction. |
| 2 | Locke R. et al., 2011 | Cross-sectional | Jun-Aug; Sep-Dec 2009 | USA; 456 parents. | Evaluate whether structured provider communication improves pediatric ED satisfaction. | Structured communication increased caregiver satisfaction and perceptions of professionalism and empathy. | ED communication protocol & 24-h post-discharge call. | Press Ganey satisfaction survey. | Communication-focused practice can improve family experience in pediatric EDs. |
| 3 | Shefrin A.E. et al., 2012 | Cross-sectional survey | Not reported | Canada; 282 adolescents (12-18 years). | Assess adolescent satisfaction in an urban pediatric ED. | Overall satisfaction was high (92%); waits >2 h significantly reduced satisfaction. | None | 33-item adolescent satisfaction survey. | Priorities are shorter waits, age-appropriate waiting areas and private physician contact. |
| 4 | Fitzpatrick N. et al., 2014 | Cross-sectional survey | Oct 2011-Feb 2012 | Australia; 133 parents. | Assess parent/guardian perceptions of ED care, waiting times and triage. | Parents were satisfied overall; wait-time views generally matched triage, but semi-urgent cases rated waits less favourably. | None | Structured 5-domain questionnaire. | Clear triage and wait-time communication helps maintain satisfaction. |
| 5 | Jang H.Y. et al., 2015 | Cross-sectional | Sep 2011 | Korea; 1,000 parents. | Examine parent satisfaction and related factors in pediatric ED care. | Satisfaction was driven by nurses' professionalism, doctors' explanations and a child-friendly environment; physical environment was weaker but less predictive. | None | 21-item pediatric ED experience questionnaire. | Professionalism, empathy and explanations are core satisfaction drivers. |

