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Research Article

Factors Predicting the Family Centered Care Practice of Community Nurses

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Abstract

Purpose: Family Centered Care practice will direct nurses, especially those working in the community, to become considerably more aware of their roles in dealing with family members appropriate in distinct contexts, valuing diversity, decision-making, and relationships. However, only a few studies provided evidences to confirm the level or factors relating to Family Centered Care practices. The major aim of this study is to determine the factors predicting the Family Centered Care practice of community nurses.

Design: A predictive correlational design.

Methods: The sample included 150 community nurses in Thailand. Data were collected using a questionnaire with Content Validity Index 0.96 and reliability 0.97. Stepwise multiple regressions was used as the method of analysis.

Main findings: Subjects had an overall Family Centered Care practice score at a moderate level. The highest score was in the aspect of achievement goals, specialization, and holistic approach. These nurses had Family Centered Care practice at a moderate level, especially in the domain of care setting practices and policies, community systems of services and support, and family/provider partnerships. Family Centered Care practice could significantly explain 59% of the variability in FCC practice. Family Centered Care practice. The Family Centered Care components which most effectively predict Family Centered Care practice were a proactive approach, holistic approach, and collaboration.

Conclusions and implications: Specific activities which enhance Family Centered Care practice, especially activities relating to family engagement, comprehensive care, and health care team collaboration were the areas that should be given enough concern. Other factors such as perceptions or satisfaction could be given more emphasis on the study in promoting efficient Family Centered Care practice.

Keywords: Family centered care; Community health nurse

Introduction

The illness of family members often causes family imbalances. Roles, responsibilities, image, values, and the space of families could as well be the cause. Uncertainty and unexpected events may emerge to affect family members as a result of illness [1]. Naturally, nurses try to seek appropriate methods for helping family members to perform their roles and functions well on the basis of family strength and interactions. Family Centered Care is an important concept which emphasizes self-reliance and caring among family members. Also, partnerships among families and health care providers are the most important resources for family members. Nursing care practice under F.C.C. therefore emphasized the encouragement of capacity, collaboration, open communication, and sufficient information for families to take effective decision making through acknowledgement and sharing when given adequate choices [2]. F.C.C. practice was composed of 3 parts: 1) partnership between family and the provider; 2) care setting practices and policy support, and 3) community system of services and support. All of these guided the directions in evaluating the effectiveness of how nursing care improve potential of families to incorporate this into strategic planning for their members. In addition, quality of care by health organizations and stakeholders can improve their capability in working with families according to the diversity and the cultural context of communities (Family Voices, 2008: p. iii). Moreover, F.C.C. practice will direct nurses, especially working in the community, to become considerably more aware of their roles in appropriately dealing with family members in distinct contexts, with value diversity, decision-making, and relationships. These values support a feeling of trust and understanding between families and community nurses [3]. In addition, it helps community nurses to achieve their competencies, which can sometimes be difficult to accomplish in real situations on account of the simultaneous complexity and unique nature of the family context. Evidence clearly demonstrates that the F.C.C. concept is appropriate and available for various types of health problems, and for enhancing well-being, especially in families with sick children, through strengthening them to care for their members in a health partnership. Families will be engaged in responding through their members in everyday life, increase functioning communication, taking more action in prevention and protection for their family health, and effectively counseling their members [4] so that the final impact is one of greater family satisfaction with health care. These results were absolutely prompted by nursing care based on competencies which was able to generate valuable relationships, develop family capabilities, encourage family participation, help to improve communication, and provide expertise to favor information and support the decision-making of family members [5]. F.C.C. practice in the community context is both accountable and more challenging in integrating with continuing care due to the need for awareness of the family

