

Original Article

Exploring Paediatric Nurses' Experiences on Application of Four Core Concepts of Family Centred Nursing Care in Malawi: Findings from a Resource Limited Paediatric Setting

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Abstract

Background: The traditional model of care places emphasis on restricting patients and families while family-centered model emphasises on strengths that patients and families bring to the healing process. It is evident that for effective family involvement, there is need for a mutual partnership between nurses and families. Nurses need to respect the patient and family members, share unbiased information and collaborate with the families in accordance with the set policies and guidelines. In a resource limited setting like Malawi with a high nurse-patient ratio, one would assume that family centred care is a challenge. This has not been illuminated before and the way nurses involve parents in accordance with the four concepts of FCC is not clear in Malawi.

Objective: The objective of the study was to explore registered nurses' experiences in applying the core concepts of family centred care when involving families in the care of hospitalised children at a tertiary hospital in Southern Malawi.

Methods: A descriptive qualitative design using semi structured interview guide was used. 14 full time registered nurses participated, and data were analysed using qualitative content analysis.

Results: The findings showed that nurses were able to apply these core concepts in daily practice. Six themes emerged: Power and control, respect and dignity, information sharing and communication, family participation in care, Collaboration and partnership and Nurses impression family involvement.

Conclusion: Registered nurses are knowledgeable and apply the four concepts of family centred care. However, the true application of core concepts of family centered care is constrained by lack of resources and absence of policy. These findings have implications for nursing management and research.

Key words: Respect and dignity, collaboration, power, control, hospitalised children, inconsistent, registered nurses

Introduction and background

Family involvement is an approach in family centred care which entails that care is planned around the whole family and the family is part of caring team (Harrison, 2011). It is known that hospitalization of a child is stressful and families of hospitalised children have multiple needs when in the hospital (Coyne & Cowley, 2007).

Nurses are best placed to meet the needs when caring for hospitalised children and their families (Noyes, 2011). In developing countries like Malawi, studies have mainly focused on perceptions and experiences of the parents and families during the care of the admitted children (Phiri, Kafulafula, & Chorwe-Sungani, 2017).

Literature on studies on how nurses involve families in childcare in the country's health facilities is hard to find. The positive contribution of family involvement is that it is associated with quality of children's care (Kuo, Bird, & Tilford, 2011). Family involvement is also related to increase in participant satisfaction (Maria, Pandey, Hans, Verma, & Sherwani, 2017). However, it is evident that negative or difficult situations related to the involvement of families in the care of their sick child in critical care units from the perspective of nurses exist (Dennis, Baxter, Ploeg, & Blatz, 2017).

Assumptions exist that most registered nurses involve families in care of their children. However, their actions are not evident (Abraham & Moretz, 2012). The extent to which registered nurses involve families depends on the nurses' experiences, time and willingness to act and the prevailing situation in the hospital (Pongjaturawit & Harrigan, 2003). This implies that these nurses' ability to apply concepts of FCC and experiences need to be explored.

For family involvement to be effective, nurses and families need to share unbiased and timely information (Sodomka, 2006). However, the researcher's observations at a tertiary hospital in Malawi showed that guardians of hospitalised children knew little about their children's treatment plans. This observation agrees with that of Stanley et al. (2017) who reported that guardians of children knew little about treatment of their

patients in Malawi. This may imply that communication, collaboration and family participation challenges exist. Inadequate interpersonal and communication skills affect good collaboration and communication between nurses and families (Söderbäck & Christensson, 2007).

Registered nurses take a leading role both on planning and provision of care to children and their families in Malawi and their willingness, experiences and commitment when working with families is paramount.

However, nurses' willingness and motivation to act influences the degree of family involvement (Espezel & Canam, 2003). Evidence from elsewhere in the world shows that nurses' experiences about interventions with families of sick children are key factors in the way care is delivered.

Studies on nurses' application of the core concepts of FCC in family involvement in the care of hospitalized children in Malawi are not well documented.

Significance of this research

The importance of this study is underpinned in its findings in that it will influence policy makers to formulate policies and guidelines on family involvement in child health care in Malawi.

These findings may provide knowledge and understanding that can guide the implementation of family involvement in care of hospitalised children. In research the study findings may serve as a basis for future research.

Materials and methods

Objective of the study

The objective of this study was to describe registered nurses' application of the core concepts of family centred care when involving families of hospitalised children in the care of hospitalized children in Malawi.

The research design

A descriptive qualitative approach was employed (Noyes, Jane, 2010). The study was conducted in the paediatric wards at a tertiary and largest referral hospital in Malawi. This study was done between August 2014 and September 2015. The setting was chosen because it is a hospital for

critically ill children from all over Malawi and family members are involved in the care of their sick children.

