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Nurse-Mediated Parental Involvement in Pediatric Oncology: A Scoping Review

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ABSTRACT

Parents investing time in caregiving is an essential component of their child's treatment in pediatric oncology. The literature describing the processes through which parents engage is often vague. This study collated evidence regarding engagement of parents in the care of pediatric oncology patients by nurses and care processes pertaining to nurses, and examined this evidence. A Scoping review designed according to PRISMA-ScR was conducted. The literature was collected from Scopus, Web of Science, PubMed, and CINAHL. Literature pertaining to pediatric oncology, parents, or family caregivers in the context of nursing from 2021-2026 was included. Of the 168 records, 20 studies were included. The evidence was framed as five facets of nursing: presence, information translation, family process support, coaching for home care and symptom management, and technology-supported care. Parent engagement in care was articulated through four process qualities: understanding, confidence, participation, and continuity in care from hospital to home. Evidence was most readily available for relational work and for the communication domain. Evidence was scarce for guidance on systematic discharge, preparation for home care, and inclusion of fathers and families of diverse language groups. Engagement of parents in pediatric oncology is better articulated as a process with nursing as a central element with clearly defined components rather than as a general family-centered construct.

Keywords: family-centered care; nurses; children with cancer; parental involvement

INTRODUCTION

Caregiving for a child with cancer is a unique and extended situation for families. Families experience psychosocial challenges in addition to the complex nature of the child's illness and reintegration of the family after treatment (Bates et al., 2023). From a modern nursing and integrative family-centered care perspective, facilitating the ongoing care of children with cancer requires not only TBM care but also the empowerment of families to engage in the care of their ill child (Hodgson et al., 2024; Rørbech et al., 2024). In this case, the mother and father are not the “passive companions” as they take on the role of care givers and provide the physical and emotional aspects of care from the hospital and home. They also engage in the complex care of the child, which involves appraising various symptoms and participating in clinical decisions (Roug et al., 2025; Mensah et al., 2025). They also serve as the primary caregivers within the family unit, which is particularly important during the period of survivorship and

follow-up appointments when there are potential gaps in health care communication due to cultural and linguistic barriers (Ochoa et al., 2021).

Translating clinical data and providing therapeutic support at multiple transitions throughout the cancer trajectory further situates nurses within the therapeutic triad of the varying clinical phases. While evidence suggests considerable variation in the content, timing, and reporting of pediatric oncology nursing interventions, several family-centered care studies tend to conceptualize a partnership without addressing the specific nursing processes that foster parental collaboration (Hodgson et al., 2024; Mcharo et al., 2022; Rørbech et al., 2024). Communication is perhaps the most significant of such processes. Healthcare practitioners' ability to make clear, logical answers to parents' inquiries and engage in an interactive process with parents fosters active parental engagement. Perceived role ambiguity, uncertainty, and health literacy and language disparities can inhibit the process of effective communication (Aristizabal et al., 2023; Sisk et al., 2021, 2022; Williams et al., 2024). Results of recently conducted triadic communication studies show that parental engagement is not the result of parent-professional communication alone, but rather the result of interaction and coordination of healthcare practitioners, parents, and the child (Ye et al., 2025).

Parental engagement includes relational, psychosocial, and educational aspects. Nursing presence, trust, and the establishment of therapeutic relationships can positively impact parents' perceived support and participation in care. Family-centered approaches such as the Family Talk Intervention indicate potential to improve family communication and the relational comprehension of parents and families during the treatment stress of family members (Ayoub et al., 2024; Holm et al., 2024; Lövgren et al., 2022; Mcharo et al., 2022). Research concerning the views of children suggests that the organization of family meetings can enhance understanding in the family system, and can be beneficial beyond the communication of parents and health care providers (Eklund & Lövgren, 2022). Furthermore, studies demonstrating the use of innovations have shown that technology can increasingly encourage parental participation. When integrated into a supportive care framework, digital relaxation interventions, virtual reality, and various technology-enabled methods can improve the coping of caregivers, decrease treatment-related stress, and enhance parents' psychosocial and cognitive resources and self-efficacy (Gerçeker et al., 2021; Hélie et al., 2025; Ozdemir Koyu & Kilicarslan Törüner, 2023; Ozturk & Katikol, 2024).