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context in providing good quality care. Many factors determine the degree of nursing competence, including personal characteristics, job patterns, and competencies. The literature reveals that older nurses have developed greater implicit skills than younger nurses on the basis of their experience [6]. The duration of working with families, either in hospital or in the community, shows that nurses will more readily enroll with F.C.C. practice because this can clearly support health care organizations in caring for the family under the efforts of the nurses. Also, this induces the creation of facility design with relatives in mind and encourages clinical decision making power along with use of the right drugs for reasonable outcomes [6,7]. Nurse competencies are important for F.C.C. practice and involve skills, knowledge, and capabilities or necessary behaviors for work [8,9]. The literature indicates that open communication, collaboration with clients and families in making health care plans, and viewing clients and families members both as individuals and as members of a family and community could intensify family functioning and also contribute to F.C.C. advantages [11,10]. Not much of the literature in the past 10 years in Thailand reflects the attention of health care professionals upon the association of client factors with or affecting the F.C.C. practice of health care personnel. Also, the effectiveness of F.C.C. practice in terms of health outcomes and patient satisfaction indicated by sick children and patients in hospital were further points of research interest. [12,13]. While the concept of family represents the health of each member, with interconnected families the main targets of community nurse, systematic study has focused mainly on community nurse factors which affect F.C.C. practice, since these may be appropriate for suggesting the process to intensify practice and improve the efficiency of F.C.C. practice for family wellness. While Thailand has much more primary health care units with professional nurses providing family care at the sub-districts around the country and community hospitals situated in almost every district of the country. Moreover, Thai Nursing Council clearly determined the scope of roles and competencies of professional nurses at all levels to perform primary health care tasks related to family care [14]. The reports showed that one fifth of primary health care units were in the central region of Thailand. Also, it has high proportion of population per service unit and highest proportion in urban areas. In addition, the number of registered nurses is one-fourth and their distribution is almost the highest in the country [15]. However, there are still undocumented family-centered levels of community nurses and lack of predictive study factors of F.C.C. Although the family is the foundation of health care among individuals and groups with social relationships, and living in various communities in which community nurses have given importance to being the main target of nursing care no less than personal and community care as a whole. A study of the level of family-centered care among nurses in the community and the nursing factors that affected family-centered care are therefore necessary and will provide important knowledge to be used as a guideline in the development of community nursing performance. Also, in accordance to the strategy of primary health care development as an important basis of the health service system must be efficient, fair, and there should be a reduced gap in the accessibility of health services [16]. Moreover, these factors those have significant effects on the community nurses practice can be employed to improve their competencies and enhances F.C.C. to become more effective.

Review of the Literature

There are two main points while working with the F.C.C. concept. First, family-focused care is centered on meeting family members' needs within their context. By contrast, family-centered care focuses on meeting the needs of both individuals and families. It emphasizes relationships, and recognizes and builds on the strengths and interconnectedness of family members. Adopting a family-centered care concept into the community requires a shift in organizational practices and in the attitudes and behaviors of providers from a model in which professionals are seen as the only people in possession of expert knowledge to a model that is based on knowledge exchange, empowerment, increased capacity, and mutual partnerships [17]. Research demonstrates the efficiency of this concept to hasten clients' recovery in the case of special health care needs [18,19], the decrease in patients' emergency department visits, faster recovery, and decreased utilization of health care resources [20,21]. Both health care professionals and clients have found that this collaborative approach results in greater satisfaction with health care and improved patient outcomes [22], enhances patients' engagement with treatment, and provides more effective treatments [23,24]. However, most studies were in hospitals which intended to respond to the needs of special groups. Very few researchers objected to a collaborative nurse-parent relationship in hospital or community settings [25]. For community circumstances, it was found that this concept was employed with clients suffering chronic conditions. The literature clearly demonstrated that a regular review of F.C.C. competency and practice could be applied within the guidelines in real-life situations. More recently, research related to validated measures and outcome measures for F.C.C. have emerged. An index of family-centeredness based on the Consumer Assessment of Healthcare Providers and Systems survey has been used in national surveys [26,27]. The AAP and Family Voices recently developed a new F.C.C. index model to be used in practice assessment. This tool asks providers to reflect on the family centeredness of care and ways to improve that care [28]. However, only a few studies provided evidence to confirm the level or factors relating to F.C.C. practice. The knowledge about the factors predicting F.C.C. will help incorporate these ideas within community care delivery and practice guidelines. Specific F.C.C. competencies should be explored and evaluated as part of quality improvement projects. Such practices should be linked with measurable practice in the community. Measurement and evaluation of F.C.C. practice should be measured. Institutions should be familiar with all F.C.C. competencies and integrate them in high-level planning and design before the F.C.C. label is applied to home health care initiatives or processes. Ongoing nursing management in the community should raise awareness of the short- and long-term value of F.C.C. practice as the standard for clinical care within health care systems. Providers can team up with family advocacy groups to advance the importance of F.C.C. Payment and reimbursement policies should recognize the time necessary to engage in F.C.C. Examples includes the time needed for information sharing through counseling in-person or on the phone, care coordination, and other areas of family support. The upfront costs of reimbursing F.C.C. practices may lead to more efficient and streamlined home health care use overall for individual practices, families, and health care systems in the community (Figure 1).

