Family-Centered Care In Ontario General Hospitals: The Views Of Pediatric Nurses

Caty, S.
Larocque, S.
Koren, I.

Abstract

Registered nurses and registered practical nurses working on pediatric units in 35 Ontario general hospitals participated in a study that examined their perceptions and practices of family-centered care (FCC). The Family-Centered Care Questionnaire-Revised (FCCQ-R) was used to collect the data. The participants were asked to rate their level of agreement regarding necessary elements (**perceptions**) of family-centered care and whether these elements are part of their current work (**practice**). The participants had a reasonable knowledge of the necessary elements of family-centered care, but were not consistently including these in their every day work. A number of barriers to the implementation of family-centered care were also identified. Perception and practice scores were higher among those who had participated in continuing education on family-centered care than those who had not. The findings suggest that some nurses may be having difficulties shifting from a medical helping model of care to an enabling helping model of care, which is considered the foundation of family-centered care. Difficulties in implementing family-centered care appear to be systemic, both at the unit and organizational level. Based on the findings, implications for practice, education and research are suggested.

Introduction

It is widely accepted that hospitalization of a child is a stressful experience for both the child and family. Policies to reduce this stress such as, allowing unrestricted parental visiting, providing rooming-in facilities for parents and involving parents in the care of their child (Ahmann, 1994; Coyne, 1995a; Brown & Ritchie, 1989; 1990) are now well established in paediatric settings. This change in view of the parental role has led to the development of a philosophy of family-centered care. Family-centered care is a philosophy of care that recognizes and respects the pivotal role of the family in the lives of children with health care needs (Johnson, Jeppson, & Redmond, 1992; Bruce & Ritchie, 1997). Parents and professionals have struggled to describe what is meant by family-centered care and great strides were taken on this matter when the Association of the Care of Children's Health (ACCH) defined the key elements of family-centered care (Shelton, Jeppson, & Johnson, 1987). These principles are now frequently seen in the mission statements of pediatric hospitals and pediatric units of general hospitals.

Implementation of family-centered care necessitates a new approach to the delivery of health care services to children and families and as noted by Bruce & Ritchie (1997), this model of care continues to evolve and expand. The foundational principles of family-centered care promote self-determination, decision-making capabilities, control, and self-efficacy and reflect an enabling model of helping (Dunst, Trivette, Davis, & Cornwell, 1988). It views parents and professionals as equals in a collaborative partnership committed to excellence at all levels of care (Ahmann, 1994; Bruce & Ritchie, 1997). However, barriers such as the physical environment, knowledge, skills and attitudes appear to prevent many health professionals from incorporating the principles of family-centered care in their practice (Hylton Rushton, 1990; Bruce & Ritchie, 1997; Letourneau & Elliott, 1996).

Nurses often experience role ambiguity and confusion regarding the role of parents in family-centered care (Brown & Ritchie; 1990; Coyne, 1995b; Letourneau & Elliott, 1996). Some of these difficulties are due to a need to shift from a medical helping model to that of an enabling model of care. Nurses practising under the medical helping model of care, have traditionally exerted power and control in their interactions and decisions with children and their families (Brown & Ritchie, 1989; Thorne & Robinson, 1988). In contrast, the enabling model of care empowers the family to be fully involved in the care of the child with health care needs (Letourneau & Elliott, 1996). Even though there has been a shift to increase parental involvement in the care of their children, this has not always been done without problems (Brown & Ritchie, 1990; Coyne, 1995a; Dunst, Trivette, Davis, & Cornwell, 1988).

Two recent studies (Bruce & Ritchie, 1997; Letourneau & Elliott, 1996) done in pediatric hospitals examined nurses' perceptions and practices of family-centered care. In both studies, statistically significant differences were noted between the nurses' perceptions and practices of family-centered care. Nurses were found to have a good understanding of the key elements necessary for family-centered care, but these elements were less evident in their every day practice. Furthermore, the element "parent/professional collaboration" received a very low rating on the perception scale suggesting that

it was not viewed as important to family-centered care (Bruce & Ritchie, 1997; Letourneau & Elliott 1996). The results of these studies provide evidence that nursing practice continues to reflect inconsistencies in the desired level of family-centered care. Letourneau & Elliott (1996) conclude that although family-centered care has been recognized as a satisfying and useful experience for children and their families, it has not found its rightful place among health care providers.