While family-centered care is evolving, there is still much to learn about how nursing care specifically influences and assesses parental engagement in pediatric oncology. The existing

literature widely addresses communication, psychosocial care, and technology-related support; however, these also encompass home-based caregiving, leading to a holistic conceptualization of parental involvement rather than a structured process with nursing actions and tangible endpoints. Most available evidence is multidisciplinary or relevant to nursing as a whole, rather than pertaining specifically to nurse-led models of care. This greatly limits our understanding of how, and in what ways, nurses affect parents' knowledge, confidence, and engagement, as well as their demand for and readiness to provide ongoing care (Costa, 2026; Sisk et al., 2022; Zaben et al., 2025). Several factors remain poorly examined, including organized caregiver preparation as part of the discharge process, evaluation of parents' readiness to provide home care, involvement of fathers, assistance for families with limited English proficiency, and post-discharge follow-up after the child transitions from the hospital to the community.

Continuity of care is one of the least developed themes in the reviewed literature. Qualitative studies show that elderly people often take up at home as "mini-nurses," attending to symptoms and performing aspects of care, but they can hardly know if they need to seek professional help since expectations are not clear (Roug et al., 2025; Mensah et al., 2025). There is some emerging evidence suggesting that parents can undertake certain home-based care tasks safely. This is especially the case when parents are provided with structured education, coaching, and ongoing support. However, the field remains lacking in nurse-managed transition frameworks of this sort, which are sufficiently detailed and integrated (Roug et al., 2025). To further develop family-centered oncology practice, there is a need for greater understanding of how nurses prepare, support, and assess parents across diverse phases of pediatric cancer care.

While past studies examining the role of parents in the caregiving of children with cancer have studied individual components of the role, these studies have generally not examined the role of parents in a caregiving framework. This focused on describing the role of parents in caregiving within the context of different nursing functions and caregiving as a process that involves the parents' understanding of the child's condition and the child's treatment, the parents' self-efficacy, the parents' involvement in verbal and non-verbal decision making, and the parents' ability to provide seamless care throughout the transition from the hospital to the home. This study describes the role of parents in the caregiving process within the context of the nurse's professional role and other related functions in the care of children with cancer, and organizes this information into the four dimensions of understanding, self-efficacy, involvement, and seamless care. This study employed a scope review design to identify and map the available evidence on the role of parents in the caregiving of children with cancer,

identify the central concepts, and describe the research gaps. The review questions guiding this research are: What roles, processes, and mechanisms of nursing support effective parental involvement in pediatric oncology, and how can this be organized into measurable dimensions for practice?

METHOD

Study Design

This study used a scoping review design to provide an overview of identifying research on parental involvement in the care of children with cancer. The preparation and reporting process follows the guidelines of Preferred Reporting Items for Systematic Reviews and Meta-Analysis Extension for Scoping Reviews (PRISMA-ScR). The scoping review approach was chosen because the study covered different research designs, aimed to describe parental involvement in the care of children with cancer based on available evidence, and did not assess the effectiveness of the intervention.

Eligibility Criteria

Inclusion and exclusion criteria are determined based on the Population, Concept, and Context (PCC) framework.

a. Population: a study involving children or adolescents with cancer, parents or caregivers, and healthcare workers in pediatric oncology services.
b. Concept: research that addresses parental involvement through nurse roles or service processes related to nursing, including communication, health education, psychosocial support, symptom management, home care preparation, and technology-based support.
c. Context: research conducted on a variety of pediatric oncology services, including inpatient, outpatient, home care, treatment transition periods, and survivor follow-up.

The included articles are empirical research using qualitative, quantitative, and mixed-method approaches, published in English during the period January 2021 to 2026. Articles in the form of editorials, comments, research protocols, conference abstracts, literature reviews, cancer research in adult populations, pediatric non-oncology research, as well as articles that do not discuss parental involvement, are excluded from the review.

Literature Search Strategy

The search strategy and selection process are shown in Figure 1. A total of 168 records were identified, including 52 in Scopus, 41 in the Web of Science Core Collection, 46 in PubMed, and 29 in either CINAHL or a journal website search. The core concept combines the oncology of the child, the parent or caregiver, and the nursing engagement process. The main search string is customized to each database. In terms, they are: ("pediatric oncology" OR "pediatric oncology" OR "pediatric cancer" OR "pediatric hematology-oncology") AND (parent* OR family* OR caregiver*) AND (nurse* OR communication OR education OR support OR empowerment OR "family-centered care" OR "home care" OR reteaching OR symptom management). The search syntax of PubMed, Scopus, and Web of Science topics is used as intended.