Study Aim

The study aims to explore the level and the predicting factors of the F.C.C. practices among community nurses.

Methods and Materials

Design

A correlational predictive design.

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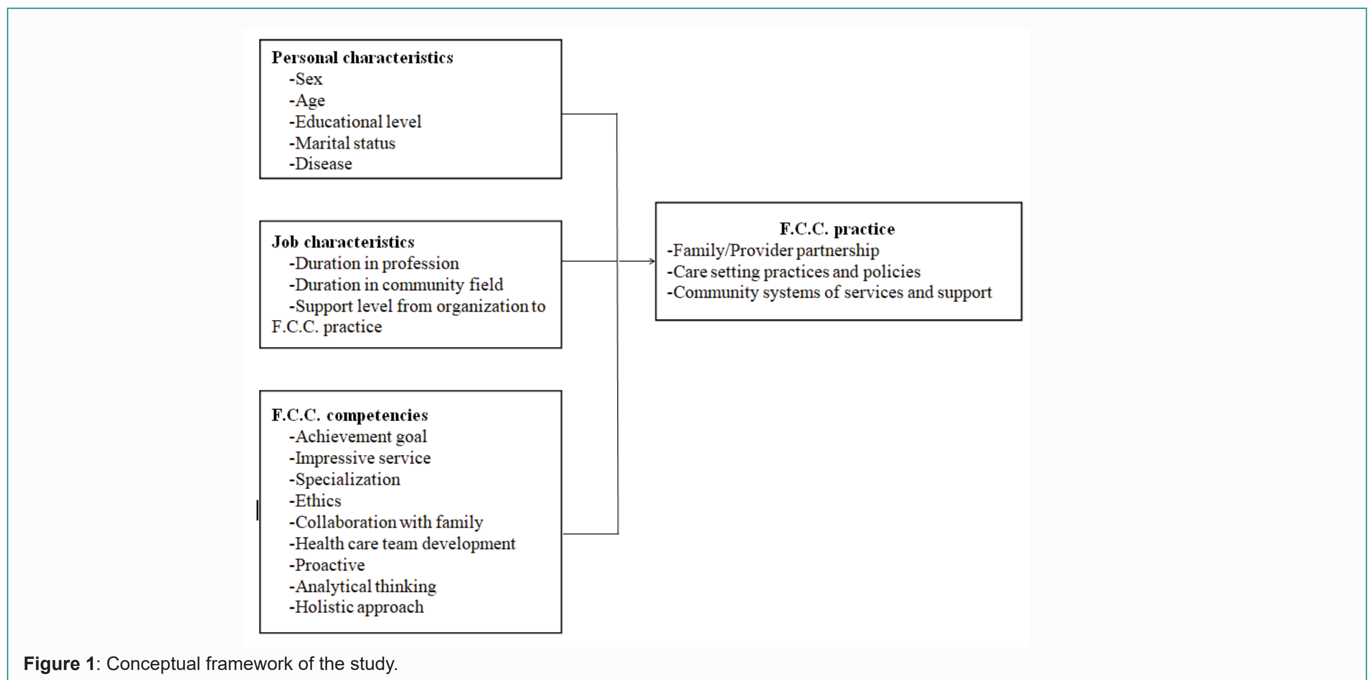

Figure 1: Conceptual framework of the study.

Sample and setting

The population comprised of community nurses who worked at least 1 year in primary health care hospitals of the central region of Thailand. Sampling was deployed in line with Pedhazur & Schmelkin [29] which suggested the proportion of samplings and primary determining predicting factors was 30:1. The primary determining factors in predicting were age, duration of work as a registered nurse, duration of work in the community field, level of organizational support in F.C.C. practice, 149 nurses (calculated sample were 150 nurses) who work in 60 primary hospitals in 5 various provinces around the central region of the country were selected to complete the designed questionnaires. Cluster random sampling method was employed at the beginning with simple random sampling in selected provinces, then, purposive sampling in selecting primary health care hospitals were utilized due to insufficient database from each province. All of the professional nurses in primary health care hospitals were the target population that accounts to 1-2 professional nurses who often work from each primary health care hospital in general. After rechecking the numbers and completeness of the questionnaires that were sent back to the researcher from professional nurses who were the target population, the researcher will also send the questionnaire to other primary health care hospitals and wait within 6 months to complete the entire process.

