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Title

Acute care nurses' views on family participation and collaboration in fundamental care

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Summary box:

What does this paper contribute to the wider global clinical community?

- Involving family in patient care positively affects self-management, patient outcomes, and quality of life for patients and family members
- Healthcare service providers should deliver care that fosters family participation and collaboration.
- Nurses have a central role in promoting family in care processes. The behaviours of nurses are influenced by underlying beliefs, attitudes and context, which may both help or hinder family participation in patient care.

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INTRODUCTION

The attitudes and beliefs of nurses influence the quality of clinical practice and the delivery of fundamental care. Clinicians who have adopted the Patient and Family Centred Care (PFCC) approach believe that patients and their families should be integrated as partners in care, and that this promotes patient comfort and self-determination (Kitson, Muntlin Athlin & Conroy, 2014). Assisting patients in a dignified, respectful manner that reflects their unique cultural and emotional needs has been described as “fundamental care” (Feo & Kitson, 2016, p. 2) and aligns with a PFCC philosophy described by the Institute of Patient and Family Centred Care (2017; IPFCC). Fundamental care reflects a diverse range of care processes that combine the physical, psychosocial, and relational dimensions of care (Kitson *et al.*, 2014). Failure to attend to patients’ fundamental care needs in the acute hospital setting has been associated with poor quality healthcare (Bureau of Health Information, 2014; Francis, 2013; Kalish, 2006), and may lead to adverse patient events (Vlayen *et al.* 2012).

In hospitals, fundamental care is advanced through positive and trusting therapeutic relationships (Feo *et al.* 2017). Nurses are uniquely placed to foster therapeutic relationships with patients and their families because they spend the most amount of time engaged in direct patient care when compared to other healthcare professionals (Westbrook, Duffield, Li & Creswick, 2011; Zomorodi & Foley, 2009). For nurses to implement PFCC practices, and thereby promote the delivery of fundamental care, they need to develop relationships that empower patients and their families to participate and collaborate in care process; however, evidence suggests that: (1) translation of the concepts underpinning PFCC into practice has been slow (Berger, Flickinger, Pfoh, Martinex & Dy, 2014); (2) nurses do not always practice in a way that supports family participation (Doane & Varcoe, 2015); and (3) some nurses believe that the onus is on family members to initiate interactions, and form a relationship (Astedt-Kurki, Paavilainen, Tammentie & Paunonen-Ilmonen, 2001). As part of a larger PFCC study exploring how family participation and collaboration in care is enacted in the context of adult hospitalized patients we sought to specifically explore the beliefs, attitudes and perceptions of nurses regarding family participation and collaboration in the care of their hospitalized adult relative and what factors help or hinder this process.

BACKGROUND

PFCC emphasizes delivery of healthcare services from the perspective of the person receiving care, and when appropriate, their family (Conway, 2006; Feinberg, 2014). Clinicians who adopt this approach perceive the family as the basic social unit (Bamm & Rosenbaum, 2008) and recognise that family are a source of support for hospitalized patients. The social and emotional support family provide during times of acute illness are important in helping patients overcome feelings of vulnerability, and enhance their sense of well-being (Lolaty *et al.* 2014; Mitchell & Chaboyer, 2010). Furthermore, when family members partner with healthcare staff they can successfully achieve fundamental care (Feo *et al.* 2017), and assist patients transition through the acute healthcare system (Berube *et al.* 2014; Marshall *et al.* 2016). There is mounting evidence to suggest that engaging family in care processes may enhance the delivery of fundamental care (Conroy, Feo, Alderman, & Kitson, 2016), and reduce hospital costs through improved efficiency of resources (Kuo *et al.* 2012; Bertakis & Azari, 2011). Consequently, the perceived benefits of family participating in care have led to an international emphasis for healthcare service providers to plan, deliver and evaluate care using a PFCC approach (Johnson *et al.* 2008, McTavish & Phillips, 2014), an approach grounded in mutually beneficial partnerships (Bass, 2012).

PFCC interventions have been successfully implemented in a variety of healthcare settings. Paediatric settings have led the way with patient, family centred rounds actively incorporating young patients and their families in planning care (Kuo *et al.* 2012; Benjamin *et al.* 2015). Bedside rounds have progressed to the adult acute care context because they present an ideal opportunity for patients and families to share in healthcare decisions (Tobiano, Chaboyer & McMurray, 2013). Similarly, nurses' working in intensive care units (ICUs) have used the PFCC approach to improve communication and facilitate close physical and emotional contact between patients and their families (Mitchell & Chaboyer, 2010; Wyskiel, Weeks & Marsteller, 2015). Further, ICU nurses who facilitate family participation in care may improve the psychological recovery and wellbeing of patients (Black, Boore & Parahoo, 2011). Mental health clinicians have also implemented PFCC practices, such as family psychoeducation and support groups, which have improved outcomes such as reducing patient relapses, reducing hospital readmissions and decreasing criminal activity (McNeil, 2013).

