#### **ABSTRACT**

**Aim:** This qualitative study explored clinicians' and educators' perspectives o how knowledge and skills about family assessment and family nursing are translated from student learning to clinical nursing practice, together with barriers and supports to family-centred nursing practice.

**Background:** Previous studies have explored educational preparation for family nursing and indicated that family-focussed nursing contributes to greater satisfaction with practice, however, little research has explored nurses' perceptions about the usefulness of family nursing content and theory in clinical settings.

**Method:** Data were collected from a Canadian school of nursing offering comprehensive undergraduate, postgraduate and staff development workshops in family nursing. Collection methods included participant observation in the school, a review of the school's teaching and learning documentation, and in-depth interviews/focus groups with teachers, students, graduates and workshop participants. Data were collected from 26 current students, undergraduate and postgraduate graduates, workshop participants and teachers from the school. Data were analysed for themes using grounded theory techniques of constant comparison and theoretical sampling.

**Findings:** It was found that family nursing is more likely to be implemented in clinical practice areas where: patients experience serious or life-threatening illnesses, staff are educationally prepared, there is ongoing mentorship, and management support for family nursing. A family focus is less likely in areas with high patient turnover, such as acute medical-surgical wards.

**Conclusion:** There is a need to adequately prepare nurses for family nursing, provide staff development and management support in the workplace to promote family-centred nursing practice.

### **WORKING WITH FAMILIES: FROM THEORY TO CLINICAL NURSING PRACTICE**

### INTRODUCTION

This qualitative study explored clinicians' and educators' perceptions about how knowledge and skills in family assessment and family nursing are translated from student learning into clinical nursing practice, together with barriers and supports to family-centred nursing practice.

Family nursing centres on the family as a unit of care, addressing family needs in response to a member's illness or threat to health, rather than focusing on the individual. Nurses work with families as they suffer fear, anxiety, grief and loss, strive to adjust to changes they are experiencing, and provide care for family members. An understanding of families' needs at particular developmental stages, how they communicate and function, and an ability to undertake a family assessment is foundational knowledge for family nursing. Theoretical approaches used to assess and intervene with families include: systems theory; structural functional theory; family development theory; and family stress, coping and adaptation (Friedmann, et al. 2003, Wright & Leahey 2005). How a nurse conceptualises and works with a family is influenced by their expertise and the philosophy and structures of their practice environment. The five levels of family nursing described by Friedman et al. (2003, p.195) provide a useful model for understanding increasing levels of complexity of family nursing practice as nurses develop knowledge and expertise. The levels develop from viewing the family as a social context of the individual client, the sum of its parts, a subsystem (the primary focus of assessment and care), a system where the entire family is viewed as the client and, finally, viewing the family as a system within a larger system.

The literature indicates that family nursing content has been included in nursing curricula for over two decades. Although there is variation in nursing curriculum content (Wright & Bell 1989, Hanson & Heims 1992, Green, 1997, Ford-Gilboe et al.1997), nursing students usually study family nursing in their undergraduate programs, learning theoretical concepts, family assessment, family interviewing techniques, interventions and documentation. Reported teaching strategies include exemplars, case studies, role plays, self-directed activities with

structured feedback, clinical experiences and home visits to families (St John & Rolls 1996, Tapp et al. 1997, Moules & Tapp 2003). Most leading family nursing scholars (Friedman et al. 2003, Wright & Leahey 2005, Hanson 2001) argue that, while undergraduate programs prepare registered nurses to work with families at a beginning level, graduate nurse education is required for advanced specialist practice with families. However, there are only a few postgraduate programs with a major focus on family nursing reported in the international literature (Richards & Lansberry 1995), (is there any literature later than 1995 to support this? There are a range of tools and approaches commonly used in family nursing and family assessment. The Calgary Family Assessment Model (CFAM) (Wright & Leahey 2005) consists of three major areas of assessment: family structures (internal, external and context); stage of family development (stages, tasks attachments); and functional status, which include instrumental (activities of daily living) and expressive (communication, problem solving, roles, power, beliefs, alliances and coalitions). During assessment, areas that are identified as important are explored in greater depth, depending on the circumstances of a particular family. Two common tools used in family assessment are the genogram, which is a picture of the family generational and intergenerational relationships, and the ecomap, which identifies the connections within families and with outside systems. A range of interviewing approaches are used in assessment and intervention with families including: the "one question question", where a family is asked "If you could have only one question answered during our work together, what would that one question be?" (Wright & Leahey, 2005, p. 235); problem identification; circular questioning techniques; developing hypotheses; goal exploration (Wright & Leahey 2001a, 2001b), and post-session therapeutic letters (Moules, 2002).

