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Abbreviations used in this issue

COPD = chronic obstructive pulmonary disease
FEV₁ = forced expiratory volume in 1 second
QoL = quality of life
RCT = randomised controlled trial
TBI = traumatic brain injury

Welcome to issue 75 of Rehabilitation Research Review.

According to the findings of a systematic review and meta-analysis, initiating pulmonary rehabilitation within 2 weeks post-discharge in patients hospitalised with acute exacerbation of COPD is most effective for reducing readmissions, alleviating dyspnoea, and enhancing quality of life, while initiating such therapy after 48 hours of admission provides greater benefits for improving exercise capacity. These findings emphasise the need for a tailored approach to rehabilitation delivery in this patient group. A Canadian qualitative descriptive study exploring healthcare providers' perceptions of implementing the patient-led Bedside Exercises for hospital FITness (BE-FIT) programme highlighted that for its successful implementation, operational barriers, such as time constraints, resource limitations, and resistance from some patients and staff need to be addressed. An integrated review undertaken in New Zealand examining physiotherapy interventions for school-aged non-ambulatory children with cerebral palsy and intellectual disabilities, identified power wheelchair training as having significant beneficial effects across all aspects of health. I hope that you find the information in this issue useful in your practice and I welcome your comments and feedback.

Kind regards,

Professor Nicola Kayes

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The timing of the commencement of pulmonary rehabilitation in hospitalized patients with acute exacerbation of COPD: A systematic review and network meta-analysis

Authors: Jia P et al.

Summary: With an aim of providing evidence-based recommendations, this systematic review and network meta-analysis evaluated the therapeutic effects of initiating pulmonary rehabilitation at different time points after hospitalisation for acute COPD exacerbation. Twenty-six RCTs involving a total of 1800 patients were included. According to network meta-analysis, pulmonary rehabilitation delivered within 2 weeks of discharge significantly reduced re-hospitalisation. Furthermore, compared with usual care, pulmonary rehabilitation delivered in this timeframe was effective at alleviating dyspnoea (modified Medical Research Council scale) and improving St. George's Respiratory Questionnaire health-related quality of life score (secondary outcomes). When pulmonary rehabilitation was delivered after 48 hours of hospital admission, it was significantly more effective than usual care at improving exercise capacity (Six-Minute Walk Test). No significant differences were observed across timings of pulmonary rehabilitation for dyspnoea (modified Borg scale), mortality, or predicted percent FEV₁.

Comment: This review provides a strong example of how existing evidence can be synthesised to address practical implementation questions – here, the optimal timing of pulmonary rehabilitation following acute COPD exacerbation. Importantly, the findings resist simple interpretation: no single initiation point emerged as universally superior, with benefits varying by outcome. Rehabilitation within two weeks of discharge appeared most effective for reducing readmissions and improving health-related quality of life, whereas initiation after 48 hours of admission better supported gains in exercise capacity. Rather than viewing these findings as conflicting, they point to a more nuanced “and/and” interpretation. As the authors suggest, different outcomes are likely driven by distinct mechanisms – exercise capacity by early inactivity, and readmissions or quality of life by post-discharge behaviours and supports. This invites a more tailored approach to rehabilitation delivery. Given the multi-component nature of pulmonary rehabilitation, I also wondered if there may be value in staging its elements. For example, initiating exercise training early during admission, followed by a stronger emphasis on education and self-management support after discharge. Such an approach could better capitalise on the strengths of each time window to optimise outcomes.

Reference: *BMC Med.* 2026;24(1):260

[Abstract](#)



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Telerehabilitation for pain, function, and quality of life in patients with cancer: A systematic review

Authors: Ordoñez-Mora LT et al.