The impact of PFCC has been limited in the acute care setting (Alharbi *et al.* 2012; Berger *et al.* 2014) despite its emphasis within healthcare standards such as the Joint Commission International (JCI, 2017); the National Institute for Health and Care Excellence (NICE, 2011); and the Australia Commission on Safety and Quality in Health Care (ACSQHC, 2016). One reason why the implementation of PFCC practices has been slow is the legal context of care that focuses on maintaining individual patient rights (Gilbar, 2011), and thus tension arises for healthcare staff who may view family members as potentially jeopardizing patient autonomy. The implementation of the PFCC approach is further challenged by the lack of systematic strategies to support clinicians to form meaningful relationships with patients and their families, and promote the delivery of fundamental care (Feo *et al.* 2017; Smith, Cassell, Ferguson, Jones & Redberg, 2016). To support PFCC implementation, various international and government bodies, such as the JCI (2017), the ACSQHC (2016), and the NICE (2017), have developed a range of resources and evidence-based recommendations to assist in aligning clinical practice with a PFCC approach. Currently, despite the existence of these resources, consistent and widespread implementation of PFCC in clinical practice remains sporadic (Palonen *et al.* 2016). Further, the meaning of working in partnership is still not clearly defined in the context of nursing practice (Baillie, 2016).

The beliefs and attitudes of nurses have been identified as both fostering (Verloo, Desmedt & Morin, 2017) and hindering (Weng *et al.* 2013) the adoption of PFCC. Further, findings from a recent integrative review in the adult acute care setting suggest that the attitudes of nurses influence the enactment of PFCC practices (Mackie, Mitchell & Marshall, 2017). For instance, nurses may engage in behaviours that restrict family participation when they perceive families as demanding, troublesome or difficult in regard to communication (Benzein, Johansson, Arestedt & Saveman, 2008; Doane & Varcoe, 2015; Verhaeghe *et al.* 2005). Family engagement may also be limited when family are viewed purely in a legal sense where people who are important to the patient are excluded because they are not life partners or blood relatives (Doane & Varcoe, 2006). Nurses' perceptions regarding the value of family partnering in care is also influenced by their professional and personal experiences, and organizational factors (Saveman, 2010; Coyne, Murphy, Costello, O'Neill & Donnellan, 2013). This was evident in a recent study examining workplace culture on an acute surgical ward where nurses' actions were influenced by a ward culture that valued efficiency of work causing nurses to prioritize tasks instead of fostering relationships with patients and their families (Sharp *et al.* 2017). Survey data from Sweden also suggest that being a newly graduated nurse, the lack of an organizational approach to care for families, and being a male nurse are variables that predict a less supportive attitude about involving families in nursing care (Benzein *et al.* 2008).

Understanding the influence of nurses' beliefs and attitudes on PFCC practices in the adult acute care setting is limited, and thus requires further examination, preferably using a variety of approaches to understand complex phenomena such as this (Ostlund, Kidd, Wenstrom & Riwa-

Dewarm, 2011). Investigating nurses' beliefs and attitudes towards PFCC, from a naturalistic perspective will help us to better understand how nurses develop relationships with patients and their families, and how they enact fundamental care in their environment, thereby generating rich data that other study designs are unable to provide (Barker *et al.* 2002; Johnstone & Kanitsakit, 2006; Athens, 2010). To date, no studies have been found which explore nurses' facilitating and constraining behaviours, and their underlying beliefs when establishing a partnering relationship with families in an adult acute hospital setting.

Aim

The aim of this study was to understand how family participation and collaboration in care is enacted for hospitalized adult patients and their relatives. The study sought to answer the following research question: How do nurses, patients and families enact family participation and collaboration in care? Two further subsidiary questions were also explored that are the focus of this paper: (1) What are the beliefs, attitudes and perceptions of nurses regarding family participation and collaboration in the care of their hospitalized adult relative; and (2) What are the facilitators and barriers to PFCC in adult acute-care wards from the nurses' perspective.

METHODS

Study design

Naturalistic inquiry provided the framework for this study that used mixed methods with an exploratory sequential design (Lincoln, 1992; Athens, 2010). PFCC provided the underlying conceptual foundation for this study. The core principles of PFCC, as outlined in Table 1, were used to understand the beliefs, attitudes and perceptions that nurses ascribed to family participation and collaboration in the care provided to their acutely ill, hospitalized adult relative. This study consisted of two sequential phases. Observer-as-participant observations were conducted in Phase 1 and analysis of the data informed the questions used in the semi-structured interviews in Phase 2.

insert table 1 here

Setting

The study setting was an acute inpatient ward of a 324-bed regional referral hospital in Queensland, Australia that provided medical, surgical, obstetrics and coronary care services. The hospital was staffed by 870 full-time equivalent nurses. A hospital wide survey of nurses was recently conducted using the Families' Importance in Nursing Care – Nurses' Attitudes (FINC – NA) survey (Saveman *et al.* 2011); these data informed study site selection. Originally developed in Sweden, the FINC-NA is a 26 item self-reporting instrument with a five-point Likert response scale and demonstrated reliability and validity (Oliveira *et al.* 2014; Saveman *et al.* 2011). The higher the total FINC-NA score the more positive the nurse's attitude towards the importance of involving families in nursing care. The acute adult ward in the hospital with the highest total mean FINC – NA score was selected as the study site, and reflected a unique case sampling approach (Patton, 2005; Ritchie *et al.* 2003).

The hospital's 28-bed medical assessment and planning unit (MAPU) nurses showed the most positive overall attitudes with a total FINC-NA mean score of 95 out of a maximum possible score of

130. The MAPU was a clinical area accepting acutely unwell patients direct from the emergency department where patients had rapid physician assessment, early referral and interventions from allied health professionals. The MAPU had formal visiting hours from 08:00h to 20:00h daily, and a patient average length of stay of 72 hours.