Family nursing interventions seek to promote, improve or sustain family functioning and focus on alleviating suffering, facilitating sustaining beliefs and challenging constraining beliefs (Wright et al. 1996; Wright, 2005). The Calgary Family Intervention Model (CFIM) provides organising principles for addressing three family domains: cognitive (commending family and individual strengths, offering information and opinions) affective (validating or normalizing emotional responses, encouraging the telling of illness narratives, drawing forth family

support), and behavioural (encouraging family members to be caregivers, encouraging respite, devising rituals) (Wright & Leahey 2005, p. 157-185).

While studies have explored educational preparation for family nursing, reported student satisfaction with preparation for practice (see for example, Goudreau et al. 2006), and indicated that family-focussed nursing contributes to greater satisfaction with practice (LeGrow & Grossen 2005), little research has explored nurses' perceptions about the usefulness of family nursing content and theory in clinical settings. Thus, this study investigated the question: what are clinicians' and educators' perceptions about the integration family nursing knowledge, skills and family assessment in clinical nursing practice? In particular the translation of student learning to clinical nursing practice, together with barriers and supports were explored.

### **METHOD**

This study explored the perspectives, thoughts, ideas and experiences of students, teachers and graduates of a Canadian school of nursing offering comprehensive undergraduate, postgraduate and staff development education in family nursing, particularly related to integration of family assessment and family nursing in clinical nursing practice. Approval was granted from the relevant university human research ethics committees to undertake this study.

# STUDY CONTEXT

The school's substantial track record in teaching, research and publication in the area of family nursing, meant that students, teachers and graduates of the school were well placed to provide information that informed the study question. Undergraduate and master students at the university engaged in theoretical learning that assisted understanding about families and ways of working with families. They participated in a range of learning strategies, including reading literature, simulated classroom activities aimed to develop their assessment and family interview skills, particularly their questioning techniques. Video-tapes of family interviews were used to assist student learning by enabling reflection on assessment content and skill development, such questioning techniques. Postgraduate students undertook

theoretical work, engaged in simulated activities and undertook practicum with client families under supervision. The school conducted family nursing workshops for clinicians, who engaged in theoretical learning, simulated activities, discussion, and observations.

### **DATA SOURCES AND DATA COLLECTION**

The researchers visited the school and participated in observations and activities within school for a period of one month, including classroom activities, and student practicums. Data were collected from a wide range of sources over the four week period, and included participant observation, a review of documentation, and in-depth interviews and focus groups with teachers, current learners and previous learners who were practising as nurses (see Table 1). Our role as researchers and the purpose of our study was disclosed when we were introduced in each setting, and written consent was obtained from participant staff and students. Only the researchers had access to the raw data, and care has been taken to ensure descriptive detail does not identify participant information in publications.

Interview and focus group participants were purposively selected to provide a range of perspectives about the translation of family nursing knowledge and skills into clinical nursing practice. Selection criteria included that they: were registered nurses or undergraduate nursing students, had completed a course of study in family nursing / assessment, had current experience in clinical nursing practice, were older than 18 years, could speak English, and were prepared to share their thoughts and experiences. Current students included undergraduate and postgraduate nursing students. Graduates and workshop participants (n=18) were selected on the basis that they had engaged in learning about family nursing and were currently practising in clinical nursing or teaching relevant to family nursing. The current master, workshop, graduate and teacher participants had extensive general and family nursing experience (see Table 1).