Instruments

The questionnaire comprises of four parts. Part one covers demographic data and multiple choice items. Part two involves ten items regarding job characteristics. Part three covers F.C.C. competencies (37 items) with 9 sub-groups of F.C.C. competencies using a 5-point Likert scale. Part four covers F.C.C. practice (49 items) with 3 sub-groups using a Likert scale. The instruments used were tested for validity and reliability in many different professions, including nursing. In this study, the Content Validity Index was 0.96 and validated by 3 experts. The reliability of F.C.C. competency was 0.95 and F.C.C. practice was 0.97 which test nurses who worked at a primary health care hospital in Samutprakarn province in the central region of Thailand but is not the specific target area of the study.

Procedure of data collection

After an approval from the ethical committee, the questionnaires were distributed to the selected samples. Two methods of data collection were employed. The researchers went to see the sample participants, while others sent the questionnaire by mail after permission was sought from the directors of primary health care hospitals.

1. The manual data collection is done by the researcher, ~~by~~ meeting each of the sample participants and explained the objectives of the study and the assurance of confidentiality. After agreement, the participant signed the consent form and completed the questionnaire. The researcher would answer questions whenever a participant had any doubts. Then the questionnaire was rechecked prior to the end of the session.

2. In case of mailing back the questionnaires, the researcher checked the completeness of the needed information before analysis. Following up by phone call was managed at least two times for unreturned questionnaires. Two weeks was the total duration prior to the second follow-up via phone call. A total of 149 (99.33%) completed questionnaires were finally analyzed.

Data Analysis

Demographic data, job characteristics, total scores and components of F.C.C. competencies, and total scores and components of F.C.C. practices were analyzed using mean and standard deviation. Factors predicting F.C.C. practices were tested by using stepwise multiple regression analysis after all the assumptions of multiple regression including normality of distribution, linearity, and homoscedasticity were met.

Ethical Considerations: The research proposal was approved by the Institutional Review Board for the protection of human subjects, Huachiew Chalermprakiet University (No. 293/2558) before data collection.

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Results

Table 1 shows that most of the subjects were female (91.3%), age less than 40 years old (49.6%), (educated to) attained bachelor's degree level (88.6%), married (70.0%), healthy (86.6%), worked as a registered nurse between 11-20 years (49.7%), worked in the community field for less than 10 years (45.6%), and received an organizational support for F.C.C. practice at a high level (scores 7-10) (81.2%). In terms of F.C.C. competencies, subjects had total F.C.C. practice score at a moderate level. The highest score was in the aspect of achievement goal ($\bar{x}$ = 2.69, S.D. = 0.50), followed by specialization ($\bar{x}$ =2.62, S.D. = 0.63), and holistic approach ($\bar{x}$ = 2.55, S.D. = 0.61). The lowest score was about ethics ($\bar{x}$ = 1.93, S.D. = 0.51) (Table 2). With regard to F.C.C. practice, subjects had F.C.C. practice scores at a moderate level, especially in the aspect of care setting practices and policies ($\bar{x}$ = 2.23, S.D. = 0.54), followed by community systems of services and support ($\bar{x}$ = 2.14, S.D. = 0.63), and family/provider partnership ($\bar{x}$ = 2.08, S.D. = 0.49) (Table 3). Five variables were selected for testing the attributes for the assumption of regression [30]: age, duration of professional practice, duration in the field of community practice, support level from the organization to F.C.C. practice, and F.C.C. practice. Multicollinearity was not shown (r = 0.002-0.698). Linear correlation between the five variables and F.C.C. practice, homoscedasticity, and autocorrelation were manifested. Stepwise multiple regression analysis was conducted. The regression analyses generated only one model to predict F.C.C. practice. As presented in Table 4, F.C.C. practice resulting from F.C.C. competencies is supported by the effects of beta (0.735) and b2 (0.843) and also had significant R-squared (0.541, p > 0.000). In Table 5, three F.C.C. practice factors were significantly predicting F.C.C practices. Beta values showed that proactive approach had the strongest predictive power (ß = 0.319, p < 0.01), followed by holistic approach (ß= 0.252, p < 0.05), and collaboration with family (ß = 0.202, p < 0.05). In the overall results, predictors could explain 59.3% of the variability in F.C.C. practice.