Sample

Participants were purposefully selected to ensure that nurses with a range of years of clinical experience were represented. Registered (RN) and enrolled nurses (EN) were eligible to participate in the study if they were permanent staff of the hospital, and who in their day-to-day work had direct contact with MAPU adult patients and their families. A RN has an increased scope of practice compared to an EN; however, they work collaboratively to assess and meet patient needs. Participants in the observation and interview groups differed. A family member was defined as an individual who had a close and continuing relationship or formed part of the patient's pre-existing support system.

Data Collection

Demographic data were collected from participants, and included: age, gender, highest level of education, years practicing as a nurse, and their role. Data collection occurred between June and August 2016.

Phase One - Observational data

Observations of nurses' interactions with patients and their families were conducted by an experienced acute care nurse (the first named author) using a field guide (Supplementary 1), which was informed by the International Family Nursing Association core competencies (IFNA, 2014) and the principles of PFCC as described by Johnson et al. (2009). The observer followed the participating nurse for a two-hour period to observe for events where family partnering and collaboration in care may or may not have occurred. In this study, family participation and collaboration was seen as nursing care that was informed by the patients and family's preferences, and expressed needs. Purposive sampling was employed to select observation periods across various times and days of the week to increase the opportunity to observe how PFCC was broadly enacted. The observer (first author) adopted an observer-as-participant approach (Kawulich, 2005). Specific probing of participants occurred to clarify a situation or interaction, or to make a participant feel more at ease with the observation process (Manias & Street, 2000; Spradley, 1980). Digital recordings of observer thoughts

were the primary means of documenting participant behaviour and occurred at the end of each observed period. Written contact summaries, and observer reflections were also recorded directly after each observational period to ensure contemporaneous data collection (Creswell, 2013).

Phase two - *Interview data*

Analysis of observational data allowed the researcher to generate interview questions that aligned with the context, and how participants used language to construct family partnerships. The Theoretical Domains Framework (TDF) is founded on psychological and organizational theory that recognises healthcare professionals' clinical behaviour change is key to improving the quality of patient care (French *et al.* 2012). Interview questions were designed to explore the domains of the TDF, and identify nursing clinical behaviours that could hinder family partnerships and collaboration in care (Cane, O'Connor & Michie, 2012). An interview schedule was developed to facilitate the process (Supplementary 2). Individual, semi-structured interviews were conducted with nurse participants to provide rich descriptions of what helps and hinders PFCC in adult acute-care wards. Interviews were conducted for approximately 25 minutes and were digitally recorded and transcribed verbatim.

Data Analysis

Descriptive statistics were used to summarize the demographic data collected. After each data collection period, the audio recordings were professionally transcribed verbatim and the accuracy of the transcriptions checked by re-listening to the tapes. Qualitative data were stored and managed using the software program NVivo 11™ (QSR International Pty Ltd., Melbourne, Victoria). Data collection and analysis occurred simultaneously. Data analysis followed the process described by Miles, Huberman and Saldana (2014), and occurred in three concurrent stages to develop categories and themes by the study team:

1. Data condensation: first cycle coding was applied to the raw data, and the affective method of values coding (Gable and Wolf, 1993; Saldana, 2015) was

used to enable more detailed exploration of value and belief systems. Codes of meaning were assigned to a word or short phrase that captured the essence of the data. Second cycle coding methods were then applied to the first cycle codes to group similar meanings into key categories and consolidate codes.

2. Data display: A visual matrix was used to display the data enabling cross case analysis, and for subthemes and themes to be generated.
3. Conclusion drawing/verification: themes and subthemes were integrated into higher level connections through seeking plausibility, clustering, noting patterns and making metaphors (Miles, Huberman & Saldana, 2014).

Following separate analysis, the observational and interview data were merged to provide a comprehensive description and deeper understanding of family partnerships and collaboration in patient care within the adult acute-care ward (see Supplementary 3 for an example of audit trail). This data triangulation provided an added depth of analysis and enhance credibility of the qualitative data collected in this study (Guest, 2007). The qualitative triangulation protocol as described by Farmer, Robinson, Elliott and Eyles (2006) guided this analysis.

Trustworthiness of the study

The approaches outlined by Holloway and Galvin (2016) were adopted to guide the specific strategies used to ensure the trustworthiness of the data. These are: credibility, transferability, dependability and confirmability. The specific strategies are listed in Table 2.

insert table 2 here

ETHICS

Ethical approval to conduct this study was granted from both the hospital and health service district: HREC/16/QTDD/1, and university Human Research Ethics Committee: 2016/144. Verbal and written explanations were given to nurses about the risks and benefits, and how information would be de-identified and used. All nurses were given an information sheet, and signed a consent form prior to undertaking observations or interviews.

RESULTS

Thirty nurses in total participated from MAPU; the majority of nurses were female RNs who held a bachelor of nursing degree, and were new to the nursing workforce (Table 3). Thirty hours of observational data were gathered in 2-h periods across all days of the week; 14 nurses were interviewed.

The analysis uncovered two contrasting categories: (1) enacting family participation; and (2) hindering family participation (Figure 1). The first category contained four themes which revealed evidence of nurses enacting PFCC through fostering family participation and collaboration in patient care, while the second category contained five themes which reflected gaps in PFCC practices and nurses' expressed attitudes and beliefs that limited family involvement in their relative's care. Additionally, contextual factors were found that influenced the beliefs, and actions of nurses, which inadvertently caused tension for nurses and constrained PFCC practices.

****insert figure 1 here****

Enacting family participation

Four of the themes that emerged and reflected enacting family participation included; family as key informants, advocate for quality care, respecting family concerns and personal experiences shape nurses' views. These themes reflected beliefs, attitudes and practices of nurses that aligned with the PFCC approach, and facilitated family participation and collaboration in patient care on the MAPU.