Participants were provided with information about the study and invited to participate. It was made clear to participants that they were free to withdraw from the study at any time without providing a reason and that only the researchers, who were not members of the school, would

have access to the raw data. Audio-taped in-depth interviews or focus groups of approximately an hour were conducted at the University with 26 participants. Eight undergraduate students and two master students participated in two separate focus groups, and the remaining participants were interviewed individually. The audio-taped focus groups were held at the university using the principles outlined by St John (2004). All individual interviews were audio-taped except one, where the tape recorder malfunctioned and notes were taken. This participant reviewed the researcher's notes to ensure that they accurately represented her views. A summary and field notes were made after each interview. In-depth interview techniques were based on methods described by Minichiello et al. (1995) as an attitude of listening, which Denzin and Lincoln (2003) described as a process of interpreting, knowing, and comprehending the meaning intended, felt, and expressed by another. Data were collected until saturation occurred, that is, no new information was being identified. To guide interviews an aide memoire (Table 2) identifying major topic areas to be discussed was used and refined as the study progressed.

## **ANALYSIS**

Audio-taped interviews were transcribed verbatim. Transcripts, field summaries, document data and notes were managed and analysed with the assistance of NUD\*ist version 6.

Constant comparison analysis was used to identify and code categories and themes from the texts related to knowledge, experiences, perspectives, understandings and interactions in relation to family nursing practice. Analysis focused on developing an understanding of the way in which participants learned about family assessment, implemented and documented family nursing in every-day clinical nursing practice. Barriers and supports to implementing family nursing and family assessment in clinical nursing practice were explored. Triangulating by using multiple data sources served to clarify meaning and verify interpretation of the data (Stake 2003).

### FAMILY NURSING IN CLINICAL NURSING PRACTICE

The findings of this study indicated that family nursing has developed as an area of clinical nursing practice in Canada. Some participants had designated 'family nurse practitioner'

roles, usually in nursing specialties and settings where patients' illnesses and/or life-threatening diseases were likely to have a major impact on the family. Others practised in nursing units or agencies with clearly articulated family-centred philosophies, some having chosen their current position because of the unit's underpinning philosophy of family nursing:

In these settings participants often took leadership roles in staff development and practice, because they had educational preparation in family nursing. Where agencies valued family nursing practice, time was allocated to hold family meetings, discuss matters with families and document family nursing. One facility had purpose-built interview rooms with one-way mirrors, enabling family interviews, a team approach and feedback sessions. These participants indicated that they undertook a complex level of family nursing where the entire family is viewed as the client.

Although participants described a robust culture focussing on family nursing in some clinical practice areas in Canada, they indicated that this was not universal. The nature of the patient population appeared to affect the focus on family nursing. Nursing units described as encouraging or implementing family nursing tended to be in practice areas where patients had chronic or life-threatening illnesses, such as gerontology, palliative care and mental health.

Family nursing just <u>has</u> to be done when you work with the population I work with [palliative care]. Cindy

In contrast, participants indicated that few general medical / surgical wards encouraged or actively supported family nursing approaches. General wards have greater patient throughput and address acute rather than chronic illness. In these settings, families were viewed as the social context of individual clients. The only nurse currently working in general medical / surgical wards practised as a specialist family nurse consultant and provided support to other staff. (Note below you refer to patients- should the terms be used interchangeably?)

### Family Nursing and Family Nursing Assessment in Practice

Participants consistently identified the processes and strategies that could be used to facilitate interaction with families (such as questioning techniques) were the most useful

content from their family nursing studies. The genogram was identified as the most frequently used family assessment tool. However, while genograms were considered to be useful, they were not used by all participants or for all patients. In some instances genograms were routinely completed by non-nurse health practitioners. Few participants used ecomaps, generally considering that they did not add useful information to assessments. One participant reported using themed ecomaps with clients to emphasise such concepts as hope, strengths and support. and to facilitate communication and share understandings with families. Other areas included in assessments were general information about the family, family concerns and beliefs about prognosis.