| N. | Source | Design | Period | Country; sample & sampling | Aim | Key findings | Intervention | Experience indicators | Main conclusion |
|---|---|---|---|---|---|---|---|---|---|
| 6 | Parra C. et al., 2017 | Cross-sectional | Jul-Dec 2015 | Spain; 257 children (8-17 years). | Compare children's and parents' pediatric ED experiences. | Children reported more problems than parents, especially waits, entertainment, pain control, privacy and communication. | None | Modified Picker Patient Experience Questionnaire. | Children's reports should be collected directly, not inferred from parents. |
| 7 | Bryans A. et al., 2018 | Cross-sectional | Feb-Aug 2015 | UK; 254 adolescents (12-16 years). | Explore adolescents' ED views and priorities. | Key priorities were fast care, cleanliness, comfort, clear explanations and communication; entertainment was less important. | None | Adolescent preference-based experience indicators. | Promptness, cleanliness and communication should guide youth-centred ED improvement. |
| 8 | Ellbrant J. et al., 2018 | Cross-sectional | Feb-Mar 2013 | Sweden; 962 patient visits. | Assess links between parental origin/language ability and pediatric ED use and management. | Non-native background and limited Swedish were linked to less appropriate and more direct ED use. | None | Appropriateness, prehospital use, triage, access/equity and care process indicators. | Social and linguistic barriers affect ED use even in a universal system. |
| 9 | Kemp K.A. et al., 2018 | Cross-sectional | Oct 2015-Mar 2017 | Canada; 3,389 parents/guardians. | Describe Child HCAHPS use and variation in family experience. | Parents rated pediatric hospitals better than pediatric units in adult hospitals; ED communication scored highest. | None | Telephone Child HCAHPS survey. | Standardised tools help benchmark pediatric care and identify improvement areas. |
| 10 | Parra C. et al., 2018 | Cross-sectional | Sep 2016-Aug 2017 | Spain; 50 parents in resuscitation room. | Describe parent experience during child care in the ED resuscitation room. | Experience was positive, but accompaniment and information provision needed improvement. | None | 16-item resuscitation-room parent survey. | Parents wanted to be present and usually perceived benefits for their child and themselves. |
| 11 | Janhunen K. et al., 2019 | Cross-sectional | Nov 2015-May 2016 | Finland; 98 children (7-16 years) and parents. | Compare child and parent assessments of ED care quality and satisfaction predictors. | Children rated participation in care and private communication lower than parents; satisfaction varied by parent education and previous ED visits. | None | Children Revised Humane Caring Scale (adapted). | Care quality was high, but child participation and private communication need attention. |
| 12 | Bal C. et al., 2020 | Cross-sectional | Dec 2016-Jan 2017 | Canada; 237 parents and 109 children. | Measure pediatric ED experience and compare child and parent reports. | Child and parent experiences differed, especially for communication and privacy. | None | Child PREM for urgent/emergency care. | Children's voices are essential in pediatric care-quality assessment. |
| 13 | Parra C. et al., 2020 | Cross-sectional | Nov 2014 | Spain; 170 children (8-17 years). | Explore children's experience in a high-complexity pediatric ED. | Most children felt well cared for; improvement areas were waits, waiting environment, privacy and age-appropriate communication. | None | 12-item Picker-adapted questionnaire. | Child-centred changes should target communication, environment and privacy. |
| 14 | Janhunen K., Kankkunen P. & Kvist T., 2021 | Cross-sectional + register | Nov 2015-May 2016 | Finland; convenience sample, 89 child-parent pairs from 4 EDs. | Examine relationships between ED process factors, length of stay, care quality and satisfaction. | Satisfaction related to more procedures, higher triage level and pediatrician care track; length of stay was not predictive. | None | ED length of stay and interaction with ED professionals. | Process factors should be reviewed with outcomes; length of stay alone is insufficient. |