Several studies have identified factors that influence positively perceptions and practices of family-centered care. These factors include being married or being a parent, having a higher level of education (baccalaureate or master's prepared) (Gill, 1987,1993; Letourneau & Elliot, 1996) and years of experience (Gill 1993). Bruce & Ritchie (1997) also found that nurses in administrative or educational positions consistently reported a higher level of understanding of the key elements of family-centered care than did staff nurses.

The need for education activities such as skill development in interpersonal relationships, negotiation, and clarifying parental and professional roles have been identified as essential to the implementation of family-centered care (Brown, & Ritchie, 1989, 1990; Bruce & Ritchie 1997; DePompei, Whitford, & Hosang Beam, 1994; Gill, 1987; Hylton Rushton, 1990; Letourneau & Elliott, 1996). Involving families in policy development and orientation programs have also been suggested as a way to enhance family-centered care initiatives (Bruce & Ritchie, 1997; DePompei, Whitford, & Hosang Beam, 1994; Hylton Rushton, 1990).

In summary, recognition that hospitalization is a stressful experience for children, and that families have an important role to play in the care of their hospitalized child, has led to the development of a philosophy of family-centered care. The studies that have looked at nurses' perceptions and practices of family-centered have been mainly conducted in pediatric hospitals. Little is known about perceptions and practices of family-centered care of pediatric nurses working in general hospitals.

Purpose

The purpose of this study was to examine how nurses working on pediatric units in general hospitals perceive and practice the key elements of family-centered care.

Research Objectives

1. To describe nurses' views of the necessary elements (**perceptions**) of family-centered care.
2. To describe nurses' views of the necessary elements of family-centered care that are part of their current work (**practice**).
3. To examine the relationship between perceptions and practices of family-centered care and the following variables: age, education background, position, professional designation, experience and having children.

Methodology

This descriptive study was designed to measure nurses' reported perceptions and practices of family-centered care by means of a multi-site survey. Ethical approval for the study was obtained from the Ethics Committee at Laurentian University.

Setting

All Ontario general hospitals having a designated pediatric unit with a minimum of ten beds were considered eligible to participate in the study. The list of hospitals eligible for participation was generated from the 1995 Guide to Canadian Health Care Facilities directory. Forty-nine hospitals were found to meet the inclusion criteria. In the spring of 1997, a letter explaining the study was sent to the Director of Nursing or their equivalent inviting the hospital to participate. Hospitals interested in participating returned a short questionnaire indicating their intent to participate, the name of a contact person for the researchers, the number of pediatric beds and the number of registered nurses and registered practical nurses working on the unit.

Following the initial invitation to participate, 12 hospitals indicated that one or both inclusion criteria were not satisfied. Four of these hospitals were retained for the final sample as they expressed a strong desire to participate in the study. Six hospitals declined the invitation to participate. Therefore, 35 hospitals were included in the final sample and these hospitals were located in the northern, southern, eastern and western regions of the province. The number of pediatric beds in these hospitals ranged from 8 to 50.

Sample

All registered nurses and registered practical nurses working on the pediatric units of the participating hospitals were eligible to participate in the study. Based on information obtained from the hospitals at the time they agreed to participate, the number of potential respondents was estimated at 1035.

Instrument

The Family-Centered Care Questionnaire – Revised (FCCQ-R) developed by Bruce (1995) was used for the survey. The FCCQ-R is designed to measure health care professionals' perceptions and practices of family-centered care. It consists of 45 items distributed over nine sub-scales. The sub-scales represent the eight

elements of family-centered care defined by the ACCH and operationalized by Bruce (see Bruce & Ritchie, 1997). A ninth element was added by Bruce to reflect the importance of having a supportive work environment in order to fully implement family-centered care. The sub-scales and a representative item are presented in Table 1 found immediately below.