Study Selection

A total of 168 articles were identified, namely 52 from Scopus, 41 from Web of Science, 46 from PubMed and 29 articles from CINAHL. After removing 46 duplicate articles, 122 articles were filtered by title and abstract. Thirty-eight reports were sought for review, 36 were assessed in full text, and 20 studies met the eligibility criteria. Reasons for excluding the full text include a lack of direct focus on the parent or caregiver, insufficient relevance to nursing, non-primary literature, or unavailability of the full text. The review team used a phased screening approach with predefined criteria; feasibility uncertainties are resolved by examining each research project against the agreed charting domain.

Data Analysis and Synthesis

Data were analyzed using a descriptive narrative approach, identifying similarities, differences, and gaps in the research evidence. The results of the synthesis were used to illustrate how nurses supported parental involvement in different stages of the care journey of children with cancer.

Study Quality Assessment

Methodological quality assessments are not conducted because the purpose of this scope review is to map the characteristics and scope of available evidence, not to evaluate the effectiveness of interventions or to draw conclusions based on the quality of the evidence. This approach is in line with the guidelines of the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis and PRISMA-ScR, which state that critical appraisal in scoping reviews is optional and depends on the study's purpose.

RESULTS

The final review includes 20 articles. Figure 1 shows that the greatest reduction occurred in the title and abstract filtering step, where records without direct parental involvement or a nursing-relevant focus were removed. Figure 1 shows that the final review was conceptually focused rather than citing evidence: only studies informed the pathways of involvement of nursing parents that were retained. Table 1 provides a complete study audit trail, mapping each study to the four operational dimensions developed in this review.