Discussion

Findings from the study show that the overview of F.C.C. competencies ($\bar{x}$= 2.29, S.D. = 0.42) and F.C.C. practice ($\bar{x}$= 2.16, S.D. = 0.49) were at a moderate level. Also, their components accordingly reflected a moderate level. These results corresponded to personal characteristics of the sample participants, of whom nearly half had worked in the community less for than 20 years, although nearly half of them were professional nurses who worked between 11-20 years and supports the organization for F.C.C. practice in the community was at a high level (score 7-10). It (can be) explained that the moderate levels of demonstrating practice does not depends on the long duration of habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, values, and reflection upon daily nursing practice with family in community which is actually accorded to personal characteristics and job patterns. Also, these characteristics reflected to the competency level of community nurses in integrating knowledge, skills, abilities, and judgment for the benefit of the family members who are the center of care. In addition, it is accorded with the moderate competency level which orderly concrete to abstract manner from achievement goal, specialization, and holistic approach. Then, these finding continuously reflect to the practices of community nurses involving family partnership, policy mobilizing, and community system development [31]. The above results showed that the respondents had F.C.C. competencies predominantly in the aspects of achievement goal, specialization, and holistic approach, respectively. These competencies were derived

Table 1: Number and percentage of sample participants classified from personal characteristics and job patterns (n = 149).

Personal characteristics and job patterns of subjects	Numbers	%
Sex		
Male	13	8.7
Female	136	91.3
Age		
Less than 40 years	74	49.6
41-50 years	57	38.3
More than 51 years	18	12.1
Educational level		
Bachelor's degree	132	88.6
Master's degree	17	11.4
Marital status		
Single	30	21.0
Married	105	70.0
Divorced/Widowed	14	9.0
Health status		
Healthy	129	86.6
At least 1 chronic disease	20	13.4
Duration of working as a registered nurse		
Less than 10 years	36	24.2
11-20 years	74	49.7
21-30 years	32	21.5
More than 31 years	7	4.7
Duration of working in the community field		
Less than 10 years	68	45.6
11- 20 years	121	35.6
21-30 years	25	16.8
More than 31 years	3	2.0
Level of organizational support for F.C.C. practice		
Low (Score 1-3)	4	2.7
Moderate (Score 4-6)	24	16.1
High (Score 7-10)	121	81.2

Table 2: Average, S.D., and F.C.C. competency level (n = 149).

F.C.C. competencies	Average	S.D.	Level
Achievement goal	2.69	0.50	Moderate
Impressive service	2.03	0.50	Moderate
Specialization	2.62	0.63	Moderate
Ethics	1.93	0.51	Moderate
Collaboration with family	1.95	0.49	Moderate
Health care team development	2.21	0.61	Moderate
Proactive approach	2.32	0.52	Moderate
Analytical thinking	2.31	0.51	Moderate
Holistic approach	2.55	0.61	Moderate
Total	2.29	0.42	Moderate

Table 3: Average, S.D., and F.C.C. practice level (n = 149).

F.C.C. practice	Average	S.D.	Level
Family/Provider partnership	2.08	0.49	Moderate
Care setting practices and policies	2.23	0.54	Moderate
Community systems of services and support	2.14	0.63	Moderate
Total	2.16	0.49	Moderate

Table 4: Multiple regression analysis of the factors predicting F.C.C. practice (n=149).

F.C.C. practice	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	S.E.	Beta		
F.C.C. competencies	0.843	0.064	0.735	13.162	0.000

Full model: F = (173.230); R^2 = 0.541; p = 0.000

from professional experiences and were mostly based on individual care given for each family member. This care naturally focused on responding to individual's needs at any health conditions which emerged the application of nursing processes according to family context. To achieve individual care from each family, the community nurses tried to ensure each family member is being assessed in terms

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Table 5: Multiple regression analysis of the F.C.C. competency factors predicting F.C.C. practice (n=149).