Table 1, The FCCQ-R Sub-Scales and Representative Items

FCC Sub-Scales	Number of Items	Representative Item
Family as a constant	3	Staff encourage parents and siblings to come and go any time that meets the family's needs.
Parent & professional collaboration	6	Parents contribute to the development and review of hospital policies & practices.
Family individuality	5	Staff discuss with the child and family what helps them deal with events during hospitalization.
Sharing information	5	Staff promote pre-admission programs which familiarize children & families with hospital staff, routines, & equipment prior to a scheduled admission.
Parent- to- parent support	4	Staff encourage parents to discuss concerns with other parents with similar experiences in formal or informal parent groups.
Developmental needs	5	Direct care managers have an adequate knowledge in child development to support hospital staff in the practice of family-centered care.
Emotional support for families	4	During procedures, a staff member is designated to explain to the child and family exactly what is happening.
Design of the health care delivery system	7	The physical layout of the unit is designed to meet the developmental and psychosocial needs of the child and family.
Staff support	6	Continuing education programs provide opportunities for staff to learn to deal effectively.

Respondents indicated on a 5-point Likert scale (strongly disagree to strongly agree) the extent to which each item is necessary to provide family-centered care (**perceptions**) and is included in their everyday work (**practice**). A sixth category, not applicable, was added enabling participants to respond to all items. The total possible score for the perceptions and practice scales was 225. The FCCQ-R also included eight questions relating to socio-demographic information and one open-ended question inviting the respondents to make suggestions on what was needed to enhance family-centered care in their workplace.

Internal consistency of the FCCQ-R

The internal consistency of the FCCQ-R was determined by calculating Cronbach's alpha for the total scale and the nine subscales. The alpha for the necessary elements (**perceptions**) scale was 0.84 and 0.85 for the current work (**practice**) scale. The reliability coefficients ranged from 0.53 to 0.80 for the necessary elements (**perceptions**) sub-scales and 0.50 to 0.76 for the current work (**practice**) sub-scales. The first sub-scale consists of only 3 items, which may partially account for the low alpha for this sub-scale.

Procedure and Data Collection

After finalizing the list of participating hospitals, each contact person was called by one of the researchers in order to review the study and their role. In September 1997 each contact person was mailed a packet containing the following: information letters for the potential respondents, FCCQ-R questionnaires, pre-addressed envelopes and a pre-addressed large envelope to be used to return the completed questionnaires to the researchers. Also included in the packet was an information letter for the contact person describing their role and responsibilities and a copy of the ethics approval

Table 2, Characteristics of the Respondents

Characteristic		Number	Percentage
Professional status:	Registered nurse	258	92.8
	Registered practical nurse	20	7.2
Age group:	21-30 years	26	10.8
	31-40 years	90	35.5
	41-50 years	106	41.7
	51-60 years	32	12.6
Primary position:	Administration/management	24	8.7
	Direct patient care	253	91.3
Parental status:	Parent	227	82.8
	Not a parent	47	17.2
Nursing experience:	0-9 years	39	14.9
	10-19 years	81	30.9
	20-29 years	110	42.0
	> 29 years	32	12.2
Pediatric experience:	0-9 years	92	36.4
	10-19 years	80	31.6
	20-29 years	72	28.5
	>29 years	9	3.5
Education background:	College/hospital diploma	230	83.3
	University degree	32	11.6

Note: Some respondents did not provide all requested information
The percentages are based on actual responses

letter. The contact person was responsible for explaining the study to the nurses, distributing the information letters and questionnaires to all potential subjects, and setting up a place where the respondents could deposit the completed questionnaires and returning the questionnaires to the researchers at the end of the data collection period.

Because of a postal strike and that some of the hospitals were dealing with ongoing restructuring and mergers the data collection period lasted until the end of November. In December, a reminder phone call was made to the contact persons who had not returned their packet of completed questionnaires. A final follow up phone call was made in April 1998 to the three hospitals that had not returned the completed questionnaires. These were received and included in the final sample. Questionnaires were received from all of the participating hospitals. A total of 338 questionnaires were returned for overall response rate of 33%.

Data analysis

In preparation for analysis, 27 questionnaires with eight or more FCCQ-R items left unanswered were removed. As well another 25 were removed because the demographic information section was not completed and seven were removed because the respondents were not registered nurses or registered practical nurses. A total of 279 questionnaires were retained for analysis. Data from the FCCQ-R were analysed according to the subscales representing the nine elements of family-centered

care and the total scale scores. Rating scores were coded as 1 strongly disagree, 2 disagree, 3 neutral, 4 agree and 5 strongly agree. Descriptive and inferential statistics were used. Quantitative analyses involved SPSS software on a VAX/VMS 4000 computer. Content analysis was conducted on the open-ended question and recurrent themes were identified.