| 15 | Borg et al., 2021 | Cross-sectional survey | Aug-Dec 2019 | Malta; 1,834 pediatric ED cases. | Assess pediatric ED care quality using local quality indicators. | Documentation gaps were found; weight documentation, time to triage and safety-netting needed improvement. | None | Patient feedback forms and local quality indicators. | Valid local indicators and regular review are needed for continuous improvement. |
| 16 | Wennick A. et al., 2021 | Cross-sectional | Mar-Jun 2019 | Sweden; 203 children. | Translate, adapt and test the pediatric CECSS for Sweden. | The Swedish p-CECSS-S showed good validity and reliability for nonurgent pediatric ED satisfaction. | None | 19-item Swedish p-CECSS-S. | p-CECSS-S is suitable for measuring pediatric ED satisfaction in Sweden. |
| 17 | Donaldson C.D. et al., 2021 | Cross-sectional | May 2018-Jun 2019 | USA; 15,895 pediatric patients and parents. | Examine how opioids, pain severity and age relate to parent satisfaction. | Opioid use was linked to higher satisfaction overall, but effects varied by age and pain severity. | None | 0-10 satisfaction survey, pain score and analgesic records. | Pain management should be tailored by child age and pain intensity. |
| 18 | Hu G. et al., 2021 | Cross-sectional | Aug-Sep 2020 | China; 2,258 children (7-17 years) and caregivers. | Develop and validate a Chinese Child HCAHPS survey. | Child HCAHPS was successfully translated and culturally adapted following AHRQ guidance. | None | Chinese Child HCAHPS. | The tool provides a valid standard measure of pediatric inpatient experience in China. |
| 19 | Zaigham M. et al., 2022 | Cross-sectional | Mar 2020-Jun 2021 | Sweden; 5,003 mothers. | Describe women-reported care quality during pregnancy and childbirth in COVID-19. | Care-quality gaps concerned caesarean birth, breastfeeding support and respectful care. | None | 40 WHO-based quality-of-care indicators. | Respectful, evidence-based maternity care remains essential during crises. |
| 20 | Keating L. et al., 2023 | Cross-sectional | Jan 2019-Mar 2020 | UK; 104 adolescents. | Pilot measures of needs and expectations after self-harm versus suspected fracture ED visits. | Expectations were similar, but self-harm patients reported lower ED satisfaction than suspected-fracture patients. | None | Patient-reported communication, involvement, information, emotional safety, satisfaction and follow-up indicators. | ED care after self-harm needs more sensitive, youth-centred approaches. |
| 21 | Heyming T.W. et al., 2023 | Cross-sectional | May 2018-Sep 2019 | USA; 2,324 caregivers: 1,162 NDD and 1,162 matched non-NDD. | Compare ED satisfaction among caregivers of children with and without neurodevelopmental disorders. | Caregivers of children with NDDs were less satisfied; drivers were waits, communication breakdowns and sensory challenges. | None | NRC 10-item patient experience survey. | Targeted systemic changes are needed for equitable ED experience. |
| 22 | Yeung M. et al., 2023 | Cross-sectional | Jan 2020-May 2021 | Canada; PTC: 34 adolescents/38 parents; ATC: 25 adolescents/25 parents. | Compare adolescent trauma care experience in pediatric vs adult trauma centres. | Adolescent ratings were similar, but caregivers reported communication, logistics and support gaps in adult centres. | None | QTTAC-PREM. | Adult trauma centres should strengthen caregiver-centred supports for older adolescents. |
| 23 | Lategan et al., 2023 | Cross-sectional survey | Feb 2020-Jan 2021 | Canada; 646 children/adolescents with mental health concerns. | Evaluate satisfaction with ED mental-health care and associated experience factors. | Respect and confidentiality scored high; perceived symptom/problem improvement scored low; waits and limited mental-health access were concerns. | None | Service Satisfaction Scale. | Respect, confidentiality and perceived support shape mental-health ED experience. |
| 24 | Buclin C.P. et al., 2024 | Cross-sectional | Oct 2019-Apr 2023 | France; 25,626 adults, 293 adolescents and 1,640 parents. | Adapt PPE-15 for teenagers and parents of hospitalized children and establish reference values. | Adults reported lower satisfaction; parents tended to rate highest; communication and decision involvement varied. | None | French PPE-15 versions. | PPE-15 versions can assess inpatient experience across age groups in France. |

