

Family-centred practices of healthcare professionals in three emergency departments in KwaZulu-Natal, South Africa

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Background. Emergency healthcare professionals can practise family-centred care (FCC) by engaging in active partnerships with families. In a chaotic environment, which challenges communication and supportive behaviours, responding to and acknowledging families' individuality enhance positive family outcomes.

Objective. To describe the adherence of emergency healthcare professionals to family-centred practices in some emergency departments in KwaZulu-Natal, South Africa.

Methods. A quantitative survey was conducted among healthcare professionals in three emergency departments. A previously published checklist was used to collect data on adherence to relational and participatory family-centred practices.

Results. A total of 77 completed questionnaires were received from the 79 participants surveyed, giving a response rate of 97.5%. Analysis showed that healthcare professionals endeavour to practise FCC, but that their implementation of practice indicators of family-centred care is inconsistent. Results suggested that healthcare professionals used relational practices to a larger extent than participatory practices.

Conclusion. In the emergency department, collaboration and partnering with families should be emphasised to ensure that principles of FCC are practised as a standard.

Keywords. Family, health care professionals, emergency department, relational practices, participatory practices.

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Family-centred care (FCC) is holistic in that it conceptualises illness as a family experience.^[1] Effective implementation of FCC involves collaboration between families and healthcare professionals, creating an enabling partnership that respects the sociodemographic diversities of families.^[2] Various challenges to the slow evolution of FCC to practice have been cited, with the threat to healthcare professionals' locus of control superseding all barriers.^[3] This may be attributed to difficulties among both organisations and staff to implement a triad of cognitive, behavioural and attitudinal changes. Other challenges include the limited understanding of FCC principles by healthcare professionals and communication difficulties.^[4,5]

In South Africa (SA), trauma accounts for the greatest number of unnatural deaths and disabilities in emergency departments (EDs).^[6] The initial management of a critical illness occurs in the ED, which results in emergency care and critical care being considered as one in the continuum of acute care.^[7] Families and critically ill patients often remain in the ED owing to access block and high bed occupancy in critical care units.^[8] Families accompanying their loved ones to the ED are usually unprepared for the turmoil associated with the experience and depend on healthcare professionals to support them through this crisis.^[9] To help a patient's family members to adapt, it is important for healthcare professionals to adhere to relational and participatory family-centred practices.^[10,11] Relational practices enable healthcare professionals to build effective and authentic relationships with families; participatory practices are action oriented, aimed at assisting families in capacity building.^[11,12] Family-centred practices may appear incompatible with the ED culture, in which objectivity and detachment have priority in clinical decision-making.^[13] Healthcare professionals, accustomed to

providing life-saving care, need to be quick thinkers who are decisive and in control,^[14] and to camouflage the vulnerability that emergency cases may expose them to, they are taught to remain detached lest their emotions interfere with effective decision-making.

Despite the escalation in trauma in SA and the subsequent need to support families in the ED, little research has been conducted on family care in this setting.^[15] Relationships with a patient's family members are shaped by how healthcare professionals perceive the relationship: the more responsive the healthcare professional to the values of FCC, the greater the adherence to family-centred practices.^[13,16]

To comment on potential gaps in implementation, this study considered the adherence of emergency healthcare professionals to family-centred practices in three EDs in KwaZulu-Natal, SA.

Methods Setting and study design

The study was conducted in the EDs of three hospitals in KwaZulu-Natal, SA, using a descriptive survey design. Setting A is a private hospital situated in the eThekweni Metropolitan municipality, Setting B is a state hospital (regional and district) located in the eThekweni health district and Setting C is a state hospital that offers regional and tertiary services to the uMgungundlovu district and the western part of the province. EDs at state hospitals in SA are commonly short staffed,^[17] which may impede healthcare professionals' ability to implement family-centred practices consistently.^[18] The settings were specifically chosen with this in mind and to include diversity. All three hospitals have dedicated EDs that provide emergency services to patients with either acute or chronic conditions.

Population, sample and sampling

The population comprised healthcare professionals staffing the three EDs, including: (i) doctors; (ii) nurses registered with the South African Nursing Council as an enrolled nurse with a two-year certificate or as a professional nurse with a diploma or degree in nursing, and (iii) healthcare professionals with or without a qualification in emergency nursing. On advice from the statistician, all ED staff who met these criteria were invited to participate to accommodate a small population size ($N=82$).^[19] The sample size ($n=77$) derives from sampling of healthcare professionals working in specialised, high-acuity EDs.