Findings

Profile of the Respondents

The major characteristics of the respondents are listed in Table 2 on the previous page. Nearly all were registered nurses (92.8%) and most were employed in positions involving direct patient care (91.3%). The average age was 41 years (SD = 7.97) with a range of 22 to 58 years. The average years of nursing experience was 19.15 years (SD =8.79) with a range of under one year to 40 years. Slightly more than one half (54.2%), had more than 20years of nursing experience. The average years of pediatric nursing experience was 13.99 (SD =8.90), with a range from under one year to 37 years. Almost one third (32%) had 20 years or more of pediatric experience. Most participants were diploma prepared (83.3%) and some (10.5%) were currently pursuing university studies. While only a third (33.2%) reported having participated in family-centered care continuing education sessions, the majority (87.3%) expressed interest in attending such sessions.

FCCQ-R Rating Scores

The mean scores of the nine elements of the perception and practice scales are presented in Table 3. All but one of the mean scores of the perception subscales was above 4.0 indicating that the respondents agreed on the necessity of these elements for the practice of family-centered care. However, the mean scores of the practice sub-scales ranged from a low of 3.14 to a high of 4.06 with only two elements rated above four, suggesting that they were not included consistently in every day practice. In order to determine if statistically significant differences existed between perceptions and practice, t-tests for paired samples were conducted on the total scale and sub-scale scores for reported perceptions and practices of family-centered care. All were found to be statistically different at the $p<.001$ level (see Table 3). Total score on the perception scale (M=189.34, SD = 18.52), was higher than that of the total practice scale score (M=159.41, SD =23.86), (t=14.56, df 129, $p<.001$).

Congruency between Perceptions and Practices of Family-Centered Care

The element "family individuality" received the highest mean score on both the perception and practice scales. Respondents agreed that respect for privacy during interviews, assessments and teaching based on individual needs and learning styles, and discussion with child and family of what helps to enhance coping with events during hospitalization were important elements of family-centered care and were generally part of their practice. The smallest difference between the mean scores was found on the perception and practice subscale "family as a constant" with a mean score of over 4.0 on both scales. The nurses agreed that in their practice the family is the key decision maker in the care of the child, they work with families to determine the level of participation in direct care, and encourage parents and sibling to come and go as they need.

Differences between Perceptions and Practices of Family-Centered Care

The greatest difference between the perceptions and practice mean scores was found in the sub-scale "staff support". While the respondents agreed that issues such as practice guidelines, continuing education programs, and recognition of staff knowledge and skills are needed to care for children and families from a family-centered care approach, these were frequently lacking in their actual work situation. The lowest mean score (3.96) on the perception sub-scale was "parent and professional collaboration". The nurses only somewhat agreed that activities such as parent participation in policy making, parental involvement in identifying their child's needs, and educational programs that convey a sense of trust that families are key participants in care, are necessary for parent/professional collaboration. Furthermore, "parent and professional collaboration" mean score (3.98) on the practice scale supports that activities included in this element were not a priority in their every day practice. The element "design of the health care delivery system" received the lowest mean score (3.14) on the practice scale, suggesting that factors such as the lay out of the paediatric unit, and the lack of resources (material and personnel) impeded their ability to practice family-centered care. However, the mean score (4.05) on the perception scale suggest that they agreed that the element was necessary to family-centered care.

Factors Influencing Perceptions and Practices of FCC

One-way analysis of variance tests were conducted in order to determine if reported perceptions and practices varied with education level, professional designation, position, whether they had children, participation in family-centered care continuing education, and interest in participating in a family-centered care workshop. Perceptions of family-centered care were higher for those who had completed university studies [$F(1;170) = 9.99$, $p = .002$] than those who had not, however, everyday work scores were not significantly different [$F(1;143) = 1.88$, $p = 0.17$]

Respondents who had participated in continuing education had significantly higher scores on the perceptions scale, [F (1;171) = 12.38, p= 0.0006], and practices, [F (1;144) = 6.61, p = 0.01] than those who had not participated. Scores were not significantly different for the perceptions [F (1;170) = 2.59, p =0.11] and practices, [F (1;143) = 0.68, p= 0.41] scales between those who had interest in participating in a workshop and those who did not. No other statistical signifcant differences were found. Multiple regression analyses revealed no statistical evidence to support any linear effect of age or nursing experience on the difference between perception of necessary elements and current practice of family-centred care.