A particularly striking finding was that most participants did not use the formal structured family assessment tools they had used at university, such as CFAM, to organise their assessment of families in clinical practice.

I can't say that I use the [family assessment tool] at all. Sandy

Although the formal structures of assessment tools were considered to be useful for developing academic knowledge and understanding about families, participants indicated that in clinical practice assessments were much more intuitive and focussed on needs as identified by the family. Further, when participants were specifically asked about family assessment, rather than focus on the structural aspects of family assessment and use of family assessment tools, many emphasised the importance of using the skills and family interaction processes they had learned (such as circular questioning techniques). These approaches enabled them to gain a deeper insight into the *family*'s perpective on what was important, and elicit appropriate information about family functioning.

And I'd say "Tell me about that. Tell me about what you're feelings about being here". And because he's heard the openness about the process of the questioning, usually in my experience it has been, that they open up. And then the interview takes on a whole new level of integrity or of openness or of honesty, right. And so I think they [the family] feel that because I'm able to do that it [be involved with the family]. One, I'm willing to do and, two, I have the skill to do it. To ask which questions [to know which questions to ask]. ... So in my assessment I want to understand what is the biggest problem for the family. Liza

All questions I guess could be good questions, but what questions will help bring out more information and sort of get at what is sort of important and what's going to be of service.... Jean

### **Documentation**

Participants had been asked to produce comprehensive documentation when working with families during their clinical placements at university. They contrasted this with the limited time for documentation in clinical settings. Participants indicated that clinical requirements affected the type and nature of their documentation about the family in clinical settings:

You don't have to do all that documentation [in the clinical setting] - there just isn't time. I mean I think it was a very useful vehicle at the time as a student ... Sally Well the documentation of course is driven by the setting. Each setting will have its own requirements. Sandy.

Great variation in the extent of documentation about family nursing in clinical practice was reported. The most comprehensive documentation was undertaken by participants who were designated as family nursing specialists or who worked on units with a family-centred philosophy. Some of these participants took up to an hour to document a family interview. By contrast, other participants reported that very little family assessment was carried out or documented:

There is not a whole lot of documentation. Judy [work setting – medical surgical]

There is one little box on our flow sheet that says "Other". [Laughter] (...) and that's usually where we fill in our family assessment. Loretta [work setting - palliative care]

... there is just a list of all the members in the family. The nurses are asked to identify supports that the family has, you know, who do they contact for support, other phone numbers in case there are emergencies. But as far as a full family assessment, that's not gathered on every family, no. Deborah [work setting – paediatrics]

Some participants documented family assessment in a team family meeting setting, rather like taking minutes, while others documented family assessment in relation to discharge:

There was a different coloured sheet at the back close to the end of the chart (...) and that's where I saw the family stuff included in the discharge plan. Margaret

## **Barriers to Family Nursing in Practice**

Barriers to the development of family-centred nursing models included a lack of time, family nursing being seen as an "add-on" or the province of other health professionals, together with a lack of knowledge and skills in family nursing, mentoring, staff development and administrative commitment.

The time taken to attend to families was a major barrier to family nursing practice. Where family nursing was implemented, the time taken to contact families, conduct family meetings and document family issues was extensive and was an important issue in terms of nurses' usual workload. In order to allocate this time, the ongoing care of other patients needed to be 'covered', particularly on generalist acute wards:

... but when you're first starting [out in nursing], there's other things that you know you have to do to get through the day. And there just doesn't seem to be the time to do that [family nursing]. Loretta

Yes I have to say I did [have support for family nursing]. As long as [I didn't] "neglect other patients". Liza

Many commented that addressing family needs was seen as an 'add on', extra or "trimming", to be attended to after other care had been completed:

If you have six patients to take care of .. I think it has a beginning there so at least it would be difficult to feel calm and confident that you are going to get everything done while also taking that extra moment, and it doesn't have to be 15 min but ... Wendy

Participants commented that many staff lacked the skills or confidence to work with families, and/or an understanding of family-centred nursing approaches:

... it's time, and it's also lack of, I think, comfort, confidence, competence you know, in dealing with those issues, just simply not seeing it as their role. Bernice 692-693

I think one key, one kind of really problematic belief out there is that families are difficult. Katrina

Some participants indicated that family-centred approaches were not always valued and supported by management or senior nurses on nursing units:

... she was criticised, for trying to spend some quality time with them as a couple. So, again, if things aren't valued and supported ... Sally

There's not a lot of support from the more senior nurses [for family nursing]. Loretta I know (some)? one critical care nurse (...) and [she] had great dreams and aspirations for providing this kind of clinical work in emergency department and that type of thing, and how it wasn't necessarily consistent with the philosophy of caring in those departments. So that tremendous sense of isolation and if you don't have that kind of support from management, it's very difficult to create a new way of doing business. Sally

Participants identified that it was difficult to implement family nursing approaches when the philosophy of a nursing unit was underpinned by the medical model, where there was a focus on patients' medical condition:

Ah, I see historical individualism, medical model [as barriers to family nursing] Sandy I certainly think the environment, particularly the environment in the hospitals ... less so in the community, the community is much more open ...to that kind of model [family nursing] ... the hospitals are unfortunately established in such a way that ... it's very much a medical model. Delia

At times there was overlap with other health practitioners. For example, some participants reported that genograms were completed by the medical practitioner, and another reported that in some areas other health practitioners may be responsible for addressing family issues:

... if I worked in ICU or some other area, they might be more, you know, the social worker sees the family, or, you know, you as the nurse at the bedside don't see the family, but I don't have any of those constraints [as a family specialist]. Bernice

## **Building Capacity**

Most participants suggested facilitating change and implementing family-centred care required staff development for the whole organisational unit:

I think that one of the very biggest issue[s] is developing and building [staff] capacity.

Because if there is one or two [nurses] on the unit who have an understanding [of family nursing], who have the skill, it is so difficult for them to be able to practice without that collegial support. The success that I found in working with nurses has been getting the whole unit involved in just this [family nursing] as a practice model.

Delia

Most participants identified initial and ongoing staff development as a major issue requiring attention. A common strategy was to engage either a qualified staff member or an outside consultant to provide staff development and leadership in promoting family nursing approaches:

The other thing that I've had some success with is being able to have a consultant ...

Delia

Family nursing approaches required resources in terms of time, physical facilities and staff education development. University educated family nursing specialists were identified as an important resource for providing well qualified staff, research, and information:

... [place] actually had a program for nurses for about sixteen years actually, run by a couple of graduates from this program and they did a fabulous training program for all the nurses on the [ward] unit. So their documentation is different. They actually do have a particular form that they use. And almost all their nurses do the genograms. It's just lucky that their program is situated in a place where they have a lot of [university family nursing] grads. Sally

Modelling of excellent family nursing practice, collegial support, and a need to be able to work with or debrief with other nurses was identified as supporting family nursing practices:

And I guess that would be mentoring. You know, when you first get out into practice and you're being oriented into a unit or whatever. Loretta 301-309

It would be good to meet with other nurses regularly to be able to talk about doing family interviews and working with families. We could support and learn from each other. Cindy

Opportunities to have consultation, I think there needs to be people on the units that they can call and have available to work with, to role model, to assist them in developing their family skills, family nursing skills. Deborah

Valuing the need to work with families and administrative support was considered crucial to successful implementation of family-centred care. Participants in family nursing roles all worked in agencies with a strong commitment to supporting family-centred approaches to care:

There is support from management about family nursing. [The manager] understands that a family-centred approach is important. (...) The multi-disciplinary team is very supportive of a family centred approach in nursing. Sometimes if a nurse-led family interview is not done, they push for it. Cindy

A major benefit of family nursing was greater job satisfaction. Several participants indicated that using holistic and non-judgemental approaches to working with families had rejuvenated their interest in nursing, with one participant stating that it had "transformed" her. In one instance, a participant had joined a facility in which staff morale was low. She had provided leadership, instituted staff development, introduced family nursing approaches, and had assisted the agency to develop their nursing unit. Morale had improved in the unit to the extent that they had waiting lists of nurses wanting to work there.