Study population

The target population included all 19 registered nurses in paediatric wards. Purposive sampling was used to recruit participants. Participants were selected because they were knowledgeable and had experienced (McHugh & Lake, 2010).

Initially, a sample size of 10 nurses was suggested. However, fourteen registered nurses from all paediatric wards were interviewed based on data saturation (Noyes, 2010).

The following was the inclusion criteria: Agreeing to participate in the study, being a registered nurse working fulltime in the paediatric unit and having one year working experience in paediatric wards at the hospital

Data collection methods

Data collection tool was developed based on the Institute of Patient and Family Centred Care Framework (Johnson, 2009) and objectives of this study.

The philosophical underpinnings of the framework view the expertise of families as critical in care delivery (Johnson, 2000).

Qualitative data were collected in August 2014. In-depth interviews were conducted and data were collected from 14 participants focusing on how nurses engaged patients and their families based on dignity and respect, information sharing, family participation in care planning and collaboration.

Each interview session was audio-recorded and lasted 45 minutes to 60 minutes.

Data analysis

Demographic data were analysed using descriptive statistics. The researcher utilized Qualitative Content Analysis (QCA) to interpret variations through identifying differences and similarities in content, which are expressed as categories,

subthemes and themes at various levels of abstraction. Five steps of QCA(Graneheim, Lindgren, & Lundman, 2017) were followed from transcription of raw data, condensation of data, grouping of data into codes, creating categories and development of themes.

Trustworthiness

In this study, trustworthiness was achieved by adhering to credibility, dependability, confirmability and transferability standards. This methodology was followed during recruitment and data collection, analysis and presentation of findings.

Information was collected from nurses who were experienced and knowledgeable about family involvement. The researcher pretested the questionnaire before the main study. Field notes were also used to complement qualitative information.

Ethical considerations

The researcher got approval from College of Medicine Research and Ethics Committee and institutional clearance from the Director and Head of Department of Paediatric Section as per protocol.

Participants signed a written informed consent prior to participation in the study. The information letter contained information on the purpose, benefits, and risks of the study.

All the principles of human subject research and ethics as stipulated by World Medical Association (Williams, 2006) were followed.

Results

Demographic characteristics of the participants

Fourteen participants who were full time practicing registered nurses the paediatric section participated in this study. 85% had a first degree in nursing (Table 1). The work experience of participants ranged from one year three months to five years ten months.

Table 1: Demographic characteristics of participants

Characteristic	<i>n</i>	% (<i>n/N</i>)
Age in Years		
20-24	3	21.43
25-29	6	42.87
30-34	4	28.60
35-39	0	00.00
40-44	0	00.00
45-50	1	07.10
Above 50	0	00.00
Total	14	100.00
Gender		
Male	2	14.30
Female	12	85.70
Total	14	100.00
Level of Education		
Diploma RN	2	14.20
BSc RN	12	85.80
MSc RN	0	00.00
Total	14	100.00
Nursing Specialty		
General Nursing	7	50.00
Nursing & Midwifery	5	35.80
Critical Care	1	7.10
Child Health Nursing	1	7.10
Total	14	100.00
Paediatric Nursing Experience		
Less than 2 years	9	64.30
2 to 5 years	3	21.40
5 years and above	2	14.30
Total	14	100.00
Religion		
Christian	12	85.70
Muslim	2	14.30
Total	14	100.00

Content analysis

The Qualitative Content Analysis resulted in six themes: Power and control, respect and dignity, information sharing and communication, family participation in care, collaboration and partnership and nurses' impression family involvement.

Power and control

Majority of participants ($n=8$) reported that they controlled amount of caregivers' participation and did not involve family members in care planning but in involved them delivery or implementation of care as most of them did not understand the planning process.

To say the truth, we don't plan the care with families in this ward... We just come and deliver the care especially when the child is very serious... We just tell them that we are doing this and this but do not incorporate them to make decisions on the care that we want to give to the child... Mostly we just impose on them what they should do... We don't involve them in planning... We tell them we are going to do this and this (Participant 6).

Respect and dignity

To demonstrate respect, first we try develop an understanding between us and them whereby we tell them what is going to happen in the hospital, our roles and responsibilities and our expectation from them, our limits and we also inform them that they have the right to choose, refuse or accept health care which they feel does not meet their choices and also the effects and in such circumstances, if this situation arises we counsel them and provide adequate information so they can make the right choices or consent to go ahead with their choice just to show that we don't work on our own in the hospital (Participant 5).