Barriers to Family-Centred Care

Many nurses provided comments that reflected their concerns and difficulties in implementing the principles of family-centered care in their everyday practice. Barriers frequently noted included the lack of staff education on how to work with families, a need for additional resources for health teaching and a need for more nursing staff. The physical environment of the paediatric unit was often described as being detrimental to family-centrered care. Examples of this included the lack of privacy areas and facilities such as telephones and kitchens for families. The lack of administrative support for family-centered care was also noted by many.

Discussion

The findings suggest that the nurses who participated in the study generally believed that the elements included on the FCCQ-R were necessary to practice family-centered care. This finding was also found in two recent studies that examined nurses and other health care professionals' perceptions and practices of family-centered care (Bruce & Ritchie, 1997; Letourneau & Elliott, 1996). Earlier studies concluded that nurses' lack some of the knowledge needed to practice family-centered care (Hayes & Knox, 1984; Knafl, Cavelleri & Dixon, 1988, Brown & Ritchie, 1989). The nurses who participated in this study indicated an understanding of the complexities of caring for children and their families. These differences may reflect an improvement in knowledge of family-centered care and suggest that strides have occurred in the understanding of the benefits of family-centered care for children and families.

The results revealed that nurses who had completed university studies or who participated in continuing education sessions had more positive perceptions of family-centered care. These findings are similar to other studies done in children's hospitals (Bruce & Ritchie, 1997; Gill, 1987, 1993; Letourneau & Elliott, 1996). As noted by Bailey, Simeonsson, Yoder, & Huntington (1990), the need for additional specific knowledge and skills in working with families in basic health professional programs is essential to the successful implementation of family-centered care. The recent decision by the College of Nurses of Ontario (Risk, 1999) to make the baccalaureate in nursing a requirement for new registered nurses should help address the need to increase the knowledge and skills in working with families in nursing education programs.

While agreement with the necessary elements of family-centered care was evident, the respondents reported that these elements were not consistently incorporated into their everyday work with families. These findings are remarkedly similar to those found in two studies done in children's hospitals (Bruce & Ritchie, 1997; Letourneau & Elliott, 1996). This suggests that while advances have been made in recognizing the key elements of family-centered care, difficulties remain in implementing these elements in practice. Difficulties identified by the respondents included, the lack of continuing education opportunities on how to work with families, a need for additional resources for health teaching, paediatric units that were not designed to support the principles of family-centered care and a lack of administrative support. Others (Bruce & Ritchie, 1997; Coyne, 1995b; Hylton-Rusthon, 1990) have reported similar barriers. These difficulties can be linked to hospital policies and priorities and suggest that unless the decision-makers, including nurse leaders, understand the special needs of children and families and the staff caring for them, barriers to the implementation of family-centered care will continue.

It has been suggested that one of the reasons why nurses have difficulty incorporating the principles of family-centered care in their practice is because they have been educated in a medical helping model of care, rather than in an enabling model of care (Bruce & Ritchie, 1997; Letourneau & Elliott, 1996). The results of this study lend credence to this assumption. The family-centered care element most agreed upon on both subscales was "family individuality", while the smallest difference between sub-scales was for the element "family as a constant". These findings suggest that the nurses cognitively understand the place of families in the life of children and recognize that families are all different with their own strengths and weakness. Nurses have incorporated these ideas in their practice. These elements fit well with the medical helping model of care. While they may encourage families to participate in some aspect of the care of their children, it is done under the guidance and control of the nurses (Brown & Ritchie, 1989; Coyne, 1995a).

FCC Sub-Scales	Perceptions Mean scores	Practice Mean Scores	s.d*	Correlation	t-value **	df
Family individuality	4.55	4.06	0.54	0.48	14.63	271
Emotional support for families	4.41	3.85	0.69	0.42	13.28	266
Sharing information with families	4.37	3.68	0.68	0.42	15.63	239
Developmental needs	4.32	3.82	0.58	0.45	13.66	247
Staff support	4.25	3.20	0.88	0.31	18.32	231
Family as a constant	4.23	4.03	0.49	0.71	6.60	271
Design of health care delivery system	4.05	3.14	0.76	0.33	17.36	209
Parent-to-parent support	4.03	3.33	0.75	0.46	14.19	233
Parent–professional collaboration	3.96	3.48	0.59	0.48	12.34	223
Total	**189.34**	**159.41**	**23.4**	**0.41**	**14.56**	**129**