The study describes rather than quantifies adherence to family-centred practices in a population of emergency healthcare professionals^[20] and forms part of a larger mixed-method interventional study.

Data collection tool

With permission from its developers, the Family-Centered Practices Checklist^[21] was administered to healthcare professionals to rate their adherence to 17 practice indicators (PIs). The questionnaire was designed with input from families and healthcare professionals and it enables reflection on practices that occur during interactions between the healthcare professional and the family. The checklist includes a relational component and a participatory component, each of which is divided into two clusters (Table 1). The relational component covers practices that promote effective interaction and the participatory component focuses on family interaction.^[21]

PIs were rated according to the following scale:

- 1 – yes, PI was consistently used
- 2 – PI was partially/sometimes adhered to
- 3 – PI not used/opportunity missed
- 4 – not applicable/no opportunity to observe.

The percentage of 'yes' responses in the checklist provides a measure of quality regarding family-centred practice, with a lower score indicating greater adherence to family-centred practice.^[21] A point of concern for the researcher was that the instrument had no cut-off scores. With the assistance of the statistician, the following denotations were used: a score of 17 indicated total adherence to all PIs, an average of 34 indicated that work still needed to be done to ensure adherence, and a score of 68 indicated no adherence. These interpretations were based on the premise that relational and participatory practices should always be present in interactions between a healthcare professional and a patient's family.^[22] Simple descriptive information was collected with regard to a healthcare professional's age, gender, qualification and number of years working in the ED.

Validity and reliability

Content validity was achieved through a pilot study with five participants, during which the content was examined for clarity, length and specificity in the SA context. Excellent internal consistency was confirmed (Cronbach's $\alpha = 0.94$). Face validity was established through peer review by an emergency nurse specialist and a family nurse specialist.

Data collection process

The researcher contacted the medical and nursing directors of the hospitals and was referred to a liaison within each ED, through whom the researcher met the healthcare professionals. The purpose of the study was explained and healthcare professionals were invited to participate. Written consent was obtained prior to completion of the questionnaire. Data were collected from March to April 2017.

Statistical analysis

Mean scores were calculated for each PI, as well as an overall mean score. Statistical analyses included analysis of variance and an independent sample *t*-test to assess the influences of demographic variables (gender, age, experience and qualifications of participants) on the overall scores in the four clusters. The Kolmogorov-Smirnov test showed that the scores were normally distributed, which justified the use of the parametric *t*-test. Significance was set at $p < 0.05$. Data were computed based on the total number of non-missing cases.

Ethical considerations

Ethical approval for the study was obtained from the university's Ethics Committee (ref. no. HSS/1731/015D) and the private hospital (ref. no. 20160206). Permission for conducting the study in the state hospitals was obtained from the KwaZulu-Natal Department of Health (ref. no. HR KM44/16 KZ_2016 RP 22_946). Participation in the study was voluntary. An information sheet detailing the right to withdraw from the research and the risk-benefit ratio of the study was attached to the consent form. Confidentiality was assured through coding questionnaires and electronic data were password protected.

Results

A response rate of 97.5% was achieved ($N=77/79$).

Demographic characteristics

Of the participants, 13.0% ($n=10$) were from hospital A, and 54.5% ($n=42$) and 32.5% ($n=25$) were from hospital B and hospital C, respectively (Table 2). The majority of the participants were female ($n=58$; 75.3%). The participants were predominantly between 30 and 39 years of age ($n=33$; 42.7%) and had between 1 and 5 years of experience in an ED ($n=35$; 45.5%). Nurses comprised 90.9% ($n=70$) of the sample. Only 12 participants (15.6%) had an additional qualification in emergency care (Table 2).

Family-centred practices

The average overall score for the checklist was 25.6. The mean score per PI was 1.5. Scores for individual PIs are shown in Tables 3 and 4.

Relational practices component

Interpersonal skills cluster

The average score for the cluster was 3.6. The majority of 'yes' responses were with regard to treating families non-judgementally and with dignity and respect ($n=68$; 88.3%), resulting in a mean score of 1.3.