Family as key informants

Observation data highlighted how nurses valued families' ability to provide specialist patient information. This was supported by interview data which revealed that nurses were cognizant that families could provide more extensive and privileged knowledge regarding their relative's health condition and preferences. Nurses used the information shared by families to provide timely, safe, and individualized patient care. For example, one nurse was observed conversing with a patient's wife via telephone. During this conversation, the nurse learned from the patient's wife that he normally received the drug Warfarin which the nurse realized was not currently prescribed. This prompted the nurse to raise the issue with the medical doctor so that the medication was prescribed, and a strategy formulated to address the missed dose (N13 – Observational Fieldnote).

The majority of nurses on the unit demonstrated that they valued the unique information families could provide because it enabled them to tailor the care they provided to patients; this was viewed as particularly important when patients had a cognitive impairment. For instance, it was observed in one case, when a nurse was reflecting on the role of family, she stated: "*they [the family] are critically important in the confused patient or with dementia, or someone who can't communicate*" (N15 – Observational Fieldnote). Similarly, another nurse during interview commented "*family can help with all that initial information, like for example yesterday I had a patient, she had severe dementia and she would only settle with a baby [doll] at home*" (N7 – Interview). Furthermore, nurses acknowledged that families who participated in care could also provide clinically important information when they believed their relative's condition had changed. For example, "*the family noticed that when they gave her lunch, that she wasn't eating, she didn't seem to be swallowing her diet very well*" (N1, Interview).

Advocate for quality care

During the periods of observation, families were observed to display a strong desire to communicate with nurses if they felt their relative was in any distress. In several instances family members were observed to engage with nurses to improve their relative's pain management. For example, in one observed case, a family member, upon realizing that their relative had severe pain actively engaged with the nurse to ensure that a plan was established that would ensure adequate pain assessment and treatment (N13 – Observational Fieldnote).

Almost a third of nurse participants stated that family members were well placed to advocate on their relative's behalf to ensure fundamental care was delivered. For instance, families provided critical advocacy during care transitions, and the nurses endorsed their role in promoting patient safety. One nurse reiterated a conversation she had with a patient's son who commented that it was getting late and he was not happy for her to be discharged that day. The nurse communicated his concerns and commented, "...so in the end the doctor agreed to keep her in overnight, because the family said something directly... the family were getting frustrated, and well within their rights" (N7 – Interview).

Respecting family concerns

Nurses showing respect for family members' concerns was observed when they acknowledged that families felt vulnerable, and were concerned about their relative's care. The nurses consequently modified their behaviour and communication to try to alleviate family concerns. For example, a nurse at a patient's bedside was observed to noticeably change the tone of her voice and body language when conversing with a patient and family. Later, when the researcher queried the nurse as to the reasons behind the altered communication style, she stated, "*I needed to change my persona, I could tell they were highly emotional and normally I would be happy and bubbly but I needed to change my communication and behaviour*" (N15 – Observation). Interviews also revealed that some family members who were familiar with hospital practices (due to their own experience of being a health profession) became overwhelmed and frustrated with the care delivered. In these situations, nurses frequently used communication strategies to validate the family member's concerns, for example one said: "*I can understand you're distressed, and I can understand that you probably feel a bit concerned here*". She went on to provide a rationale for care, "*Number one, her [patient] blood pressure is high, it's 188 systolic, so I'm thinking that's the cause of her feeling the way that she is and I want that addressed*" (N11 –Interview).

Personal experiences shape nurses' views

Previous personal experiences of being unwell or having family members in hospital appeared to influence nurses' views, and shaped their interactions with families and inform their practice. For example, one nurse was heard during an observation to say: "*How would I like the nurse to treat me...I've had lot of sick family in hospital*" (N6 –Observational Fieldnote).

Nurses appeared to reflect on their practice during interviews, which emphasized to them the importance of keeping families informed, and up-to-date on their relative's care. A nurse stated: "*my mum's had a lot of medical things [wrong with her]. So, I guess being aware of what's going on with a family member when they come in and the doctors haven't spoken to them or explained things, I like to make sure everyone knows what's going on and if they have any questions and we're all on the same page*" (N3 – Interview).

Hindering family participation

Five themes emerged from the triangulated data within the second category and included; nurse centric view limits collaborations: patient comes first; health literacy affects participation; privacy concerns constrain information sharing; and, championing patient autonomy. These themes reflected

beliefs, attitudes and practices of nurses that were inconsistent with the PFCC approach, and hindered family participation and collaboration in their relative's care.

Nurse centric view limits collaborations

A nurse centric view emerged as a significant theme from the data. Nurses were only willing to engage with families and support their participation in patient care if it worked to their own advantage. Consequently, it emerged that some nurses only supported PFCC practices in a superficial manner that did not reflect a partnership. For instance, in one observational case when a nurse was probed about her views on the benefit of including family in care, she commented that: *"If they [families] are happy to do it they can feed and shower patients. It saves me time"* (N14 – Observational Fieldnote). Further, this narrow perception regarding the benefit of involving family in care meant that when family members attempted to engage nurses, they were viewed as a hindrance. For example, *"I find sometimes if the relatives are already there in your face first thing in the morning it's - it's just like, you know, you're in my way. I've got to do this first before I can have that chat with you"* (N8 - Interview).