Note: Range 1-5 A higher mean score indicates a higher level of agreement
* The estimated standard deviation of the difference between current practice and necessary elements
** All statistically significant at p<.001

The element "parent and professional collaboration" received the lowest rating on the perception scale and was ranked low on the practice scale, suggesting that the respondents did not see the principles and activities included in this element as essential to family-centered care. This finding was also noted in the Bruce and Ritche, (1997), and Letourneau & Elliott, (1996) studies. Working collaboratively with parents requires trust, risk taking and relinquishing of control. As noted in other studies (Brown & Ritchie, 1989; Callery & Smith, 1991; Knafl, Calvalleri & Dixon, 1988), nurses in this study may not have been prepared for a shift in role, one in which parents are their true partners in care. Collaboration between parents and professional is at the core of the enabling model of care (Dunst, Trivette & Deal, 1988) and the acquisition of knowledge and skills needed to practice within this model appears evident.

The respondents also reported that administrative support for family-centered care must be reflecte in policies and programs, but this was not always evident in their work place. The restructuring and budge cuts that occurred in the Ontario hospital sector over th last few years has had a major impact on nursing and a noted in the Report of the Nursing Task Force (1999 opportunities for continuing education and mentorin have been greatly cut back (see p.16). This most prob ably had a negative impact on programs that were in plac to enhance the development of family-centered care.

While the staff reported that the design of th health care delivery system needs to facilitate the im plementation of family-centered care, this was not a ways so in their hospital. This finding has also bee

reported in the literature (Coyne, 1995b; Hylton Ruston, 1990). Caring for children in general hospitals poses special challenges, as the needs of children and families are frequently not understood and must compete with the needs of adults and high profile programs. A phenomenon now seen in some of the Ontario general hospitals is the merging of paediatric units with obstetrical units or even adult medical-surgical units. This is frequently done under the guise of restructuring and budget demands and poses new challenges for those who espouse a family-centered care model of care delivery.

Study Limitations

The response rate was low (33%) and affects the ability to generalize the findings. Little is known about what steps the contact persons took to publicize the study, how they distributed the questionnaire to the potential participants and encouraged their participation. Staff absence during the data collection period due to work scheduling, sick leave, holidays or other reasons may have also affected the response rate.

The estimated number of potential participants was identified during the initial contact with the hospitals. During the study period significant hospital restructuring was occurring across the province with some paediatric units being downsized or merged. It is therefore possible that the number of potential participants for each unit was in fact lower at the time of data collection. It is also possible, that the massive hospital restructuring occurring across the province was stressful for the nurses and completing the questionnaire added to their stress and was not seen as a priority for them.

A substantial number of questionnaires were returned incomplete and were not usable for data analysis. This shortcoming raised the question about whether the nurses understood the directions, their professional responsibilities to the research process and the consequences of not completing all aspects of the questionnaire as requested.

Implications for Practice, Education and Research

A number of implications emerge from the results of this study. The need for continuing education sessions that focus on skill development that facilitate parent/professional collaboration is warranted for nurses working with children and families in general hospitals. Basic nursing education programs need to incorporate, in a more systematic way, the concepts of family-centered care and give students opportunities to develop the necessary skills in clinical experiences. Administrators and nurse leaders in key positions in general hospitals with paediatric beds need to recognize the special needs of children and families and these must be translated into policies and programs that facilitate and reward nurses as they shift towards an enabling model of family-centered care. This is especially important at a time when mergers and restructuring of the hospital system continues. Advocates of a family-centered model of care delivery need to be vigilant, so that the needs of children and families are not forgotten. Future research in the field of family-centered care should include family's experiences with family-centered care, a more in-depth examination of organizational support for family-centered care, and an evaluation of the influence of continuing education sessions and a family-centered delivery model of care on patient outcomes.

Conclusion

The findings suggest that the pediatric nurses had a reasonable understanding of the elements necessary to practice family-centered care. However, the elements were not consistently included in their actual practice. The results provide important information regarding the perceptions and practice of family-centered care of nurses working on paediatric units in general hospitals and add to a growing body of knowledge regarding family-centered care. Difficulties in implementing family-centered care appear to be systemic, both at the unit and organizational level. At a time of massive restructuring of the hospital system, advocates of a family-centered model of delivery of health care for children and families will need to be vigilant so that this approach to care is not sacrificed.