Summary: This systematic review included 11 RCTs and two non-randomised comparative studies undertaken between January 2010 and September 2025 evaluating telerehabilitation in adults with cancer. Cancers included breast, lung and oesophageal cancers, and haematologic malignancies, gliomas, and mixed cohorts. Three main categories of telerehabilitation delivery were identified: supervised synchronous exercise via videoconferencing; telephone-based counselling; and web- or app-based programmes incorporating remote monitoring. Overall, telerehabilitation was found to consistently demonstrate improvements in physical function (e.g., muscular strength, walking capacity, and peak VO₂) and to reduce fatigue. Across studies, outcomes related to health-related quality of life were mixed and effects on pain were modest and heterogeneous. Supervised synchronous interventions were associated with the most pronounced benefits, while asynchronous or maintenance models exhibited diminished effects, suggesting a lower likelihood of achieving functional improvement. Therapy adherence ranged from moderate to high.

Comment: This review adds to a growing body of evidence that telerehabilitation can deliver meaningful rehabilitation outcomes — here, for people with cancer. The strongest effects were observed in supervised, synchronous exercise interventions, particularly for improvements in physical function and reductions in fatigue. Importantly, the review goes beyond effectiveness to provide detail on intervention characteristics — including frequency, duration, and intensity — helping to clarify what constitutes effective practice. These findings carry important implications for Aotearoa New Zealand, where access to cancer rehabilitation remains limited, and where telerehabilitation may offer a pragmatic pathway to extend access and reach. Overall, however, I found myself reflecting more on the broader state of the evidence base than on this review specifically. While there is clear value in continuing to establish effectiveness, I can't help but wonder if further replication of efficacy studies risks diminishing returns — particularly when persistent questions around uptake and implementation remain unresolved. There also remains a tendency to position telerehabilitation as an alternative to in-person care, functioning as a parallel or lesser substitute, rather than embracing it as a complementary, flexible component that can be integrated into care models to meet people where they are.

Reference: *Oncol Ther.* 2026;Apr 8 [Epub ahead of print]
[Abstract](#)

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A mixed method evaluation of behaviour change techniques in iSelf-help: A co-designed online group pain management programme in Aotearoa New Zealand

Authors: Devan H et al.

Summary: These New Zealand authors evaluated iSelf-help, a 12-week online group-based multidisciplinary pain management programme. iSelf-help was co-designed with people living with persistent pain and included cultural considerations for Māori. Using mixed-methods analysis, the content of 13 iSelf-help modules was mapped using the Behaviour Change Technique (BCT) Taxonomy and participant experiences (n = 15) identified using qualitative deductive analysis. Participant experiences were then coded to map them to the taxonomy. Overall, 130 resources were independently mapped by three reviewers to distinct BCTs and their frequencies were calculated by consensus. A total of 46 BCTs were identified in the iSelf-help content. From a total of seven BCT clusters, Natural consequences (#5) and Repetition and substitution (#8) were the most frequent. An alignment between content and qualitative mapping was observed in Goals and planning (#1), Shaping knowledge (#4), Repetition and substitution (#8), Comparison of outcomes (#9), and Identity (#13). The authors suggest that the identified BCT clusters could be key targets for future online group-based pain management programmes.

Comment: First, if you have not read the other papers from this programme of work, I would strongly encourage you to do so. I have reviewed several papers from this group over the past year (Rehabilitation Research Review Issues 70 and 71) – they are excellent and well worth your time. This paper usefully takes a deeper look at a specific component of the iSelf-help intervention – namely, the use of BCT. Reading this paper prompted several reflections. I suspect many rehabilitation professionals will recognise the techniques described and are likely already using them in routine practice, even if they do not explicitly label them as BCTs. This is encouraging, as it highlights a strong existing foundation and familiarity with these important behavioural strategies. However, it is important to recognise that different techniques serve different purposes; more is not necessarily better. Rather, effectiveness depends on being purposeful and intentional in selecting and applying techniques. As such, while understanding which techniques are used and how they are experienced is valuable, an important next step is determining which techniques are most effective, for whom, and under what circumstances.

Reference: *J Pain* 2026;43:106280

[Abstract](#)

Healthcare providers' perception of implementing the Bedside Exercises for hospital Fitness (BE-FIT) patient-led rehabilitation program for older patients: A qualitative descriptive study

Authors: Murad-Kassam S et al.