Patient comes first

The majority of nurses chose to prioritize their activities, and focus on tasks that related to assessing or treating patients' physical needs. Further, nurses chose not to take opportunities to engage and share meaningful information with families. For example, it was observed in one case, when a family member asked a nurse for an update on their relative's condition the nurse stated: *"I don't know anything yet"*. The nurse proceeded to assess the patient's blood pressure and the family commented to the nurse, *"that's looks high"*, to which the nurse replied in a flippant manner, *"Mine would be higher than that right now"* (N2 – Observational Fieldnote).

Nurses' actions appeared to be influenced by what they considered to be the priorities of the unit and hospital, and on many occasions comments were made such as, *"it's all about assessments here [in the MAPU]"* (N3 – Observational Fieldnote), which led many nurses to describe their day-to-day role as troubleshooting patient issues. For example, one said: *"I've got, you know, this - this many observation to do, and I've got buzzers going, and I've got, you know, being distracted with, you know, another patient, and, I think, their blood pressure is okay, you know, I'm finished with you now, I don't need to see you until 6 o'clock when your next antibiotic is due"* (N5 - Interview).

Health literacy affects participation

Nurses attempted to educate patients and their family but the communication style was problematic as it was principally one-directional, employed medical jargon, did not foster family involvement, and rarely encouraged questions or checked for understanding. For example, it was observed in one case, a patient with newly diagnosed heart disease had his wife and daughter present at the bedside while he was waiting for a cardiac echogram stress test. A male nurse was discussing with the patient his condition and was heard to say the following abbreviations without ever checking if the patient or family understood them: *"SA node, SVT, AF"* (N7 – Observational Fieldnote). In other cases, nurses endeavoured to help families understand aspects of their relative's care but it was evident that families

did not comprehend the information that was provided. This was expanded upon during interviews when the majority of nurses commented that they thought families could not understand the information they received, or how to act on it. For example, one said: *“today I put the telemetry on this gentleman, you know and his wife was there and I just explained that, he'd gone into AF. And they said, well what's fibrillation and I just said – explaining what I could to them...why he was having these medications, and why I was putting the telemetry on. Then I come back two hours later and he had his telemetry off”* (N7 – Interview). Observations revealed that opportunities to enhance families understanding of their relative’s care were missed, for example, they were not involved in the process of bedside handover.

Privacy concerns constrain information sharing

Almost half of the participating nurses highlighted that they felt duty-bound to uphold the hospital’s policy on maintaining patient confidentiality during telephone discussions with families. Nurses in our study appeared to limit information sharing because of perceived legal parameters with comments such as, *“we can’t say too much over the phone... legally we can’t divulge anything. Just comes from above, where we’ve been told. Even through university- confidentiality’s a big thing and we don’t know the face who we’re talking to, it could be Jo Blow’* (N13 – Interview), being commonly stated. Further, nurses’ language reflected an underlying suspicion towards families, which led nurses to promote patient autonomy if they believed they were competent to make decisions: *“They might say it’s a family member, but are they a family member? So, unless that patient is awake and is able to say, Oh yep. That’s fine. You can’t give them that information.”* (N10 – Interview). This confidentiality concept was extended to when family visited their relative in hospital. In one case, it was observed that a family member sought information on their relative’s condition by reviewing medical charts that were located at the end of the hospital bed. While the family member was reading their relative’s chart a senior nurse said, *“it’s hospital property [patient’s chart] and you need to formally request to review this via the freedom of information process”* (N11 – Observational Fieldnote).

Championing patient autonomy

On several occasions nurses prioritized the wishes and individual rights of patients over the preferences of families, which limited the extent that PFCC could be enacted. When nurses encountered conflicting care preferences between the patient and their family, for example; *“one family member's saying this and other family member's saying that. They're not connecting with each other, they're not listening”* (N2 – Interview), they were found to promote and advocate for the patient’s rights. For example, during an interview a nurse described how a family member expressed frustration that their relative would not accept help to transition to supported care or a nursing home placement, *“you just bring it back to the patient and just say, well, they have made this decision, we can't force them to take in-services... if they're still cognitively able to make their own decisions we bring it back to that. And say that we have to respect the patient's decisions”* (N2 – Interview). Similarly, the emphasis by nurses to uphold the rights of the patient over the family was observed in one case where a patient who had a chronic disease that prevented him from communicating verbally. The patient’s wife was heard discussing with another family member at the bedside, *“he wants to be [resuscitated], but I don’t think it is the best thing. I’ve spoken to the nurse and she says that we first*

must organize for a psychological assessment to be made to see if he has capacity to make decisions”
(N9 – Observation).

insert table 3 here

DISCUSSION

Family support positively affects self-management, patient outcomes, patients’ and family members’ quality of life, and the incidence of hospital readmissions (Boltz, 2012; Popejoy, 2011, Segaric & Hall, 2015; Wyskiel, Weeks & Marsteller, 2015). Family participation in fundamental care can be best enacted when the process is supported by nurses. However, nurses’ beliefs and attitudes influenced their behaviour, to enact, or not, a PFCC approach, which promotes the delivery of fundamental care. The findings of our study demonstrated that the practices of nurses do not always align with healthcare policies that require health services to align with the PFCC approach. Furthermore, our findings confirmed that the attitudes and beliefs of nurses both helped and hindered family participation in their relative’s care. PFCC and engagement by families in their relative’s care is fundamental care, which requires the development of a relationship (Kitson *et al.* 2014), clear communication, and open sharing of information between nurses and families. The findings of our study demonstrated that crucial factors influence nurse - family relationships (see figure 2), and these will form the focus of the discussion.

