

Paediatric Nurses Approach in Carrying Out Patient and Family Centered Care at a Tertiary Hospital in Northern Ghana

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This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Background: Patient and Family Centred Care (PFCC) is one of the fundamentals in paediatrics nursing which is struggling to gain recognition in nursing practice worldwide due to inadequate exploratory studies in the area. Others also call PFCC in paediatric world as Child and Family Centred Care (CFCC). Admittedly, its benefits to paediatric health care delivery cannot be measured but practicing is problematic. Nurses, policy makers and nursing research are yet to give the necessary attention PFCC deserves.

Purpose: The purpose of this study was therefore to explore the practice of PFCC in the Paediatric Ward of Tamale Teaching Hospital.

Methodology: This study made use of a purposive convenient design. Qualitative data was collected using validated interview guide which were administered to ten participants in the Paediatric Ward of Tamale Teaching Hospital in the Tamale Metropolis.

Key Findings: The results showed majority of the participants do not have enough knowledge on PFCC, PFCC is partially being practiced and inadequate infrastructural in the ward.

Recommendations: Policy on PFCC should be established by the government, models of Patient and Family Centred Care should be developed, refresher courses on PFCC should be given to nurses, the general public should be sensitized on PFCC and more nursing research should be carried on it.

Keywords: Patient; child and family centred care; paediatric ward; paediatric nursing; perception; mindset; Tamale Teaching Hospital.

1. BACKGROUND

Family-centered care (FCC) is defined by the Institute for Patient and Family Centered Care [1] as a method of planning, delivering, and evaluating health care that is built on jointly valuable collaborations among clinicians, patients, and families. In the twentieth century, FCC was required when mothers were physically separated from their sick children and “replaced” by healthcare workers who assumed parental responsibilities. This did not entirely support the child's recuperation, as the child need both physical and emotional assistance [2].

For most care takers, the admittance of a kid is a stressful experience. While providing care to the child, this process requires a great deal of emotional intensity as well as medical complexity [3]. Families may be anxious and fearful of a negative outcome or the death of their child. For the efficiency and effectiveness of their rehabilitation pathways, it became critical to involve families in their children's recovery plans. Essential aspects underpin PFCC. This includes getting to know the family, discussing issues about their child's health, building good relationships, including parents as members of the team, and having specific knowledge to support family members [4].

There is a scarcity of documentation on the approaches utilized in the management of hospitalized children in the third world countries. Evidence also shows that, most healthcare practitioners in Ghana do not treat unwell children holistically, instead treating them simply for the health problems they are experiencing, despite the fact that the PFCC idea is one of the basic principles in paediatric health care [5]. Following the successful training and graduation of Paediatric nurses in Ghana since 2011, it became necessary to explore the practice of PFCC in the Paediatric Ward (PW) of the Tamale Teaching Hospital (TTH).

2. MATERIALS AND METHODS

2.1 Study Design

This was an exploratory facility-based study that collected qualitative data from professional nurses working in the Paediatric section of the Tamale Teaching Hospital in Ghana.

2.2 Study Population

Caring for a sick child and his or her family entails a variety of intertwined activities and procedures carried out by a variety of experts. This knowledge was used to choose the participants for the study. All nurses who provide direct care to children admitted to the Paediatric Ward at the Tamale Teaching Hospital were included.

2.3 Setting

The research was carried out at the Tamale Teaching Hospital's Paediatric Ward in Ghana. TTH is the sole tertiary hospital in Ghana's northwestern region. It is the primary referral center for chronic disease consultation and care. Children aged one month to fourteen years are referred to the paediatric ward from all around Ghana, including parts of the Oti region and neighboring countries.

2.4 Inclusion Criteria

Nurses who have worked in a Paediatric Ward for at least one year after graduation were eligible. A minimum of six months of experience working in a children's ward was required.

2.5 Exclusion criteria

Mothers who had experienced complications during childbirth and parents who had healthy children. This was due to their inability to furnish the study with the necessary data. Because the

study was designed to analyze just the nurses' perspective on PFCC, doctors, pharmacists, orderlies, general administrative employees, and nutrition officers were also excluded from the study.

Nurses who have worked in a paediatric ward for less than a year may not have sufficient practical understanding of PFCC to provide care in the paediatric ward.

2.6 Sampling

The study participants were chosen using a purposive convenient sampling technique. Purposive sampling is a basic concept of qualitative research, according to Coyne [5] and study participants must be well-versed and experienced in the topic of investigation in order to produce relevant and accurate data. This sample approach was employed based on this premise.