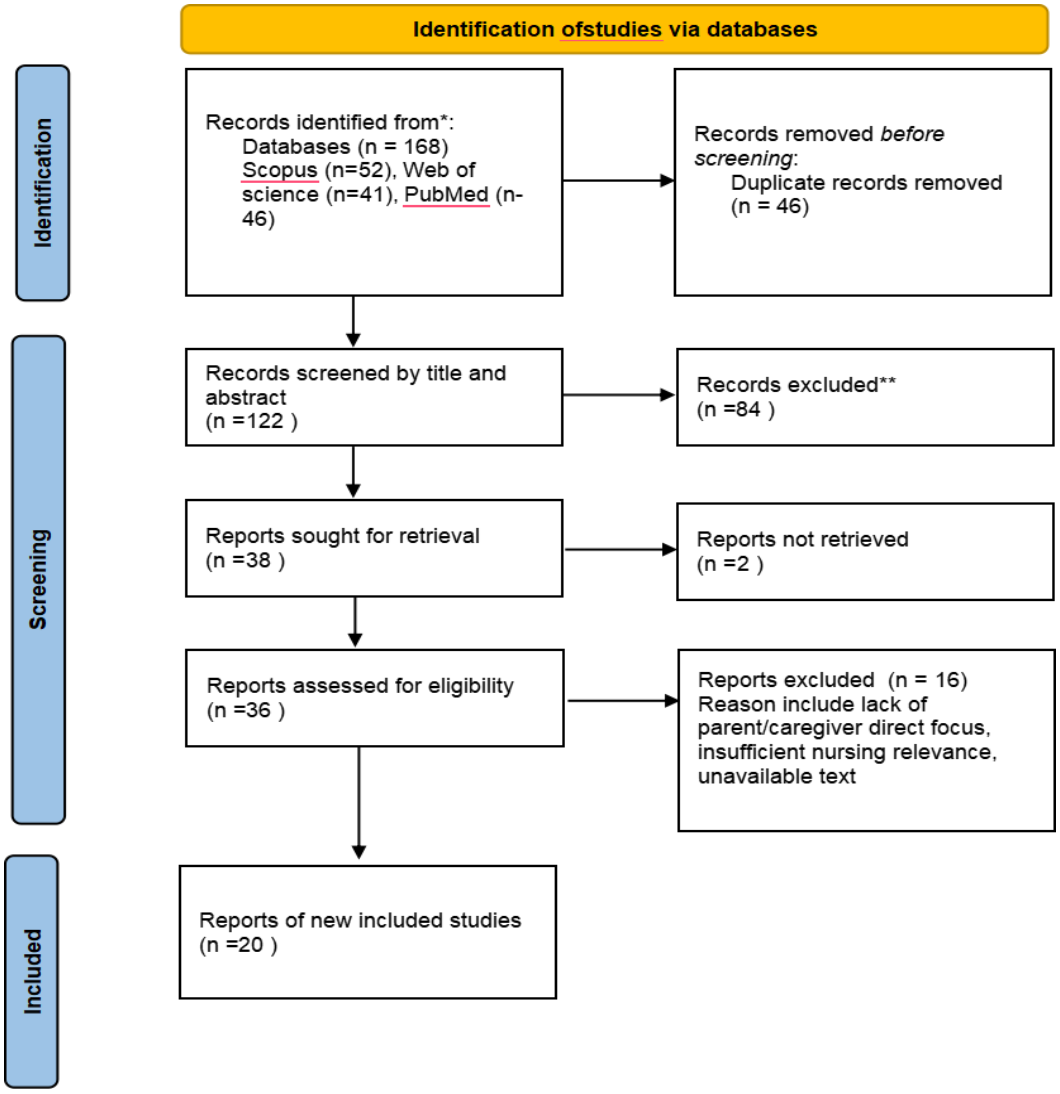

Figure 1. PRISMA flowchart

Table 1 also explains that only a small number of studies offer direct nurse-specific evidence. Direct evidence mainly comes from research on nursing attendance, parent-nurse relationships, therapeutic communication practices, symptom management, and procedure-related support. A larger share of the literature is multidisciplinary or implicit in nature, which includes diagnostic communication, prognostic disclosure, informed consent, family interventions, and

home care studies, often involving parents and clinicians broadly, with nursing relevance inferred from where nurses operate on the care pathway. This distinction is important because it explains why nurses are widely considered to be central, while the evidence for specific nurse-led mechanisms remains uneven.

When studies are re-read through the lens of operational engagement, four dimensions become visible. In Table 1, it is apparent that a limited number of studies provided evidence regarding nurses. Direct evidence was predominantly provided by studies of the nurse's presence, the parent-nurse relationship, and the nurse's role in facilitating therapeutic communication, managing symptoms, and supporting procedures. Most of the literature included was multi-disciplinary or nurse-implementable. It included studies on communication regarding diagnosis and prognosis, informed consent, family interventions, and home care, as well as studies on parents and clinicians more generally. Nursing relevance was assumed where nurses could be identified within the care pathway. This difference is important because it clarifies why nurses are seen as central to the studies, while the evidence for specific nurse-led mechanisms is more patchy.

When the studies were reread with operational engagement in mind, four areas emerged. These are described in Table 1. The higher level of representation refers to parental participation, and the other three areas, which show relatively low representation, are confidence and coping, understanding, and continuity across settings. The fact that participation was described in many ways, such as asking questions, taking part in valued interactions, engaging in care tasks, and participating in activities at home, does not mean that shared decision-making was well articulated. By contrast, continuity, one of the most frequently described and clinically significant unmet needs, was the least represented.

Geographically, the samples were drawn mostly from North America and Northern Europe, representing mostly high-income regions. Evaluating the samples from several middle-income regions, such as Guatemala, Ghana, Jordan, and Turkey, would have strengthened the review. As it stands, the results must be interpreted cautiously. The mechanisms described in this review, teach-back, family dialogue, home-care coaching, symptom monitoring, and technology-enabled follow-up, are likely to function differently in health systems with different staff-to-patient ratios, different family financial burdens, and varying continuity of care. Accordingly, Table 1 should not be interpreted as a list of the same interventions. It should be interpreted as a list of common nursing functions described across different service configurations.

The first dimension, understanding, was built mainly through communication and translation work. Studies on diagnostic communication, informed consent, and prognostic disclosure highlighted that parents' engagement was often contingent on information being explained in plain language, revisited, and adapted to the uncertainties and/or timeframe. Teach-back was largely absent from Table 1 and was typically supported by communication literature. Additionally, there was very limited evidence on nurse-led structured understanding checks.