| N. | Source | Design | Period | Country; sample & sampling | Aim | Key findings | Intervention | Experience indicators | Main conclusion |
|---|---|---|---|---|---|---|---|---|---|
| 25 | Ma K. et al., 2024 | Cross-sectional | Oct 2018-Mar 2020 | Canada; 514 children (7-17 years) and caregivers at 10 PEDs. | Describe children's ED needs and experiences. | Most children reported privacy, understanding and high satisfaction; satisfaction did not always mean full understanding. | None | Child-reported fear, communication, privacy, quality and satisfaction indicators. | Direct communication with children is essential because their experiences are distinct. |
| 26 | Dinc F., Kurt A. & Yildiz D., 2025 | Cross-sectional survey | Apr 2023-Apr 2024 | Turkey; 596 parents of children (0-18 years) with ED return visits within 72 h. | Explore parent experiences with emergency nurses. | Parents wanted to stay with the child, communicate effectively and receive up-to-date information. | None | Parent-perceived need for more medical testing and information. | Parent perspectives can guide nursing practice and reduce unplanned ED returns. |
| 27 | Ali S. et al., 2025 | Cross-sectional survey | Oct 2018-Mar 2020 | Canada; 2,005 caregivers at 10 PEDs. | Describe caregiver ED experiences and whether needs were met. | More than one in five caregivers reported unmet needs; gaps were prompt care, practical issues and communication. | None | Caregiver communication needs and experience. | Timely care, clear communication, pain control and caregiver engagement improve family experience. |
| **Qualitative studies** | | | | | | | | | |
| 1 | Byczkowski T.L. et al., 2016 | Qualitative | Oct 2010-Sep 2011 | USA; 68 parents/guardians accompanying a child to ED. | Define family-centred care elements valued by parents in pediatric EDs. | Six domains emerged: information exchange, emotional support, respect/partnership, care coordination, comfort and family involvement. | None | Parent-informed conceptual quality indicators. | A parent-informed framework can guide PED measurement and quality improvement. |
| 2 | Barbarian M. et al., 2018 | Qualitative | Jul-Sep 2016 | Canada; 12 parents of children <14 years visiting a PED. | Identify parent-reported experiences that matter most in the PED. | Compassionate communication and respectful engagement were more influential than operational factors alone. | None | Waiting-room, assessment, provider-family interaction, engagement and safety indicators. | Empathy and communication should be priority targets for PED experience improvement. |
| 3 | Peeler A. et al., 2019 | Qualitative | May-Sep 2016 | Australia; 18 parents/guardians. | Describe parents' lived experience after a child's PED visit. | Parents described anxiety, fear and powerlessness; timely, compassionate communication built trust. | None | Themes reflecting patient-centred quality indicators. | Family-centred, empathetic care reduces parental stress and improves experience. |
| 4 | Lewis P. et al., 2019 | Qualitative | 2018-early 2019 | Australia; 8 pediatric nurses. | Explore nurses' experience caring for children with intellectual disability and families. | Themes were care complexity, communication challenges, family advocacy, education needs and emotional labour. | None | Parental experience themes. | Training, communication tools and interdisciplinary support are needed for equitable care. |
| 5 | Pulcini C.D. et al., 2021 | Qualitative | Jun-Oct 2019 | Australia; 20 parents and 16 pediatric emergency physicians. | Explore ED care for children with medical complexity from parent and physician perspectives. | Shared challenges were long treatment times, communication gaps, inefficient data exchange and convenience barriers. | None | Experience and improvement suggestions from parents and physicians. | Improvement should focus on time, data exchange and communication. |
| 6 | Zamor R.L. et al., 2022 | Qualitative | May 2019-Jan 2020 | Canada; 16 Latinx parents. | Identify improvements to reduce ED disparities for Latinx families. | Communication barriers and unfamiliar systems caused uncertainty and stress; in-person interpreters improved understanding and comfort. | None | Parent perspectives from qualitative interviews. | Better language services and support can reduce ED disparities. |
| 7 | Lysak et al., 2024 | Qualitative | May and Nov 2023 | Canada; purposive sample, 9 parents of children with medical complexity; 60-90 min interviews. | Explore parents' ED information needs for children with complex medical needs. | Parents acted as care coordinators; themes covered ED differences, resilience, communication and learning preferences. | None | Repeated ED experiences, painful procedures and communication level. | EDs need systems to transfer key health information for medically complex children. |
| 8 | Ciurria J.A. et al., 2025 | Qualitative | Feb-Jun 2022 | USA; convenience sample, 15 caregivers of children with complex medical conditions. | Explore caregiver communication experiences during ED care. | Caregivers wanted to be heard, believed and understood; they felt staff undervalued their knowledge. | None | Parental communication needs and experience. | A communication framework may help clinicians meet caregiver needs. |
| 9 | Gutman C.K. et al., 2025 | Qualitative | Sep 2023-Feb 2024 | Country not reported; 19 parents. | Explore ED clinician-parent communication among marginalized racial/ethnic communities. | Speaking up helped parents feel included; prior bias/racism shaped communication expectations. | None | Information, empathy, partnership, recognition of prior experiences and parent agency. | Past and current racism shapes how parents perceive ED communication. |
| **Mixed-method studies** | | | | | | | | | |
| 1 | Byczkowski T.L. et al., 2013 | Mixed methods | Oct-Sep 2011; Jan-Feb 2013 | USA; 68 parents in focus groups and 4,004 survey respondents. | Develop and validate a parent-centred pediatric ED experience measure. | A behaviourally anchored tool measured 8 family-centred care dimensions and correlated strongly with overall satisfaction. | None | 24-item Quality Care Tool; 8 dimensions. | A valid, behaviour-focused pediatric ED experience measure was developed. |
| 2 | Toomey S.L. et al., 2015 | Mixed methods | Nov-Dec 2011; Nov 2012-Jan 2014 | USA; 17,727 parents/guardians from 69 hospitals in 34 states. | Develop Child HCAHPS for pediatric inpatient and family experience. | Child HCAHPS was developed as a valid standard survey for quality improvement and accountability. | None | 62-item instrument: 39 experience, 10 screener, 12 demographic and 1 open-ended item. | Child HCAHPS supports benchmarking and public reporting of pediatric inpatient experience. |
| 3 | Remtullah A.Z. et al., 2020 | Mixed-method cross-sectional | Feb-Apr 2018 | Tanzania; 107 caregivers of admitted children and healthcare providers. | Evaluate Acute Pediatric Care Unit quality using the Donabedian model. | Perceived care quality and clinical quality diverged, mainly because mortality was high despite high caregiver satisfaction. | None | Donabedian structural, process, clinical outcome and caregiver satisfaction indicators. | The high-satisfaction/high-mortality paradox requires further investigation. |
| 4 | Litwin S. & Sellen K., 2023 | Mixed methods | Mar 2018-Mar 2020 | Canada; 14 interviews and 21 caregiver satisfaction surveys. | Co-design and implement a low-cost sensory intervention for children with ASD in the ED. | The sensory kit reduced sensory distress and behavioural challenges and was well received by caregivers and staff. | Sensory kit for children with ASD. | 5-question satisfaction survey. | Sensory kits can reduce distress and improve ED experience for children with ASD. |