Few participants ($n=3$) reported that sometimes they knew that the family choices were detrimental, however, they discussed and consulted with members of the multidisciplinary team and family members but family members insisted on holding their choices. The participants still honored such choices to show respect to the families. One participant said

I would give an example of religious beliefs when one client and other people refuse blood transfusion, I first explained to them to make them understand why it is important for the patient to get that particular medical care before I start arguing with them but they insisted I respected their belief whilst letting them know that I have done my part on why it was important to provide that kind of care...so if the child dies it's up to them (Participant 11).

Information sharing

All the participants reported that they communicated verbally on one to one basis. Participant 2 said that:

We tell them about their condition. We basically explain to them verbally as said earlier. Upon arrival we tell them about their condition...of course there also posters on the wall for those who can read...they are in English and Chichewa. For patients we communicate in Chichewa when they come. We do both group and individual communication... We also inform them on procedure say blood sample collection, transfusion etc...We don't have disease specific leaflets which we give to patients because we cannot manage- stationary problems in the hospital.

All participants ($n=14$) mentioned that feedback was given verbally. One Participant narrated that:

The feedback goes in two ways; feedback from us nurses and feedback from them as parents or children. So feedback goes in two ways. There are things which they tell you like they may think their child is improving yet he is not improving and you exchange ideas and come up with a conclusion on the matter...We do not have specific times, sometimes we do meet them during ward round and sometime during medications or they can come any time in short.

Family participation in care

This theme had four subthemes namely, care planning and delivery, tasks and roles, role preparation and negotiation and nurses support

Care planning and delivery

Some participants ($n=7$) indicated that they involved families from planning, delivery and evaluation of care and discharge. They said involving family members in care assisted in reducing workload as shortage was real and also improved understanding between family members and nurses. Participant 12 said

I first explain to them, teach them and give a try. Considering the state of our hospitals, there are shortages...that is real. So I teach so that they can help me...e.g. I talked about emptying of urine bags, tepid sponging and feeding...they help me and that is one way of incorporating them in the care. I just tell them to inform me when there is a problem or there is need to record urine. Yes. I do involve them in both planning and delivery of care and even evaluation.

Ironically, few participants ($n=3$) who said they did not involve family members in care also reported that it was good to involve them. One participant said:

No we do not usually involve them in evaluation as well...It is really important because if you involve them during planning it helps them to cooperate during evaluation and care delivery...It would help us to work better with them (Participant 8).

Role negotiation and preparation

Majority of participants ($n=9$) identified their core function in family involvement as role preparation and negotiation with the families. Participant 14 said that:

I have to plan what care to give to each child and then isolate those that the family member can assist me during that time...So then I come to discuss with them that this is what we are going to do and this is what I feel you can do such as bathing, nasogastric tube feeding, turning or positioning the child. So we discuss and ask them if they are comfortable to go ahead with the care or not... Then you start preparing them for that task.

Tasks and roles

All the participants reported that family members assisted in the following tasks: tepid sponging, bed making and bed bathing, giving oral medications, oral or nasogastric tube feeding were commonly reported by all participants.

Collaboration

Participants reported that collaboration involved working with families. Participant 1 said

In collaboration with the patients, its communication between you two people. You need to be respectful, be free with them. In that way you will be able to collaborate and partner with each other but if you bring in the negative attitudes and the like, it means it won't work...You want see them work with you....We basically check on them on what they can or have managed to do...those that have difficulties we come in and teach them.

Nurses support

Most participants ($n=11$) reported that they provided support to family members. Participant 2 said:

After counseling and telling them what we have done to the patient together encouraged them to go ahead doing what we taught them and to keep caring for the child. There was a child with nephritic syndrome and the parents were so worried, the condition was deteriorating and the parents almost just gave up. We told them that we are there for them...They continued doing the tasks as we agreed and they developed courage to care for the patient.

Registered nurses' impressions of family involvement

Participants reported that family involvement was both a good and bad idea. Six participants felt it was a good idea because it would improve quality of care but must be regulated. One participant said;

"Family involvement is good but sometimes I feel bad that the work that I could do is done by the family members" (Participant 2).