Table 1. Composition of the Family-Centered Practices Checklist^[21]

Component	Clusters	Number of practice indicators
Relational practices	Interpersonal skills	3
	Asset-based attitudes	4
Participatory practices	Family choice and action	5
	Practitioner responsiveness	5

Table 2. Demographic characteristics of study sample (N=77)

Characteristics	Hospital A* (N=10), n (%)	Hospital B† (N=42), n (%)	Hospital C† (N=25), n (%)
Gender			
Male	5 (50.0)	7 (17.1)	7 (28.8)
Female	5 (50.0)	35 (82.9)	18 (72.2)
Age (years)			
18 - 29	5 (50.0)	12 (28.6)	2 (8.0)
30 - 39	3 (30.0)	16 (38.1)	14 (56.0)
40 - 49	2 (20.0)	10 (23.8)	6 (24.0)
50 - 59	0 (0)	4 (9.5)	3 (12.0)
≥60	0 (0.0)	0 (0.0)	0 (0.0)
Experience in emergency department			
6 - 11 months	5 (50.0)	11 (26.2)	7 (28.0)
1 - 5 years	3 (30.0)	24 (57.1)	8 (32.0)
6 - 10 years	0 (0.0)	2 (4.8)	3 (12.0)
11 - 20 years	2 (20.0)	1 (2.4)	4 (16.0)
>20 years	0 (0.0)	4 (9.5)	3 (12.0)
Qualification			
Enrolled nurse	4 (40.0)	7 (16.7)	0 (0.0)
Diploma in General Nursing	6 (60.0)	32 (76.2)	16 (64.0)
Degree in Nursing	0 (0.0)	1 (2.4)	4 (16.0)
Medical doctor	0 (0.0)	2 (4.7)	5 (20.0)
Additional emergency care/trauma qualification	1 (10.0)	3 (7.1)	8 (50.0)

*Private hospital.

†State hospital.

Asset-based attitudes cluster

The average (mean) score in this cluster was 5.8 (1.2). Communicating positively with families was consistently used by the majority of respondents ($n=61$; 79.2%).

Participatory practices component

Family choice and action cluster

The average score across this cluster was 8.8. Working with families to identify and address their desires was cited as being adhered to most often ($n=43$; 56.6%) and was associated with a mean score of 1.6.

Practitioner responsiveness cluster

The average score for the cluster was 7.4. Supporting and respecting families' decisions was adhered to most often ($n=61$; 79.2%) and was associated with a mean score of 1.2.

Demographic influences on the overall scores within clusters

The results revealed a significant difference between years of experience in the ED and the cluster of practitioner responsiveness ($p=0.04$) (Table 5). No statistical variations in the overall cluster scores were evident in the remaining possible associations.

Discussion

Demographic characteristics of participants

Similar to studies from some other developing countries,^[10,23] the majority of participants were nurses. This might contribute to FCC in the current setting, as Duran *et al.*^[24] concluded that nurses tend to have a more positive attitude towards family-centred practice than physicians.

Family-centred practice

The mean overall score achieved with the checklist indicates that participants did not consistently adhere to the 17 family-centred PIs.

The finding could be attributed to staffing constraints, which remain a challenge in EDs in the SA setting and may have hindered collaboration with families.^[9] Such a situation would be of concern, as relational and participatory practices are associated with greater family empowerment. Practitioners' adherence to relational and participatory practices is essential in building effective partnerships through increased family involvement^[25] and positive interactions of this kind lead to effective implementation of family interventions. Although a mean score of 1.5 per PI in the study could be regarded as satisfactory, it indicates that family-centred practices are not consistently adhered to and do not feature in every family interaction. This is similar to a finding by Shields *et al.*^[26] in an Australian study.

Relational practices

Interpersonal skills cluster

The majority of the participants treated families in a dignified and respectful manner. Thébaud *et al.*^[27] note that, as core values in FCC, respect and dignity help to promote partnerships and engagement with families. A similar observation was noted in a Finnish study,^[28] where nurses who had to provide emotional support to families of patients with traumatic brain injury reported that they were respectful to families and provided guidance based on their individual circumstances.