The second dimension of confidence originated within the context of relational nursing and psychosocial support. According to Mcharo et al. (2022) parents were better able to manage once nurses (or nurse-facing interventions) were prepared and/or able to be present and steady, encouraged, and practically ready. Study Ozturk & Katikol (2024) showed how structured digital relaxation support was able to improve maternal coping. In Table 1, confidence was the dimension most represented by family-focused interventions, particularly the family talk intervention, which appeared to improve communication within the family and between parents and professionals.

The third dimension, participation, connected relational and informational work to action. In the context of communication, therapeutic communication, and symptom management, parents were more likely to participate when invited to do so by being asked questions, offered input, and involved in the care decision-making process.

The fourth dimension, continuity, exposed the most significant gap in the existing body of research. Only a handful of studies, along with survivor communication work, focused directly on the situation in which parents were expected to carry on the care work from within the hospital. According to Table 1, this often meant that mothers and fathers had to become "mini-nurses," while the literature offered little to no description of a formal nursing model for staged discharge, follow-up, and verification of parent readiness.

Table 1. Characteristics of the included studies

Learn	Country	Design	Sample	Engagement mechanism	Key findings
Mcharo, Bally, & Spurr, (2022)	Canada	Descriptive phenomenology	10 parents of children with cancer	Therapeutic presence and belief	The six constituent features of nursing attendance, suggest that parents are more fully engaged when expertise is paired

Learn	Country	Design	Sample	Engagement mechanism	Key findings
					with emotional stability and family inclusion.
Williams et al., (2024b)	Guatemala	Qualitative studies	20 families and 10 providers	Diagnostic communication	The dynamics of two-way communication during diagnosis, suggest that supportive explanations and invitations to ask questions increase parental involvement.
Bates et al., (2023)	United States	Cross-sectional qualitative	44 babysitters	Support for family routines	Disrupted routines weaken the family's coping capacity, demonstrating the role of nursing in maintaining the daily structure and confidence of nurturing.
Lövgren et al., (2022)	Sweden	Feasibility study with parent surveys and interviews	26 families	Family Talk Intervention Eligibility	Structured family interventions are feasible and acceptable, especially when delivered in settings that are experienced safely by the family.
Holm et al., (2024)	Sweden	Qualitative content analysis	22 pairs	Couple communication support	Structured family conversations can help parents listen to each other and keep the couple's relationship under medical pressure.
Ayoub et al., (2024)	Sweden	Simultaneous mixing method	52 parents from 26 families	Communication and family empowerment	Map the potential effects of Family Talk Intervention on family communication, family togetherness, and parental empowerment.
Ozturk & Katikol, (2024)	Turkey	Randomized controlled trials	50 mothers	mHealth relaxation support	An 8-week cellular relaxation program reduced anxiety and improved coping stress in mothers of children with cancer.
Hélie et al., (2025a)	Canada	Qualitative studies	5 parents of children in remission	Virtual reality co-design	Parents want digital tools to alleviate distress but insist that they should complement rather

Learn	Country	Design	Sample	Engagement mechanism	Key findings
					than replace human care.
(Aristizabal et al., 2023)	United States	Cross-sectional studies	223 parents of children with newly diagnosed cancer	Understanding informed consent	Limited health literacy and Spanish-language communication were associated with poorer understanding of consent.
(Ochoa et al., 2021)	United States	Exploratory surveys	160 parents of childhood cancer survivors	Information search and provider communication	Parents remain central intermediaries of information during survival follow-up, especially where language and ethnicity form communication patterns.
(Costa, 2026)	United States	Qualitative studies	8 elderly and 8 nurses	Parent-caregiver relationship	Clarify how trust, shared humanity, and mutual recognition shape meaningful parent-caregiver relationships across the cancer trajectory.
(Gerçeker et al., 2021)	Turkey	Randomized controlled trials	42 children/teenagers	Procedural support with virtual reality	VR reduces pain, fear, and anxiety during port access, creating a more manageable environment for parental support and caregiver coaching.
(Sisk et al., 2021, 2022)	United States	Qualitative studies	80 parents	Children-Doctor Communication	Six communication functions that help children and parents engage with doctors, including information exchange, uncertainty management, and expectations.
Sisk et al., (2022)	United States	Qualitative studies	Nurses, doctors, psychosocial professionals	Communication tension	The tension between honesty, expectations, time, and role boundaries can damage communication with parents.
(Kaye et al., 2021)	United States	Prospective longitudinal mixing method	17 Dyads of Parents with Chain Re-evaluation Conversations	Prognostic communication	Direct statements about incurability increase the prognostic concordance of