**Abbreviations:** ED, emergency department; PED, pediatric emergency department; PREM, patient-reported experience measure; ASD, autism spectrum disorder; NDD, neurodevelopmental disorder.

## Discussion

This scoping review mapped evidence from 40 studies and highlights that children's and parents' experiences of paediatric emergency care are multidimensional. One of the main findings was the presence of highly satisfactory overall assessments despite repeated instances of problems with regard to the child's waiting, confidentiality, communication, age-appropriate information, pain management, and discharge preparation. The importance of such contradiction lies in the fact that high scores for overall satisfaction can be indicative of gratitude or relief, even if needs were not met. Similar patterns were reported in a recent systematic review of paediatric ED experience, in which overall satisfaction was generally positive despite lower ratings for privacy, communication, and waiting areas (Abram et al. 2025). Parents' own definitions of quality also support this interpretation. For example, in a modified Rand-Delphi study, parents and carers prioritised thorough medical assessment, a clear triage system, skilled paediatric staff, appropriate resources, and clearly communicated follow-up plans (Lacey, West & Craig 2021).

Communication emerged as the most consistent and actionable determinant of experience. The included studies show that families value explanations that are understandable, timely, honest, and adapted to the child's age and condition. This finding is consistent with the broader literature on unscheduled paediatric healthcare, where parents' decisions to seek emergency care are influenced by perceived urgency, the need for reassurance, accessibility of alternatives, previous relationships with healthcare professionals, and waiting time (Nicholson et al. 2020). In the ED, communication is therefore not only a marker of satisfaction but also a mechanism for reducing uncertainty and emotional distress. This is supported by evidence that mothers of children hospitalised in a paediatric ED had moderate anxiety and high healthcare satisfaction, while anxiety, educational level, and waiting time were associated with satisfaction scores (Efe et al. 2022). The findings of the present review therefore indicate that communication should be treated as a core clinical process, not simply as a courtesy or interpersonal skill or just a professional soft skill.

High-acuity encounters in the resuscitation room further emphasise the need for structured family support. Parra et al. (2018) surveyed parents after their child received care in a paediatric resuscitation room and found that, although nervousness was the most frequently reported emotion, parents also expressed trust in the healthcare team and wished to remain present. They perceived their presence as beneficial for the child and for themselves, while the authors highlighted the need to improve parent accompaniment and information provision. This reinforces the importance of assigning a staff member to support parents, explain the resuscitation-room process, and maintain compassionate communication during critical and time-sensitive emergency care.

This scoping review also addresses the importance of listening directly to children and adolescents. Several included studies showed discrepancies between child-reported and parent-reported experiences, especially in relation to privacy, participation, information, pain, and the opportunity to speak privately with clinicians. This is in alignment with previously published pediatric nursing research indicating that children's expectations of good care include humane and reliable nurses, safety, educational activities, entertainment, family presence, and opportunities for comfort and reassurance (Pelander & Leino-Kilpi 2004). It is also consistent with the concept of humanisation in paediatric care, which emphasises the child's right to be heard and to participate in care, alongside the essential role of the family (Tripodi et al. 2017). Consequently, paediatric emergency services that evaluate experience only through parents or caregivers risk missing domains that are particularly important to children and young people themselves.

Waiting time and crowding require particular attention because they influence both experience and safety. The findings of this scoping review show that children and parents frequently described waiting, lack of updates, and uncertainty about triage as sources of dissatisfaction. Evidence from the American Academy of Pediatrics also shows that ED

crowding is associated with delayed pain control, delayed antibiotics, medical errors, less-than-optimal care, poorer patient and family experience, and reduced staff well-being (Gross, Lane & Timm 2023). Therefore, improving waiting experiences should not be limited to reducing elapsed time. Families also need clear explanations about triage, repeated updates during delays, visible reassessment, and access to comfort measures while they wait. These practices may protect trust even when demand exceeds available resources.