### **DISCUSSION AND CONCLUSION**

In this study family-centred approaches were more likely in settings where patients suffer from serious, life-threatening or ongoing illnesses that impact heavily on the family. The findings of this study suggest that family nursing is less likely to be a guiding philosophy for nursing care

on acute general wards or wards with high patient turnover. While barriers to the development of family-centred nursing models such as time and lack of knowledge and skills were identified in this study, they are not insurmountable. Further, although families are an important consideration for all patients, these findings indicate that development and implementation of family-oriented skills and systems are more likely to be considered fundamental and find easier acceptance where health conditions impact more heavily on families. It appears that, consistent with LeGrow and Grossen's (2005) findings, family nursing approaches may also contribute to greater staff satisfaction with nursing practice, in addition to providing more holistic care,

Family nursing practice is fostered and sustained in clinical environments when there is management support and a critical mass of nurses with adequate educational preparation and/or capacity building strategies such as staff development and mentoring, particularly related to use of genograms and communication skills with families. Attention by nurse managers to these aspects could improve implementation of family oriented approaches to practice.

The extent and content of documentation about families appears to be very variable, ranging from extensive to minimal, even by these nurses who have had educational preparation for family nursing. This suggests that there is a need to develop evidence-based approaches to minimal, intermediate and extensive documentation of family assessment and care, identifying context appropriate documentation, These differences in documentation requirements also need to be reflected in curricula.

Although this study was conducted in Canada, a country with a strong tradition in family nursing, it contributes information for the future development of family nursing in clinical nursing practice settings. Knowledge about experiences in Canada will inform education about family nursing and strategies to promote family nursing in clinical nursing practice internationally.

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**Table 1: Data Sources** 

Participants	n	Data Collection Method	Clinical Experience*
Teachers	4	Interview	(n=18; $\bar{x}$ =19.71 years; range 4-34 years)
Former learners / teachers	3	Interview	
Former learner – PhD student	1	Interview	Family Nursing Experience: palliative care, gerontology, mental health (adult, psycho-geriatric, paediatric and
Former learners – masters	4	Interview (2)	adolescent), oncology (adult and paediatric),
students		Focus group (2)	management, haemodialysis, a rural hospital, family therapy, community nursing, management, consultancy,
Current learners –	1	Interview	general wards.
advanced masters			Other Experience perbrology rural home core
Current learners – beginning masters	2	Interview	Other Experience: nephrology, rural home care, medical/surgical nursing, trauma nursing, emergency, labour ward, community/home care, parent support,
Workshop participants	3	Interview	neurology, occupational health, orthopaedics, gynaecology, and research.
Current learners – undergraduate (2 <sup>nd</sup> year)	8	Focus group	(n=8) Undertaken a family nursing subject and clinical placement practice.
Total participants			26 participants

Other Sources Documentation - Course / subject outlines - School policy documentation etc

<sup>\*</sup> Data grouped to maintain confidentiality.

### **Table 2: Aide Memoire**

### Current and previous learners / clinicians

- What areas of family nursing practice / family assessment are you / have you learned about in your program?
- How do you see that family assessment and family nursing relates to the other things you are learning / have learned in your program?
- What learning activities / assessment tasks do you think have been most/least useful to prepare you for undertaking a family assessment and working with families in your current/future general nursing practice?
- What components of family assessment do you think are most/least important/useful in general clinical nursing practice? Why?
- What is the difference between what is taught about family nursing at university and what is practised in the clinical field? Why?
- What documentation did you/do you do for your family assessment/family nursing in university/clinical placement/clinical nursing practice?

Probes:

How long does it take?

What is the difference in documentation between university and clinical nursing practice? Why?

What are the barriers/supports to implementation of family assessment / family approaches in clinical nursing practice?

### Teachers

What family assessment / family practice is included in your teaching? Theoretical?

Practical?

What strategies do you use in teaching family assessment?

How do you teach documentation of family assessment?