Learn	Country	Design	Sample	Engagement mechanism	Key findings
					parents-oncologists over time.
(Aydın et al., 2024)	Turkey	Descriptive phenomenology	24 nurses and doctors	End-of-life communication	Emotional, cultural, and linguistic barriers that limit open discussions with children and parents toward the end of life.
Nogéus et al., (2023)	Sweden	Qualitative interview studies	Pediatric oncology nurse	People-centered nausea management	Nurses value partnership and individual symptom management, but parental documentation and inclusion remain inconsistent.
(Zaben et al., 2025)	Jordan	Cross-sectional survey	Pediatric oncology nurse	Therapeutic communication skills	Overall communication practices that are moderate, with weaker performance in joint decision-making, encourage questions, and explain next steps.
Mensah et al. (2025)	Ghana	Phenomenology	20 parents	Home care and symptom recognition	Parents are often de facto caregivers at home, underscoring the need for anticipatory teaching and accessible follow-up.
Roug et al., (2025)	Denmark	Ethnographic studies	13 families	Parenting expectations	Parents as 'mini-nurses' who negotiate anxiety, division of duties, and ambiguous expectations in hospitals and homes.

DISCUSSION

In pediatric oncology, the parents' physical presence at treatment does not define parental involvement. Based on the 20 studies included in this scoping review, parental involvement consists of four interconnected dimensions: understanding, confidence, participation, and continuity. Parents become more involved when trusting relationships are established, information is presented in an easily understandable manner, and they are invited to engage and share in the decision-making process. These findings align with previous studies that describe the therapeutic relationship, responsive communication, and parental empowerment

as key facets of pediatric oncology care (Costa, 2206; Mcharo et al., 2022; Williams et al., 2024). The absence of a typical pattern of parental involvement in the studies included in the scoping review means that the divergence is attributable to different healthcare systems, family cultures, the child's illness and its treatment and expressed definitions and constructs of parental involvement. With variation in focus and definitions, some studies focused primarily on communication, while others focused on education, emotional and social support, and home care, resulting in different views on parental involvement (Hodgson et al., 2024; Rørbech et al., 2024).

The results of this scoping review identify the different ways in which nursing practice may support parental involvement. There is a need to consider parental involvement within a nursing process that may be constrained and defined by specific nursing interventions, rather than as a broad, overarching guiding principle of family-centered care. Nurses are indispensable for conveying crucial yet difficult information to parents, strengthening confidence in caregiving, and fostering a participative family atmosphere. Evidence suggests that the presence, emotional support, and communicative proficiency of nurses build parents' feelings of safety and preparedness to help with caring (Costa, 2206; Mcharo et al., 2022). Pediatric oncology nursing should, therefore, clarify the need for the practice to go beyond one-directional teaching. It should be called an active partnership involving nurses, children, and parents. Progressive education, teach-back, caregiving, and emotional support are strategies that should be standard parts of nursing practice.

Involvement hinges on the quality of communication and the therapeutic relationship. Parents need help beyond the provision of diagnostic and treatment information. They need support in interpreting and applying the information to the routine care that they provide. This explains the inconsistent outcomes in communication, where many interventions have focused on the delivery of information while neglecting emotional distress, and family readiness and health literacy. Communication in pediatric oncology is most effective when it is iterative and addresses parents' changing needs (Kaye et al., 2021; Williams et al., 2024). It should be a nursing process that supports and builds understanding and confidence of parents throughout the illness.

The participation dimension shows that parental involvement increases when parents are purposefully invited to participate in care activities and decision-making. However, implementing this dimension can be difficult, as parents inevitably differ in their ability to participate, preferences, and available resources. Some parents may want to be fully involved

in care, but experience barriers such as low health literacy, anxiety, language, and financial constraints, as well as competing caregiving responsibilities. Furthermore, healthcare systems characterized by limited consultation time, high-level decision-making, and a paternalistic approach can severely limit parents' opportunities to participate in decision-making and care. It is evident from all of the above that parental participation should not be seen as the sole responsibility of individual families. It is a responsibility of the family and the healthcare systems and requires a willingness to adapt from both the family and the healthcare systems (Aristizabal et al., 2023; Ochoa et al., 2021).