Summary: The Bedside Exercises for hospital FITness (BE-FIT) programme is a patient-led rehabilitation initiative that positions patients as active participants in performing exercises after surgery, rather than relying on healthcare providers to carry out the exercises with them. This Canadian qualitative descriptive study evaluated healthcare providers' experiences and perceptions of delivery of the BE-FIT programme to older post-operative patients in acute care surgical units and aimed to identify strategies to improve programme acceptance and sustainability. A total of 14 healthcare providers underwent semi-structured interviews and data were analysed using an inductive content analysis approach. Overall, three themes were identified: (1) barriers for the implementation of the BE-FIT programme; (2) facilitators for the implementation of the BE-FIT programme; and (3) recommendations to enhance BE-FIT exercise uptake. The programme's value in promoting early post-operative mobilisation for older patients was recognised by participants, as well as its flexibility, simplicity, and patient-centred approach. Operational barriers and patient resistance to mobilisation were identified as factors affecting implementation in clinical practice. Interdisciplinary engagement, integration into routine clinical workflows, family involvement, and leveraging technology were identified as important areas for focus.

Comment: This study provides a timely contribution to ongoing efforts to enhance early mobilisation in acute care, a challenge that is widely recognised across health systems. While the theme labels themselves offer limited insight, the findings beneath them reinforce familiar yet important realities about implementation in busy clinical environments. Notably, although BE-FIT is framed as a patient-led initiative, its success remains heavily dependent on healthcare providers to educate, motivate, and reassure patients – particularly those who are fearful or uncertain about post-operative movement. This raises important questions about how "patient-led" such interventions can realistically be without sufficient workforce capability and confidence. The study also highlights a common implementation paradox: while designated champions can drive initial uptake, over-reliance on them risks diffusing responsibility, undermining long-term sustainability. Equally compelling is the participants' reflection on the cumulative burden of "one more thing." Even seemingly small additions can become untenable when layered onto already stretched workflows, particularly in the absence of de-implementation of existing practices. Overall, these findings emphasise that successful mobilisation initiatives require not only thoughtful design, but also integration into routine care, shared ownership across teams, and realistic consideration of workload pressures.

Reference: *Clin Interv Aging* 2026;21:566353

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The road to a new normal – A qualitative study on relatives' needs and roles in amputation rehabilitation

Authors: Støvring KR et al.

Summary: This qualitative study from Denmark explored the roles, experiences and support needs of 33 relatives during the early post-amputation period (0-2 years) of individuals who had undergone major lower extremity amputation. Focus group interviews and a research-driven photo elicitation approach were undertaken, and data analysed using reflexive thematic analysis to identify patterns and themes related to relatives' roles and needs. One overarching theme emerged – the road to a new normal, described relatives' adaptive processes following amputation – and three subthemes were identified: (1) a gradual realisation of the long-term emotional and practical consequences of amputation; (2) challenges in supporting patients' emotional reactions, including grief and altered identity; and (3) shifting relationship dynamics, where relatives assumed caregiving roles while striving to maintain their original relational identity. A shared 'we-perspective', emphasising joint adaptation and coping was adopted by many of the relatives.

Comment: This study offers a valuable reminder that amputation is not solely an individual medical event, but a relational and social experience. The notion of a shared "we-perspective" is particularly striking, highlighting how relatives undergo parallel processes of adjustment that are often invisible within biomedical models of care. While clinical services tend to prioritise the patient, these findings underscore the need to recognise family members as active participants in recovery who require preparation and support in their own right. The relatives' desire to be reassured that "things would get better" raises important questions about timing and receptivity. Such messages may be difficult to hear amidst the immediate crisis, yet they point to an unmet need for hope-oriented communication that evolves over time. Equally compelling is the cumulative burden described – relocation due to inaccessible housing, financial strain, and caregiving demands – each a significant stressor alone but profoundly challenging in combination. Finally, the dual task of managing a loved one's grief and identity shifts while navigating their own emotional responses illustrates the complexity of adaptation. Supporting this "road to a new normal" requires more holistic, family-centred approaches that acknowledge both shared and individual needs.