Our data suggests that nurses were unable to adapt their communication to align with the family’s health literacy level, which may have influenced their ability to engage in PFCC practices. Nurses have been identified as important providers of health information to patients and their family (Al Sayah, Williams, Pederson, Majumdar & Johnson, 2014; Johnson, 2014), and therefore, must communicate effectively using clear, focused and useable information (ACSQHC, 2014). Further, it was evident in our findings that the majority of nurses acknowledged that they, and the larger healthcare team, failed to convey information in a meaningful way to patients and their families, which hindered their involvement in care processes. Health literacy is defined as the “cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health (Nutbeam, 2000, p. 259). International data highlights that many adults struggle daily with basic literacy, a component of health literacy (Cartwright, 2016) (Goodman, Finnegan, Mohadjer, Krenzke & Hogan, 2013). Consequently, the WHO (2017) has emphasized how important health literacy is to improve the safety and quality of healthcare.

Furthermore, nurses in our study showed limited awareness of how to assess the health literacy in their patients and families, and therefore did not tailor information to enhance understanding. Other researchers have reported similar findings that nurses routinely overestimate patients’ health literacy skills (Goggins, Wallston, Mion, Cawthon & Kripalani, 2016). If patients and their families in the acute care setting do not comprehend the information provided to them by healthcare staff, they are unable to effectively exercise an informed choice when making healthcare decisions. Enhancing patients and their families’ health literacy is a key component in delivering fundamental care (Feo & Kitson, 2016). Furthermore, face-to-face interactions between nurses, patients and their families have been identified as the heart of good healthcare, and the main tool to realize PFCC (Bishop & McDonald, 2016; New Haven Recommendations, 2016).

The legal parameters nurses work within to uphold patient rights of autonomy and confidentiality restricted the extent to which participants in our study communicated, and shared information with families. The current legal position in healthcare that focuses on the patient as the

unit of care (Gilbar, 2011) may explain why nurses in our study were hesitant in sharing information, and communicating openly with families. Our findings are consistent with previous research that highlights concerns regarding patient privacy are more of an issue for nurses (O'Connell, Macdonald & Kelly, 2008; Chaboyer *et al.* 2009) than for patients (McMurray *et al.* 2011) and family members. The code of ethics for nurses in Australia includes a statement on patient confidentiality, "the ethical management of information involves respecting people's privacy and confidentiality without compromising health or safety, and personal information may only be shared with the consent of the individual or with lawful authorization" (Nursing and Midwifery Board of Australia, 2017, p. 6). Therefore, nurses are encouraged to communicate more fully with patients to establish what information they may or may not want shared with others, thereby ensuring patient privacy is maintained, and family are afforded the opportunity to engage in PFCC.

Valuing family members' knowledge, and acknowledging that families play a key patient-advocate role in decision-making, were evident in nurses' perceptions in our study. Other researchers have reported that integrating family knowledge into the delivery of care is an essential element of collaborating with family members, delivering fundamental patient care (Feo & Kitson, 2016; Williams, 2005; Wyskiel, Weeks & Marsteller, 2015), and informing clinical practice (Tobiano, Chaboyer & McMurray, 2013; Boltz, Resnick, Chippendale & Galvin, 2014). This finding was exemplified in our study when nurses acknowledged the quality of care was enhanced by the unique information provided by family members. Furthermore, nurses in our study who recalled memories and personal experiences of being unwell or having a relative hospitalized acknowledged the importance of family in promoting patient comfort, and appeared confident to promote family in care processes. Other researchers have reported that previous experience and knowledge of the families' experience in hospital positively influence nurses' attitudes towards involving families in care (Benzein *et al.* 2008; Blondal *et al.* 2014). However, if nurses are unable to see the value that family participation brings the practice of shared-decision making is less likely to occur.

Our study findings highlight inconsistencies with the hospital's FINC-NA survey data, and the prevailing context within Australian hospitals to embed patient/family partnerships in practice (ACSQHC, 2014) may have led to a social desirability response bias (Polit & Beck, 2012). Further, others have highlighted that perceptions, and beliefs cannot be meaningfully reduced to numbers or adequately understood without reference to the local context (Choy, 2014; Dudwick, Kuehnast, Jones & Woolcock, 2006). Certain contextual factors were identified as a barrier that limited nurse's ability to form relationships with families, and the enactment of PFCC practices. In this study, nurses were very clear that their focus was primarily on patient assessments, and not on involving family members in care processes. The decision by nurses to focus on patient assessments was influenced by the rapid assessment purpose of the unit, and may also reflect the international focus for hospitals to recognise and respond to clinical deterioration (Massey, Chaboyer & Anderson, 2017). MAPUs have only recently been implemented in Australia (Brand *et al.* 2010), and form part of hospital innovation programs (Queensland Health, 2013). These units are aimed at improving patient flow (Oddoye, Jones, Tamiz & Schmidt, 2009), optimizing the use of resources (Providence, Gommans & Burns, 2012), and reducing the economic burden of providing acute care (van Galen *et al.* 2016). Furthermore, MAPUs are seen as an effective strategy to reduce the length of stay in emergency departments, and improve access to hospital (Brand *et al.* 2010). The goal of MAPUs is to rapidly assess and refer patients; therefore, nurses in our study appeared to adopt an attitude that valued efficiency and clinical assessments over all other activities. For instance, nurses in our study prioritized the assessment of patients, and facilitated family participation in care if it reduced their workload but restricted participation if it was perceived to delayed or hinder their workflow, a finding which is consistent with other research (Benzien, Hagberg, & Saveman, 2008; Porter, Miller, Giannis & Coombs, 2017). For example, Sharp, McAllister & Broadbent (2017) found that nurses on an adult

acute surgical ward prioritized efficiency, and the swift completion of tasks despite voicing a philosophical commitment to the value in spending time with patients. Interestingly, hospitals are now moving to adopt policies that align with the PFCC approach, such as open visiting hours (Baharoon *et al.* 2017; Foster, 2015), and single bed rooms (Persson, Adenberg & Kristensson Ekwall, 2015). Therefore, it would be important to conduct further research to better understand the impact of policies aimed at enhancing the delivery of PFCC in the acute care setting from nurses, patients and families' perspective.