Discussion

This study showed that most registered nurses allowed family members to participate but controlled the amount of family involvement in the care of hospitalized children. Studies indicate that nurses control the degree of family involvement in

care because they believed that they are experts in care and want to control nurses' identity (Paliadelis, Cruickshank, Wainohu, Winskill, & Stevens, 2005). These preconceptions may explain why some nurses in this study relegated family members to domestic tasks instead of taking part in some nursing roles. The narrative has been shown that nurses viewed respect and dignity important aspect in family involvement. Some respected families choices and culture. Previous studies reported that problems exist on the manner in which nurses show respect to family's choices and their cultural instigma (Neves et al., 2015). The findings of this study imply that some nurses honoured and respected childrens' and families' choices. This allows family members to exercise control over their choices. This presents a mixed picture on how nurses in Malawi deliver family centered care. However, this explains reasons why some nurses indicated that parents were willing and have positive attitudes towards family participation. This concurs with findings of (Uhl, Fisher, Docherty, & Brandon, 2013) who concluded that willingness of parents to participate is dependent on nurses' respect for parents' views. It is believed that nurses who believe that family members are influential and pivotal to the child's care honour and respect family members' perspectives (Madsen, 2009). This may also explain why nurses in this study consulted family members on decisions that they regarded as difficult. According to IPFCC Model, honoring parents and children's perspectives is considered the best attribute (Espe & Sherwindt, 2008). The study showed that nurses value communication and feedback when working with family members. This is consistent with (Pongjaturawit & Harrigan, 2003; Shields & Nixon, 2004) who found that in both western and eastern countries cultures both nurses and family members valued communication. (Söderbäck & Christensson, 2007) reported that communication between nurses and parents was a consistent theme in family participation. Further, some registered nurses negotiated with family members and prepare them before they agree and share tasks. Communication and negotiation are the main interaction strategies in a partnership between nurses and families in the hospital and is a means by which power is shared. (Mikkelsen & Frederiksen, 2011) reported that nurses negotiated and prepared family members to

familiarize and prepare them for their new role in the hospital. Consideration of parents' wishes and abilities while in the hospital is consistent with values of family centred care and IPFCC Model and this makes families' hospital experience meaningful (Fegran & Helseth, 2009). This may explain why findings of this study indicate that some registered nurses involve family members in care. However, this involvement depended on the condition of the child, understanding of the family members and the number of nurses and patients on that day. A growing body of literature stated that nurses involve family members based on seriousness of the condition and resources available (Zaman, 2004). While this finding may imply that some nurses have positive perceptions towards family involvement, their practice was not consistent with the core values of the IPFCC Model. IPFCC model highlighted that health care workers should embrace families and foster collaborative partnerships with families regardless of increase in workload, condition of the sick loved ones or shortage of materials (Johnson, 2009). Despite lack of proper guidelines and policy for family involvement in the care of hospitalised children, family members were involved in giving oral medications, doing tepid sponging and giving feeds through nasogastric tube. These have been reported before (Romaniuk, O'Mara, & Akhtar-Danesh, 2014). Paliadelis et al. (2005) reported that registered nurses indicated that those skilled tasks should be left to them because they are the ones who knew nursing. This is consistent with findings of this study which showed that nurses allowed family members to take on some domestic tasks but controlled the extent to which families could take on nursing activities. The implication is that family members may see their involvement in child care as lip service.

The findings revealed that registered nurses valued family involvement in the care of the hospitalised children. This finding is consistent with western studies which have concluded that although nurses are constrained in many ways, they are proponents of family participation in child care (Harrison, 2010; Shields, 2010). However, it was clear from the participants that they were willing to involve family members but were constrained by resources. Thus, differences in the narrative supporting or against problematic implementation

of family centred care exist, are context specific and should be further clarified. Despite problematic implementation, participants in this study reported that nurses have positive attitude towards family involvement in the care of hospitalised children. This is substantiated by the finding indicated that although family involvement is a good idea, it should be regulated. This is consistent with findings of Coyne (2015) who found that nurses in Ireland felt that guidelines were important to guide family participation in care. This implies that nurses at in the current understood that family involvement is a good practice but had no standard to base its implementation which was a challenge to them.

Implications for nursing management

The study revealed that there was lack of direction on policy. Policies and guidelines act as standards against which current performance is based (Paliadelis et al., 2005). These study findings provide health care managers with an opportunity to come up with innovative strategies through a collaborative effort to develop a policy upon which nurses and families can base their practice and decisions.

Study limitations

Patients or guardians were not interviewed to get an idea of their experiences versus experiences of the nurses as the study only targeted nurses. This could have helped to compare guardians' and nurses' experiences from which solid conclusions would have been drawn. Furthermore, participants may have felt that their own practice or professionalism was being questioned and may not have given honest answers on what happens in real practice. As such the findings of this study may not be fully generalized.

Conclusion

The findings of this study were consistent with those from western countries and show that registered nurses had a positive attitude and propose family involvement. However, challenges still exist in the application of core concepts of family centered care. However, lack of resources is a compounding factor for effective implementation of concepts of FCC.

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