Pain management was another important domain. Children often report problems with pain management, and usually more often than their parents. Adequate pain control was identified among children and parental as a basic need. An integrative review of paediatric emergency pain management found that children continue to experience suboptimal pain management and that the most promising approaches include multifaceted organisational interventions, nurse-initiated analgesia, education, feedback, and family involvement throughout pain assessment and treatment (Williams, Keogh & Douglas 2019). These findings support the need for pediatric EDs to make pain assessment and response visible to both children and parents. Asking children directly about pain, using age-appropriate scales, providing early analgesia, and explaining pain management decisions can improve both clinical care and perceived quality.

The physical and sensory environment of the ED also shaped experience. The ED can be noisy, crowded, sterile, and overstimulating, which may increase anxiety and reduce privacy. A systematic review of the physical environment in hospital-based EDs identified control, positive distractions, family and social support, and safe, comfortable design as important themes for children and families (Gripko, Joseph & Mohammadi Gorji, 2023).

These issues are especially relevant for children with intellectual, developmental, or neurodevelopmental disabilities. A mixed-methods systematic review found that parents of children with intellectual and/or developmental disabilities wanted better communication, recognition of their child's needs, support in navigating the ED environment, and resources for orientation and access to services (Elliott et al. 2024). The present findings therefore support the use of practical adaptations such as quieter spaces, sensory kits, child-friendly distraction, privacy measures, and staff preparation for children with complex communication or sensory needs.

From a quality-improvement perspective, the findings suggest that paediatric emergency care should be evaluated through a combination of child-reported measures, parent-reported measures, and process indicators. Global satisfaction alone is insufficient. Patient-reported experience measures can help services identify domains that matter to patients and families, but they need to be age-appropriate, culturally sensitive, and feasible for routine use (Bele et al. 2021).

At the same time, structural and professional factors remain important. Quality of emergency care for children has been associated with hospital setting and physician training, with lower quality reported in rural non-children's hospitals compared with an urban children's hospital in one study (Dharmar et al. 2008). Variation in family experience across hospitals has also been demonstrated using Child HCAHPS, showing room for improvement across measures and settings (Toomey et al. 2017). Thus, improving experience requires both relational interventions and system-level readiness, staffing, training, environment, and measurement.

**Implications for practice**

The findings have several implications for pediatric emergency care. First, communication should be standardised without becoming impersonal. Paediatric emergency services should embed family-centred communication as a routine clinical process. Families should receive clear explanations at triage, regular updates during waiting, age-appropriate explanations for the child, and written or verbal discharge information using teach-back. Communication training should include active listening, shared decision-making, plain language, empathy and acknowledgement of parents' expertise, particularly for children with chronic

conditions, neurodevelopmental disorders or medical complexity.

Second, children and adolescents should be invited to participate in care at a developmentally appropriate level, including opportunities for privacy when clinically and ethically appropriate. Age-adapted PREMs, brief post-discharge surveys, digital feedback tools and opportunities for adolescents to speak privately with clinicians can help identify gaps that parent-only reporting may miss. This approach is consistent with family-centred care and may help services identify problems that professionals may underestimate, such as the emotional impact of waiting, confusion about triage, or lack of privacy.

Third, pain assessment and early analgesia should be embedded in routine workflows, with nurses supported to initiate evidence-based interventions where local policy allows. Pediatric EDs should also strengthen nurse-led pain assessment and analgesia pathways, offer developmentally appropriate distraction, protect privacy during examination and treatment, and ensure that discharge advice is clear and actionable. For children with sensory or communication needs, practical adaptations such as sensory kits, quiet spaces, visual supports, interpreter access and improved transfer of clinical information should be part of routine readiness rather than exceptional practice.

Fourth, pediatric EDs should adapt care for vulnerable groups. Interpreter services, culturally sensitive communication, sensory-friendly resources, and proactive identification of children with complex medical, developmental, or mental health needs should be part of routine practice. Finally, quality improvement should include feedback from both children and caregivers after discharge. Feedback systems should include domains repeatedly identified in this review: waiting, privacy, communication, participation, pain management, emotional safety, environmental comfort and discharge preparedness.