Acknowledgment

This study was funded by the Laurentian University Research Fund. The researchers wish to thank the hospitals that participated in the study, the contact persons who facilitated the data collection process and the nurses who completed the questionnaire.

Authors

Suzanne Caty, RN, MSc is a full professor at the School of Nursing, Laurentian University, Sudbury ON.

Sylvie Larocque, is an assistant professor at the School of Nursing, Laurentian University, Sudbury ON.

Irene Koren, is an assistant professor at the School of Nursing, Laurentian University, Sudbury, ON.

References

Ahmann, E. (1994). Family-centered care: shifting orientation. Pediatric Nursing, 20(2), 113-117.

Bailey, D.B., Simeonsson, R.J.,Yoder, D.Y., & Huntington, G. S. (1990). Preparing professionals to serve infants and toddlers with handicaps and their families: an integrative analysis across eight disciplines. Exceptional Children, 57(1), 26-35.

Brown, J. & Ritchie, J. A. (1989). Nurses' perceptions of their relationships with parents. Maternal-Child Nursing Journal, 18(2), 79-96.

Brown, J. & Ritchie, J.A. (1990). Nurses' perceptions of parent and nurse roles in caring for hospitalized children. Children's Health Care, 19(1), 28-35.

Bruce, B. (1995). Personal communication. Halifax, Nova Scotia.

Bruce, B. & Ritchie, J. (1997). Nurses' practices and perceptions of family-centered care Journal of Pediatric Nursing, 12(4), 214-222.

Coyne, I.T. (1995a). Parental participation in care: A critical review of the literature. Journal of Advanced Nursing, 21, 716-722.

Coyne, I. T. (1995b). Partnership in care: Parents' views of participation in their hospitalized child's care. Journal of Clinical Nursing, 4, 71-79.

Callery, P. & Smith, L. (1991). A study of role negotiation between nurses and the parents of hospitalized children. Journal of Advanced Nursing, 16, 772-781.

DePompei, P.M., Whitford, K.M., & Hosang Beam, P. (1994). One institution's efforts to implement family-centered care. Pediatric Nursing, 20(2), 119-122.

Dunst, C.J., Trivette, C.M., Davis, M., & Cornwell, J. (1988). Enabling and empowering Families of children with health impairments. Children's Health Care, 17(2), 71-81.

Dunst, C., Trivette, C., & Deal, A. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline.

Gill, K.M. (1987). Nurses' attitudes toward parent participation: personal and professional characteristics. Children's Health Care, 15 (3), 149-151.

Gill, K.M. (1993). Health professionals' attitudes toward parent participation in hospitalized children's care. Children's Health Care, 22(4), 257-271.

Guide to Canadian Health Care Facilities. (1995). Canadian Health Care Association. Ottawa.

Hayes, V.E. & Knox, J.E. (1984). The experience of stress in parents of children hospitalized with long-term disabilities. Journal of Advanced Nursing, 9, 333-341.

Hylton Rushton, C. (1990). Family-centered care in the critical care setting: Myth or reality? Children's Heath Care, 19(2), 68-78.

Johnson, B., Jeppson, E., & Redmond, L. (1992). Caring for Children and Families: Guidelines for Hospitals. Bethesda, MD: Association for the Care of Children's Health.

Knafl, K.A., Cavelleri. K.A., & Dixon, D. (1988). Pediatric Hospitalization: Family and Nurses Perspectives. London: Scott, Foresman.

Letourneau, N.L. & Elliott, M.R. (1996). Pediatric health cares professionals' perceptions and practices of family-centered care. Children's Health Care, 25(3), 157-174.

Report of Nursing Task Force (1999). Good nursing, good health: An investment for the the 21ST century. Government of Ontario: Toronto.

Risk, M. (1999) RN entry to practice – moving to a new requirement. Communiqué, 24(1), 42.

Shelton, T.L., Jeppson, E.S., & Johnson, B.H. (1987). Family-Centered Care for Children with Special Health Care Needs. Washington, DC: Association for the Care of Children's Health.

Thorne, C. & Robinson, S.E. (1988). Health care relationships: the chronic illness perspective. Research in Nursing and Health, 111, 293-300.