Reference: *Clin Rehabil.* 2026;Mar 24 [Epub ahead of print]

[Abstract](#)

Defining return-to-learn through an evidence-based systematic review

Authors: Bevilacqua ZW et al.

Summary: This systematic review aimed to report the various operational definitions of return-to-learn (RTL), return-to-school, return-to-class, and return-to-academics found within the literature and to propose evidence-based definitions for RTL following concussion in students. A total of 24 studies identified from a search of PubMed and ScienceDirect between January 2010 and January 2023 met inclusion criteria. Across the studies, the following five recovery criteria were identified: (1) guided protocols; (2) clinician determinations/clearance; (3) school attendance and days missed; (4) resumption of full academic workload; and (5) full-time without accommodations. Three researcher extracted definitions of RTL from the included literature and unanimously agreed upon definitions for college/universities and for middle and high schools. The proposed definition of RTL for college/universities is when the following criteria are met: (1) resolution of injury-associated symptoms, with and without academic engagement; (2) resume pre-injury usage of accommodations; (3) full academic participation – attend all registered courses, once minimum, attendance for the full time; (4) cognitive functioning is stable and consistent with pre-injury baseline. The proposed definition of RTL for middle and high schools when the following criteria are met: (1) tolerates full academic demands without recurrence or worsening of injury-associated symptoms; (2) has returned to their typical school schedule and workload, including extracurricular academic activities if applicable; (3) no longer requires modified cognitive activity levels or informal classroom supports; (4) demonstrates stable cognitive functioning consistent with their pre-injury baseline.

Comment: This review makes visible the conceptual inconsistency that has characterised the RTL literature. The use of multiple, overlapping definitions creates significant challenges for both concussion research and practice. It limits comparability across studies and makes synthesis of evidence challenging. From a clinical perspective, this variability may contribute to inconsistent or suboptimal management, including either premature return or unnecessarily prolonged restriction. The proposed definitions are a useful step toward greater conceptual clarity. However, challenges remain in translating these definitions into practice. Many components are difficult to operationalise and may not be readily measurable in real-world settings. The definitions also span a wide developmental range, where expectations, supports, and cognitive demands differ substantially. Finally, they rest on the assumption that return to a pre-injury baseline is achievable – an assumption that may not hold true for all. Overall, the definitions offer valuable conceptual clarity that may aid interpretation of the evidence. In practice, they provide a useful heuristic device, but should be applied flexibly and in the context of the individual and their environment.

Reference: *Front Neurol.* 2026;17:1772377

[Abstract](#)

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INDEPENDENT COMMENTARY BY

Professor Nicola Kayes

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Effect of early physical therapy initiation and adherence on functional outcomes after arthroscopic rotator cuff repair: A prospective observational cohort study

Authors: Raizah A et al.

Summary: This prospective observational cohort study investigated the independent and combined effects of early physical therapy initiation and adherence on functional recovery in 160 patients undergoing arthroscopic rotator cuff repair. Patients were categorised into early (≤ 14 days) and delayed (> 14 days) physical therapy groups. Multivariate regression analysis found that early physical therapy initiation and higher adherence were independently associated with significantly ($p \leq 0.005$) improved functional outcomes, including lower Shoulder Pain and Disability Index and Disabilities of the Arm, Shoulder and Hand (DASH) scores, reduced pain, and greater range of motion at 3-6 months. Adherence to physical therapy was found to be the strongest predictor of DASH score ($\beta = -0.34, p < 0.001$) and patients receiving early physical therapy demonstrated higher adherence levels and better functional independence. Older age and larger tear size were associated with poorer outcomes upon sub-group analysis, with a significant interaction effect observed.