Results from the current study show that only 68% of the participants communicated clearly and so provided complete information at a level that families could understand. This is similar to findings in a Brazilian study, in which Zani *et al.*^[29] found that communication between staff and families was not consistent. Communicating accurate information is essential in family-staff interactions as it enables families to exercise autonomy in decision-making. Unclear communication contributes to anxiety and dissatisfaction in patients' families when they are already stressed.^[9]

Asset-based attitudes

Most participants agreed that they communicated to and about the family

Table 3. Responses to practice indicators in the relational practices component (N=77)

Clusters	Practice indicator	Scores				Mean (SD)
		1, n (%)	2, n (%)	3, n (%)	4, n (%)	
Interpersonal skills	1. Communicate clear and complete information in a manner that matches the family's style and level of understanding (N=76)*	52 (68.4)	24 (31.6)	0 (0.0)	0 (0.0)	1.3 (0.5)
	2. Interact with the family in a warm, caring, and empathetic manner	63 (81.8)	14 (18.2)	0 (0.0)	0 (0.0)	1.2 (0.4)
	3. Treat the family with dignity and respect and without judgement	68 (88.3)	9 (11.7)	0 (0.0)	0 (0.0)	1.1 (0.3)
Asset-based attitudes	4. Communicate to and about the family in a positive way	61 (79.2)	16 (20.8)	0 (0.0)	0 (0.0)	1.2 (0.4)
	5. Honour and respect the family's personal and cultural beliefs and values (N=76)*	55 (72.4)	19 (25.0)	2 (2.6)	0 (0.0)	1.3 (0.5)
	6. Focus on individual and family strengths and values (N=76)*	35 (46.1)	35 (46.1)	5 (6.5)	1 (1.3)	1.6 (0.7)
	7. Acknowledge the family's ability to achieve desired goals (N=74)*	33 (44.6)	35 (47.3)	5 (6.8)	1(1.3)	1.7 (0.7)

SD = standard deviation.
*Missing data.

Table 4. Responses to practice indicators in the participatory practices component (N=77)

Clusters	Practice indicators	Scores				Mean (SD)
		1, n (%)	2, n (%)	3, n (%)	4, n (%)	
Family choice and action	1. Work in partnership with parents/family members to identify and address family-identified desires (N=76)*	43 (56.6)	25 (32.9)	5 (6.6)	3 (3.9)	1.6 (0.8)
	2. Encourage and assist the family to make decisions about and evaluate the resources best suited for achieving the desired outcomes	36 (46.7)	28 (36.4)	10 (13.0)	3 (3.9)	1.8 (0.9)
	3. Seek and promote ongoing parent/family input and active participation regarding desired outcomes (N=76)*	40 (52.6)	23 (30.3)	9 (11.8)	4 (5.3)	1.7 (0.9)
	4. Encourage and assist the family to use existing strengths and assets as a way of achieving desired outcomes	41 (53.2)	24 (31.2)	6 (7.8)	6 (7.8)	1.7 (0.9)
	5. Provide family participatory opportunities to learn and develop new skills (N=76)*	35 (46.1)	21 (27.6)	13 (17.1)	7 (9.2)	1.9 (1.0)
	6. Assist the family to consider solutions for desired outcomes that include a broad range of family and community supports and resources. (N=76)*	35 (46.1)	31 (40.7)	5 (6.6)	5 (6.6)	1.7 (0.9)
Practitioner responsiveness	7. Support and respect family members' decisions	61 (79.2)	15 (19.5)	0 (0.0)	1 (1.3)	1.2 (0.5)
	8. Work with the family in a flexible and individualised manner	49 (63.6)	23 (29.9)	2 (2.6)	3 (3.9)	1.5 (0.7)
	9. Offer help that is responsive to and matches the family's interests and priorities	43 (55.8)	29 (37.7)	2 (2.6)	3 (3.9)	1.5 (0.7)
	10. Assist the family to take a positive, playful approach to achieving desired outcomes	47 (61.0)	21 (27.3)	6 (7.8)	3 (3.9)	1.5 (0.7)

SD = standard deviation.
*Missing data.