****insert figure 2 here****

LIMITATIONS

The current study is limited in being confined to a single site, in one medical unit, at a regional hospital, which limits the transferability of the findings. Such limitations are accepted within naturalistic inquiry, and all diligence was taken to remain true to the data and limit researcher bias from interpretations. Participants in the observation and interview groups differed, and member checking was not conducted. However, validation of concepts with participants, which is similar to member checking, occurred during data collection. In keeping with the tenets of naturalistic inquiry, participants were not chosen randomly, instead they were chosen to increase the scope of data (Morse *et al.* 2002), and to provide rich in-depth descriptions of their perspectives, attitudes and beliefs towards family partnering in care (Patton, 2002). The findings are not intended for generalization but rather conceptual understanding; rich descriptions of the setting and sample have been provided which strengthens our study, allowing researchers to judge applicability of findings to their own setting in practice.

CONCLUSION

Our study findings highlighted that family involvement in fundamental care is best achieved when nurses' support family to participate and collaborate in their relative's care. Furthermore, it was evident in our themes that the delivery of fundamental care is underpinned by an effective nurse-family relationship. Although hospital policies and healthcare standards require nurses to form partnerships with patients and their families to enhance the quality of healthcare (Pomey *et al.* 2015), our study uncovered that nurses' beliefs and attitudes influenced their behaviour, to enact, or not, a PFCC approach in their daily practice. These attitudes need to be considered when developing strategies that are directed towards enhancing family participation in patient care. Although an

emphasis in hospitals is to optimize patient flow, and deliver services in an efficient, cost effective manner, nurses can implement simple low-cost evidenced based strategies that align their practice with the core concepts of PFCC to deliver fundamental care.

RELEVANCE TO CLINICAL PRACTICE

The findings of this study have implications for practice, and can inform nurses in the acute care setting to make simple changes that will allow them to enact the PFCC approach in a more meaningful way each day. First, acute care nurses should be aware that the delivery of fundamental care is underpinned by the establishment of a relationship with patients and their family (Kitson *et al.* 2014). Caring relationships are underpinned by effective communication (Collins, 2009), therefore, nurses must be aware that people with lower individual health literacy may be less likely to ask questions, or to ask for clarification if they do not understand their care (ACSQHC, 2014; Goggins *et al.* 2016). If low health literacy is suspected, nurses should implement evidence based strategies such as: (1) teach-back (The Joint Commission, 2007); (2) ask-tell-ask (Martino, 2011); or (3) teach to a goal (Baker *et al.*, 2011), to enhance patients' and families' understanding. Second, facilitators are crucial in translating PFCC into clinical practice (Beer *et al.*, 2010; Ploeg *et al.*, 2010; Thompson, Estabrook, & Degner 2006; Waugh, Marland, Henderson & Wilson, 2011). Therefore, opportunities should be created that involve motivated nurses in hospital orientation and education programs to act as 'PFCC champions' and role model ways that foster healthcare staff to enact behaviours that foster patient-family collaborations. Third, we endorse the view of previous researchers who recommend embedding protocols that promote family in bedside handover (Tobiano, Chaboyer & McMurray, 2013) because it provides a unique opportunity for nurses, patients and family members to share and receive information (Wright & Bell, 2004), and provide patient and family centred fundamental care. Lastly, any legal concerns nurses have regarding patient rights and privacy can, and should be clarified by establishing a relationship with the patient and their family (Kitson *et al.* 2014), and begin a dialogue regarding the boundaries for sharing information.

****insert Acknowledgements here****

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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Table 1. Core concepts for Patient and Family Centered Care as defined by the Institute for Patient and Family Centered Care (Institute for Patient and Family Centered Care; 2017, p. 4)

Concept	Definition
Dignity and Respect	Health care practitioners listen to, and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
Information Sharing	Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
Participation	Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
Collaboration	Patients and families are included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; health care facility design; and professional education. Patients and families also collaborate in the delivery of care.

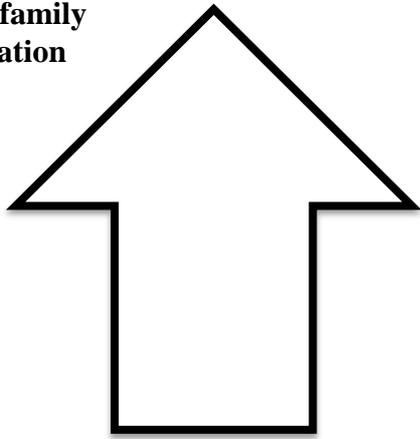
Table 2. The strategies employed to promote trustworthiness

Approaches to rigor	Strategies
Credibility	Naturalistic setting Purposive sampling strategy Varied data collection methods Triangulation Peer debriefing
Dependability	Audit trail Reflective diary
Confirmability	Participant-observer role adopted Validation of concepts with participants
Transferability	Audit trail Thick descriptions