Comment: This study offers useful insight into the relationship between timing, engagement, and functional recovery following rotator cuff repair, but its observational design warrants careful interpretation. As patients were not randomised, the decision to commence early versus delayed physical therapy was likely influenced by underlying patient and clinical factors. The observed baseline differences – such as higher pre-injury activity levels and lower initial disability in the early therapy group – suggest that those receiving earlier intervention may already have been predisposed to better outcomes. The finding that both earlier initiation and greater “adherence” were independently associated with improved outcomes is nonetheless compelling. However, I would invite a more critical unpacking of what “adherence” represents. Rather than a simple measure of compliance, it may be more meaningful to conceptualise this as engagement – encompassing motivation, confidence, therapeutic alliance, and the ability to integrate rehabilitation into daily life. These results suggest that while timing matters, how we create the context for meaningful engagement in rehabilitation may be even more important for optimising recovery trajectories.

Reference: *Front Med (Lausanne) 2026;13:1743180*

[Abstract](#)

Physiotherapy interventions for school-aged non-ambulatory children with cerebral palsy combined with intellectual disability – An integrative review

Authors: Adams K et al.

Summary: This study examined the available literature on physiotherapy interventions for school-aged non-ambulatory children with cerebral palsy and intellectual disabilities (NACCPID) to inform clinical practice and identify areas for future research within the Aotearoa New Zealand context. A systematic search undertaken in 2023 identified 24 studies meeting inclusion criteria. Coding and thematic analysis were conducted in NVivo 12 and final codes were organised within the Te Whare Tapa Whā framework through collaborative review with a cultural advisor. Overall, the following 10 themes relating to physiotherapy interventions for NACCPID emerged: (1) individual needs; (2) self-esteem and positive emotions; (3) body systems; (4) optimising ability to move the body; (5) using the body to perform a task; (6) collaboration; (7) (in)dependence; (8) participation and inclusion; (9) resourcing; and (10) accessible environments. Of note, power wheelchair training was identified as having significant beneficial effects across all aspects of health and the importance of consideration of the child and families' individual needs, wants, likes, circumstances, and values when choosing an intervention were highlighted.

Comment: I really enjoyed reading this paper. It provides a strong example of how evidence can be meaningfully synthesised with an Aotearoa New Zealand cultural context in mind, even when much of the available research has been conducted internationally. The use of Te Whare Tapa Whā as a framework for evidence synthesis was particularly valuable. I especially appreciated the inclusion of taha whenua, reflecting the importance of context and environment in shaping rehabilitation experiences and outcomes. Similarly, the use of an integrative review approach, drawing on literature from diverse paradigms, enables a more nuanced and holistic consideration of the evidence base. There is a great deal to take in and neither the above summary nor my commentary can fully do justice to the richness of the content. As such, I would strongly encourage reading the paper in full if this is an area of interest. One aspect that stood out to me – made particularly visible through the application of Te Whare Tapa Whā – was the continued dominance of a biomedical orientation in the evidence base, with most research focused on taha tinana (physical outcomes). In contrast, evidence relating to taha wairua (spiritual wellbeing) and taha hinengaro (mental and emotional wellbeing) was limited. While I have not personally undertaken research with children with cerebral palsy, research I have undertaken suggests this imbalance reflects not only the research literature, but also what is prioritised in practice. This paper helps to make visible what is left behind, with important implications for culturally safe and holistic care.

Reference: *N Z J Physiother. 2026;54(1):65-94*
[Abstract](#)

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Mapping the interplay between postconcussion symptoms and functional disability after mild traumatic brain injury: A network analysis across treatment care settings

Authors: Faulkner JW et al.

Summary: This international study investigated the network structure of post-concussion symptoms (PCS) and functional disability in adults with mild traumatic brain injury (TBI) managed in primary care (n = 503) versus specialised outpatient mild TBI clinics (n = 555). Analysis revealed that across both primary care and specialist outpatient settings, frustration and cognitive symptoms (thinking speed and concentration) were the most central PCS nodes, and within the functional disability network, household responsibilities showed the highest centrality. Estimations of combined PCS-disability networks and calculations of bridge expected influence revealed that mood disturbance and slowed thinking speed (PCS), and emotional impact and concentration difficulties (functional disability) were key bridge nodes. The primary care group exhibited higher bridge connectivity, with emotional impact and concentration difficulties showing significantly stronger bridging.