Variables	B	S.E.	Beta	t	Sig.
Achievement goal	0.082	0.064	0.084	1.271	0.206
Impressive service	0.020	0.082	0.021	0.244	0.808
Specialization	0.117	0.068	0.152	1.715	0.089
Ethics	-0.090	0.092	-0.094	-0.980	0.329
Collaboration with family	0.200	0.099	0.202	2.018	0.046**
Health care team development	0.124	0.074	0.154	1.674	0.096
Proactive approach	0.298	0.084	0.319	3.570	0.000*
Analytical thinking	-0.135	0.110	-0.142	-1.226	0.222
Holistic approach	0.202	0.082	0.252	2.466	0.015**

Full model: F = (22.525); R^2 = 0.593; **p < .05, * p< .01

of their needs, then they were given the opportunities to develop and gain confidence in self-care [32]. Also, community nurses often emphasized the promotion of health and wellness, assist healing, and preventing or alleviating any suffering present [33]. With regard to F.C.C. practice, subjects had it at a moderate level, especially in the aspect of care setting practices and policies ($\bar{x}$ = 2.23, S.D. = 0.54), followed by community systems of services and support ($\bar{x}$ = 2.14, S.D. = 0.63), and family/provider partnerships ($\bar{x}$ = 2.08, S.D. = 0.49). The F.C.C. practice had a framework that comprises ten components and divided into three sections with several subtopics [33]. Therefore, it is possible to reflect the level of F.C.C. practice of community nurses in that level. Owing to the family being the first and founding institution of Thai society for developing human quality, community health policies have always emphasized family care by determining that the role of a community health nurse is to care for each member and attend to the family as a whole [34]. These sections clearly showed their level in the first order from this study. These findings indicate that F.C.C. competency factors were an important predictor of F.C.C. practice. This is in accordance with the argument that community nurses with high F.C.C. competency display more ability to engage in a practice than do those with low competency [35]. This result suggested that when nurses are working with families in the community, it is important to hold on to many responsibilities that allow them to gain more ability and to experience success with family members so that they can build up confidence in their practices. Practice refers to the ability of an individual to be effective in work activities or specific skills and behaviors important to the role [36]. Then, competencies can be used in achieving goals, impressing through service, collaboration, holistic care, and career guidance in working with families in the community.

These analyses provide insights into F.C.C. competency subtopic factors associated with F.C.C. practice. These present proactive approach, holistic approach, and collaboration with family as important in the context of F.C.C. practice, although both F.C.C. competency and practice level are at the moderate level. It is possible that these competencies associated by working with families in the community may be the result of energetic control of independent and autonomous manners to obviously express their roles which are characterized by flexibility, adaptability, and creative approaches to situations and problems encountered in the context of service delivery to families. However, level of competency that is reflected in family care practices partly depends on personal characteristics due to nursing competency is generally viewed as a complex integration of knowledge including professional judgment, skills, values and attitude. To acquire nursing competency, nurses must possess the skills and personal characteristic necessary to effectively perform their practices while integrating multiple elements including knowledge, techniques, attitude, thinking ability and values that are required in family care contexts. Personal characteristic is one from three categories for provide care based on professional knowledge and skills. Proactive care to families is one of the competencies to which community nurses must uniquely attend, since their skills involve engaging with family health and supporting their self-care. In addition, a person in a family is not defined by their disease. Person- and family-centered care includes the philosophy of holism. This philosophy acknowledges that a human being comprises many components. Partnerships between community nurses and the family must be established within the context of the therapeutic relationship concerning their goals, beliefs, values, experience of health, and family life circumstances. Moreover, sharing among family members and community health care teams in assessing, planning, caring, and also in evaluating family health will help to effectively achieve this goal.

Limitation of study

As with any study, there are limitations in the design and analysis of this study. The results may have been modified if more job characteristics, work satisfaction, or perceptions were deeply studied. The predicting factors might appear more than the practice factors that causes F.C.C. practice by expanding its details. The selected criteria from the analyses of participants with known and detailed job patterns would likely have reduced the bias results. In addition, it should have been noted that participants in this study possessed similar personal characteristics and job patterns, and therefore the study might not have enough analytical capabilities to prove a significant association with F.C.C. practice.

Conclusion and Suggestions

Specific activities that enhances F.C.C. competency, especially in relation to family engagement, comprehensive care, and health care team collaboration should objectively address the concern directly to F.C.C. practice. Additionally, other factors such as perceptions or satisfaction may further be included in the study as these may enhance transparent presentation of predicting factors that promote F.C.C. practice more effectively. Lastly, the results or consequences to clients from specific activities that promote F.C.C. practice should further be explored.

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