Table 5. Influence of demographic variables on adherence to family-centred practices grouped according to indicator clusters (N=77)

Demographic variables	Interpersonal skills (p-value)	Asset-based attitudes (p-value)	Family choice and action (p-value)	Practitioner responsiveness (p-value)
Gender	0.47	0.80	0.73	0.11
Age	0.21	0.92	0.35	0.52
Experience in emergency department	0.58	0.10	0.63	0.04
Qualifications	0.80	0.12	0.67	0.54

in a positive way. This is in line with findings by Lukmanulhakim *et al.*,^[30] who reported that nurses in an emergency room in Indonesia displayed active listening skills and were calm and friendly towards families. The authors concluded that the more effective the communication, the less the anxiety of patients' families. Planned meetings with family members also create opportunities for honest, empathetic communication.^[27]

Less than half of the participants in the current study indicated that they always acknowledged the family's ability to achieve desired goals. The finding is noteworthy, as encouraging an asset-based attitude increases the likelihood that a patient's family will make progress, gain competence and function more effectively.^[31]

Participatory practices

Family choice and action

Responses in this cluster of PIs indicate that the respondents did not always use practices that encourage family participation and decision-making in the illness experience. In a study in Turkey, Shields *et al.*^[5] found that the family of patients in the ED wanted to partner with healthcare professionals, which suggests that participatory practices should be considered when planning FCC. Just over half of the respondents in the current study indicated that they partnered with family members to identify and subsequently address their desires. Shields^[32] notes that there is a difference between what families actually need and what healthcare professionals assume they need, and that the mismatch creates discord between family and staff.

Notably, less than half of participants reported that they always provided families with opportunities to participate and develop skills. Although genuine partnerships between families and practitioners are crucial in effective implementation of FCC,^[33] care workers tend to be more proficient in relational than participatory practices. Healthcare and allied workers need to be trained to tailor FCC practices to the needs and desires of families and be able to identify the preferences of each family, as this increases trust and indicates respect for the individuality of the family.^[4]

Practitioner responsiveness

Most participants stated that they always supported and respected families' decisions, similar to findings in a study by Gill *et al.*^[34] According to Coco *et al.*,^[28] families often want to make decisions on how they grieve and cope, and this must be acknowledged by practitioners. In a Brazilian study, Baretto *et al.*^[23] reported that systematic work needs to be undertaken so that the family is valued and can collaborate in the emergency process.

Less than half of the participants in the current study reported that they provided resources to help families make decisions. Shields^[32] notes that empowering families involves not only meeting their needs but also mobilising resources and support to help them gain control of their lives. In a study by Almaze and De Beer,^[35] the majority of emergency nurses agreed that they provided timely, factual information to families, which aided decision-making, and participants in a study by Brysiewicz and Bhengu^[4] suggested that social workers and chaplains were needed to provide families with additional support. Interdisciplinary support is especially applicable in the ED, where staff morale can be low and resource constraints may not permit staff to provide adequate support.

Demographic influences on practising family-centred care

Respondents with more extensive ED experience scored worse with regard to practitioner responsiveness. This is contrary to findings

reported in other studies.^[3,27,36] No statistically significant relationships were found between qualifications, gender or participants' age and the overall scores in the four indicator clusters. This is contrary to findings from a study in Turkey, where Shields *et al.*^[5] found that practitioners who held a specialist qualification had a better score on working with patients and their families. Similarly, an Australian study revealed that perceptions among ED staff regarding collaborating with families were influenced by education levels, gender and prior experience ($p=0.05$), marital status ($p=0.04$) and having children ($p=0.02$).^[26] In their Irish study, Coyne *et al.*^[3] concluded that nurses with a degree qualification scored better with regard to their perception of FCC than nurses with a certificate qualification. The contrasting findings of the current study are perplexing, and further qualitative inquiry is recommended. However, it has been suggested that specialist education should not include only what FCC entails, but also how to make it work.^[26,31,33] Skills training on collaboration with families is also advocated.

Study limitations

Owing to the small sample size, our findings cannot be generalised. Missing data, which may be a result of staff having had to complete the questionnaire while on duty, also impacted on the interpretation of trends.

Conclusion

Results show that healthcare professionals working in the surveyed EDs endeavour to practise FCC, but that their implementation is inconsistent. It is recommended that the Family-Centered Practices Checklist^[21] be used regularly as part of practitioners' reflections on their interactions with families. It can also form part of the assessment of staff's adherence to family-centred practices and provide focused feedback on areas where guidance and education are needed to strengthen practice.

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