Comment: This paper hurts my brain – in a good way! I recall reviewing another paper from this team that drew on network analysis some time ago, and I admit I'm still getting my head around it. The more I read, the more I appreciate its potential. The authors make a strong case for the need for more nuanced understandings of recovery. They highlight how existing models tend to be overly broad, grouping many factors together without clearly explaining how they interact. As a result, they often fail to identify which factors matter most, in which contexts, and tend to rely on assumptions of simple, linear cause-and-effect relationships. The analysis presented here helps to identify which symptoms have the greatest influence on outcomes (i.e., are more central), as well as those that may act as pathways through which difficulties in one domain (in this case, post-concussion symptoms) spread into other areas (such as functional disability). Importantly, both central and bridging symptoms may represent key targets for intervention. Interestingly, while there is still more to unpack, the analysis begins to explore how relationships between symptoms and function may differ across treatment settings and stages of recovery. While papers like this can be challenging to get one's head around, their findings have the potential for high practical utility, as they better reflect the nuanced reality of a complex recovery process. In short, they are worth persevering with. Watch this space for more research from this group.

Reference: *J Head Trauma Rehabil.* 2026;Apr 3 [Epub ahead of print]

[Abstract](#)

Child and family centred care: A three-phased principle-based concept analysis

Authors: Zgambo M et al., on behalf of the International Network for Child and Family Centred Care

Summary: These authors recognise that despite a growing multidisciplinary interest in the Child and Family-Centred Care approach, its meaning remains unclear in extant literature. They therefore set out to explore, analyse, describe, and clarify the concept of this approach and its associated terms. A search of CINAHL, PsycINFO, Medline, Scopus, and Web of Science databases from inception to 2023 identified 23 peer-reviewed studies discussing children aged zero to 17 years, healthcare providers, and/or caregivers for inclusion. The three-phased principle-based concept analysis approach was used and data were grouped into epistemological, pragmatic, linguistic, and logical principles. Common terms associated with the concept of a Child and Family-Centred Care approach were primarily collaboration, participation, communication, and respect/dignity.

Comment: I was struck by the extent to which this work reflects a broader pattern in the literature: the repeated development of new models and frameworks, often using different terminology to describe what is, at its core, person-centred practice. While these frameworks share common values, they are often positioned as distinct from one another. There is a risk that this proliferation of terms and models inadvertently fragments the field and, in doing so, may dilute or undermine the legitimacy of the underlying principles of person-centred care. That said, there is value in explicitly examining the distinct characteristics of Child and Family-Centred Care as a specific application of person-centred practice. This is particularly important given the risk that children's own agency and perspectives may be overshadowed if not given explicit consideration. The use of concept analysis is helpful in this regard, as it makes explicit the preconditions (e.g., knowledge and skills, organisational support, practice guidelines), attributes (e.g., collaboration, dignity, and respect), and consequences (e.g., physical, psychosocial, and social outcomes) of the approach, bringing much-needed clarity to what enables it, how it can be enacted in practice, and what constitutes a meaningful outcome.

Reference: *J Adv Nurs.* 2025;81(8):4542-4565

[Abstract](#)

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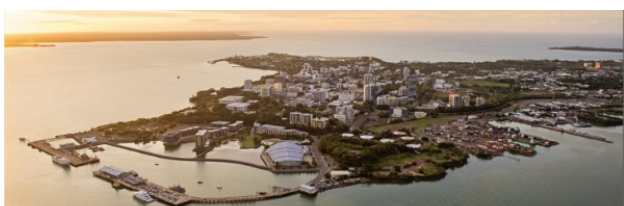
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