Such feedback should be linked to visible service changes so that experience data become a mechanism for improvement rather than a passive measurement exercise.

**Implications for future research:** Future research should move beyond descriptive satisfaction studies and test interventions designed to improve the specific domains identified in this review. Priorities include structured communication interventions, triage information strategies, nurse-led pain management pathways, sensory and environmental adaptations, interpreter-supported care, and discharge preparation tools. Research should evaluate outcomes that are meaningful to children and parents, including understanding of the care plan, anxiety, pain relief, privacy, involvement in decisions, emotional safety, confidence after discharge, and unplanned return visits.

There is also a need for stronger child- and adolescent-reported evidence. Studies should include younger children where feasible, adolescents with mental health concerns or self-harm, families from minority language or racial groups, children with neurodevelopmental disorders, and children with medical complexity. More research is needed in non-children's hospitals and lower-resource settings, because many children receive emergency care outside specialist paediatric centres. Although family-centred care is widely promoted, a Cochrane review found limited high-quality quantitative evidence on its effects and called for rigorous intervention studies across diverse settings and outcomes (Shields et al. 2012). Future work should therefore combine implementation science, mixed-methods designs, and equity-focused analysis to determine not only whether interventions work, but for whom, in which settings, and under what conditions.

**Limitations of the study:** This review has limitations. As a scoping review, it was designed to map and describe the available evidence rather than to estimate intervention effects or pool quantitative outcomes. The included studies were heterogeneous in design, setting, population, instruments, and outcomes, which limited direct comparison between studies. The search was limited to English-language publications and selected databases, so relevant studies may have been missed. Many included studies were cross-sectional and relied on parent or caregiver reports, which may overrepresent adult perspectives and underrepresent the views of

younger children. Moreover, several studies used cross-sectional designs and were satisfaction surveys, which can identify associations but cannot establish causality. Some evidence came from parents or caregivers only, and several studies did not collect children's views directly. Some evidence came from broader paediatric inpatient or hospital experience literature because these tools and concepts were relevant to paediatric emergency care, but they may not fully reflect the pressures and time-sensitive nature of the emergency department. In addition, because many included studies were conducted in high-income countries and specialised or high-volume centres, the findings may not fully represent smaller, rural or resource-limited emergency departments. Finally, the review did not undertake a formal risk-of-bias appraisal, which is consistent with many scoping reviews but limits conclusions about the strength of individual study findings. Despite these limitations, the scoping review provides a useful map of the main factors shaping children's and parents' experiences and identifies clear directions for practice and research.

**Conclusions:** This scoping review identified a heterogeneous evidence base on children's, adolescents' and parents' experiences of care in pediatric EDs. Overall, experiences were reported more positively when care was perceived as competent, respectful, empathic and communicative. Nevertheless, high satisfaction scores should be interpreted cautiously, as recurrent shortcomings were reported in waiting, explanations, privacy, child participation, pain management, emotional support and discharge preparation. Communication emerged as the most consistent and modifiable determinant of experience, supporting its recognition as a core component of safe, high-quality and compassionate paediatric emergency care.

The findings also highlight the importance of directly eliciting children's and adolescents' views. Caregiver reports provide important information but may not fully capture children's experiences of privacy, involvement, pain, emotional safety and age-appropriate communication. Particular attention is needed for families facing language barriers, children with neurodevelopmental conditions or medical complexity, and young people presenting with mental health concerns or self-harm. Inclusive, trauma-informed and family-centred approaches, including interpreter access, sensory adaptations, effective information transfer and recognition of parental expertise, are required to address these needs.

In conclusion, improving experience in paediatric emergency care requires moving beyond global satisfaction measures towards multidimensional evaluation and quality improvement. Future service assessment should integrate child- and caregiver-reported outcomes with process indicators related to communication, waiting, privacy, pain control, emotional support, discharge information and follow-up preparedness. Embedding these indicators into routine practice may help identify unmet needs, reduce inequities and support care that is clinically effective, developmentally appropriate and responsive to the priorities of children and families.

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