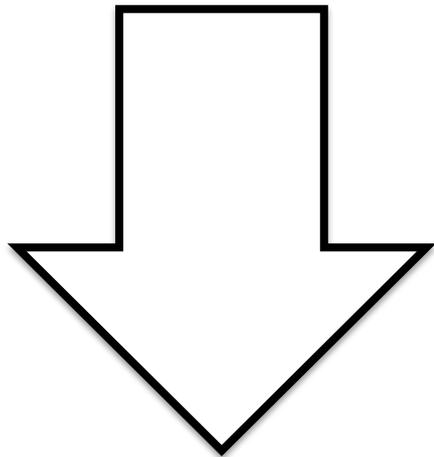
Table 3. Demographic characteristics of the observations and interviews

<i>Characteristics</i>	<i>Observations</i>	<i>Interviews</i>
<i>Nurses</i>	n = 16	n = 14
<i>Gender</i>		
Male	2	2
Female	14	12
<i>Age (mean, SD)</i>	40.75 (13.18)	41.28 (10.19)
<i>Highest Level of Education</i>		
Post graduate degree	4	2
Bachelor's degree	10	11
Associate certificate	2	1
<i>Role in hospital</i>		
Nurse unit manager	1	1
Clinical nurse	3	3
Registered nurse	10	9
Enrolled nurse	2	1
<i>Years practicing as a nurse</i>		
0 to 4	6	8
5 to 9	4	2
10 to 15	4	1
> 15	2	3

Enacting family participation



- *Family as key informants
- *Advocate for quality care
- *Respecting family concerns
- *Personal experiences shape nurses' views



- *Nurse centric view limits collaborations
- *Patient comes first
- *Health literacy affects participation
- *Privacy concerns constrain information sharing
- *Championing patient autonomy

Hindering family participation

Figure 1. Categories and themes.

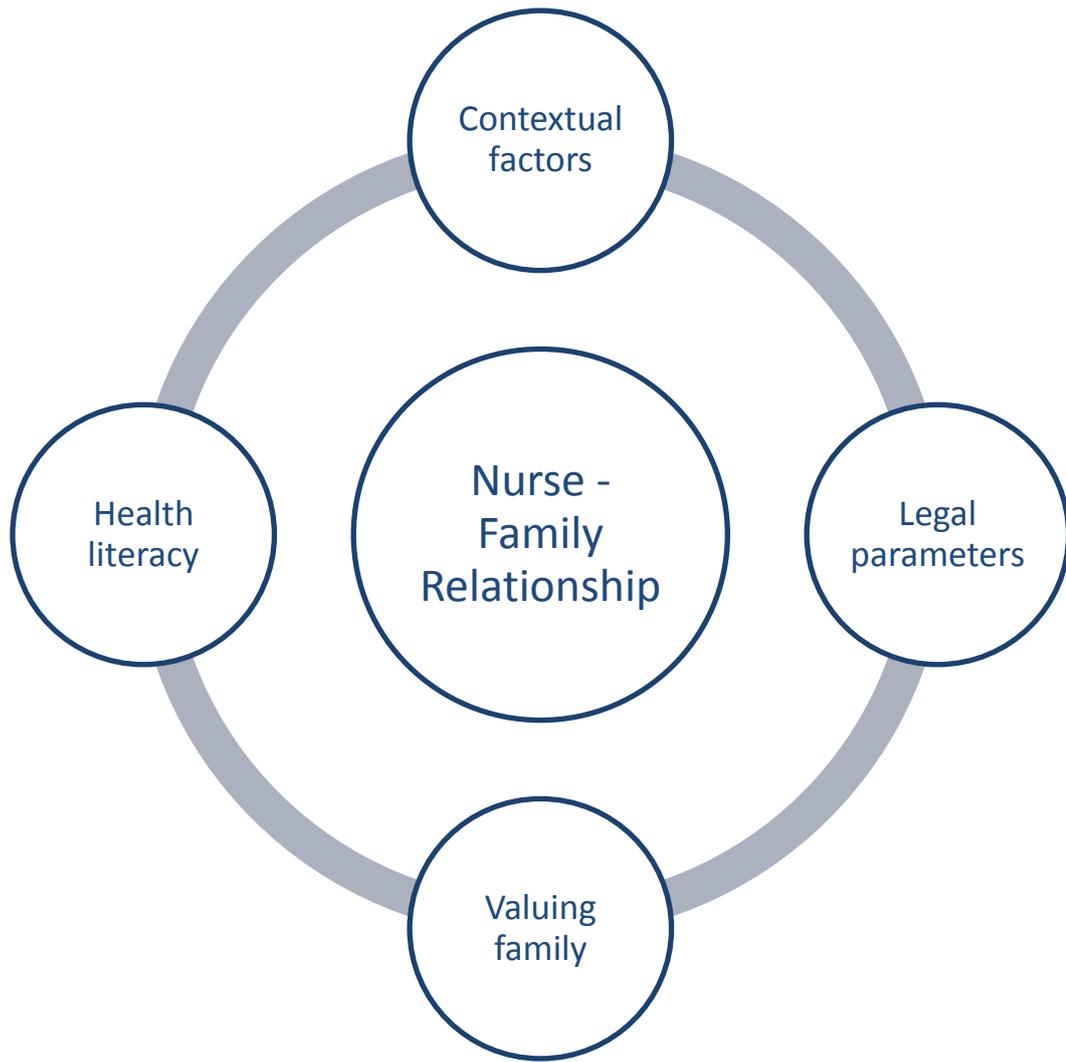


Figure 2. Factors that influence nurse-family relationship, and the delivery of fundamental care.