The continuity dimension is among the least developed areas in the existing literature, despite its considerable clinical ramifications. After formal discharge from a healthcare system, parents are expected to undertake a range of complex caregiving activities such as the monitoring of symptoms, the management of medication, and the determination of when to seek professional help. Parents have been described as “mini-nurses” in the home, which indicates an urgent need for the preparation of the healthcare system for the transition from the hospital to the home (Roug et al., 2025; Mensah et al., 2025). However, preparing healthcare systems for the transition from hospital to home, especially the implementation of nurse-led transitional care, is fraught with challenges, including inadequate resources and staffing, varied approaches to discharge teaching, and a complete absence of follow-up care. For these reasons, the lack of continuity should be viewed as a specific nursing outcome resulting from inadequate discharge planning. It requires a range of planned nursing interventions, including preparation for discharge, skill teaching, provision of written learning materials, and post-discharge professional services.

Beyond clinical care, psychosocial and technological factors affect parental involvement. Research suggests that family-based interventions strengthen communication, emotional support, and parental empowerment in the context of childhood cancer treatment (Ayoub et al., 2024; Eklund & Lövgren, 2022; Holm et al., 2024). Coupled with this, technology-based interventions such as digital health, mobile health and virtual health offer parents additional resources to improve knowledge, coping and anxiety (Hélie et al., 2025; Ozdemir, Koyu & Törüner, 2023; Ozturk & Katikol, 2024). Importantly, technology should complement therapeutic nursing relationships. When used in conjunction with nursing presence, digital tools can strengthen a nurse's role as an educator, interpreter, and professional reassurer.

This review demonstrates the need to consider social and cultural factors in developing strategies to promote parental engagement. Language obstacles, inadequate health literacy, and inequitable access to information and care may inhibit the ability of some parents to understand health information, engage in health decision-making, and participate in post-discharge care (Aristizabal et al., 2023; Ochoa et al., 2021). In addition, the lack of representation of fathers and families from diverse cultures in the majority of research indicates that existing models of parental engagement do not meet the needs of all caregivers. As a result, the next nursing interventions must include communication, use of interpreters, and stepwise education according to family needs and nursing resources.

This review shows that while this research acknowledges nurses' essential role in promoting parental participation in care, evidence is predominantly multidisciplinary rather than nurse-specific. This gap requires research that investigates direct nursing actions and measures their effects on parental engagement. Future research should look at particular nursing models that link targeted actions such as assessing parents' understanding and providing structured discharge education and training on symptom monitoring, as well as post-discharge visits, and the expected changes on the engagement and integration continuum, as well as on the participation and confidence dimensions (Nogéus et al., 2023; Zaben et al., 2025). Building this evidence will help develop parental participation as an evidence-based element of pediatric oncology nursing.

CONCLUSION

Parental involvement in the care of children with cancer is a multidimensional process supported by the role of nurses through education, therapeutic communication, psychosocial support, family empowerment, and facilitation of the transition of care from hospital to home. Parental care of children with cancer requires understanding, confidence, participation and continuity of parental care as scoping reviews have shown. This justifies the need for more research on the impact of nursing models that focus on enhancing parental role, as well as tracking changes in level of parental involvement through childhood cancer, and also to develop measures into tools that can objectively measure such parental involvement in caring for children with cancer.

LIMITATIONS

This review has some limitations. First, as a literature review, it is designed to map the concepts and patterns of evidence rather than estimate comparative effectiveness. Therefore, conclusions should be interpreted as an analytical synthesis rather than causal evidence. Second, the evidence base is dominated by qualitative studies and a single site, which enriches understanding of parents' and clinicians' experiences but limits the certainty of practice recommendations. Third, direct nurse-specific evidence is less common than multidisciplinary or implicit evidence of nursing, so some conclusions should focus more on nursing pathways than on isolated nurse-led interventions.

The process of article selection and data mapping was carried out by the first author without independent review by the second reviewer. This situation can increase the risk of bias in determining article eligibility and in interpreting data. To reduce this risk, the selection process used predetermined inclusion and exclusion criteria, and the data were mapped using a structured form.

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