2.7 Determining the Sample Size

The ultimate sample size was determined based on data saturation, which occurred when no new dimension to the categories specified could be found. Not all the 52 nurses from the TTH PW who met the inclusion criteria participated in the study due to data saturation.

Instrument for gathering data: Individual face-to-face in-depth interviews using a semi-structured interview guide began in March 2020 and concluded in April 2020. The data was gathered by the three main researchers. The interview tool was divided into four sections: section A collected data on each study participant's sociodemographic characteristics (Biodata), section B elicited the study participants' level of knowledge about PFCC, section C covered nurse practices related to PFCC, and section D was about the availability of structures for PFCC implementation at the facility level.

Data collecting procedure: A face-to-face interview was conducted among eligible PW employees using a semi-structured interview guide. Responses were questioned or diverted as needed to ensure complete grasp of questions and that respondent responses were consistent with the study's goals. All interviews were conducted in English, with audio recordings and extensive notes taken. The audio recordings were transcribed and analyzed topically after

each interview. Each interview lasted between 30 and 45 minutes.

2.8 Data Quality Assurance

Because we understand the objectives, fundamentals, and data gathering methodologies, the data was collected by the principal investigators. A pilot study was done among nurses from a separate facility, and the interview guide was corrected or adjusted as a result. The main study interviews were taped and preserved on a digital voice recorder at first. For safety reasons, these recordings were eventually copied to our own computer.

2.9 Data Analysis and Processing

Incomplete and inconsistent sentences were removed from the transcribed data. It was also double-checked for accuracy of interpretation and coherence in conveying the narrative contributions of the participants. Content analysis was done by going through the transcripts under each theme area, and emergent codes were produced and integrated.

3. STUDY FINDINGS

Four themes emerged from content analysis of the data. These major themes were; Knowledge of nurses on PFCC, determiners of PFCC among nurses, Nurses' perception on the available structures in practicing PFCC and Nurses perception on the practice of PFCC. The themes were presented and verbatim quotations used to back the claims.

3.1 Demographics

Ten professional nurses were interviewed. All the participants were both males and females with an average age of 32 years and the majority were aged between 21 and 35 years. All the participants attained tertiary education. Also, the majority of participants were diploma holders with working experience of 2 ½ years to 10 years as professional nurses and working experience in PW from 1 year to 4 years. The participants had the rank from staff nurse to senior nursing officer. Knowledge of nurses on PFCC

The subthemes that emerged from this theme were: definition of PFCC, elements of PFCC, importance of PFCC and benefits of PFCC. This theme represents the participants personal

understanding of the definition of PFCC. A high number of participants defined the PFCC.

3.2 Definition of PFCC

All the participants agreed of having heard of PFCC. Participants illustrated that, PFCC meant including and caring for the whole family, and majority of the participants indicated that it was important to let the family identify who constituted their members. All the participants confirmed that when they provided PFCC they included the whole family and cared for the patient in the context of the family because they recognized that the child was always surrounded by family.

A participant narrated;

'Ooh! What I know about it is that errrh...when you are talking about the PFCC, you see both the child and the family as constant or part of the care we've been given to them at the facility or at the ward so that we do not separate one from the other. We involve the two in the care of the child' (P4).

'Eerh actually what I know about child and family centered care is the caring for a patient involving a parent or the care taker whoever is around the patient at that particular moment when you are caring for the patient' (P1).

3.2.1 Perception of nurses on elements of PFCC

From the study, it was revealed that participants were guided by the elements of PFCC in their approach to deliver care to the child and the family.

'Whatever suggestion they come in with, if you see it beneficial, if it is for the betterment of the child, we take and build on it and respect their views, the family view as well as the child' (P5).

Also, in the study another stated the following that *'I really know u just involve the family in the child's care and sometimes you also ask the child's mind errh concerning her health or treatment' (P3).*

However, participants stated of not sharing all the information to patient and their relatives. *'We don't really give them (Child & family) all the information about the patient' (P2)*

3.2.2 Perception of nurses on importance of PFCC

All the participants stated the importance of PFCC. The participants saw PFCC as way of getting good results as far as child health is concern.

'When you involve them, especially the mothers, who usually will be there with the child, they... there is this cooperation about the child if the child knows that the mother is there.

'They bring some satisfaction also over there knowing that the mother or the family or the relative also contributes to whatever they are doing to the care giving to the child' (P4).

'emmm it makes the work easier as the child parents are always willing to take part in whatever that you are doing because they understand what they are doing' (P10).

3.2.3 Perception of nurses on benefit of PFCC

All the participants stated the benefits of PFCC to the child, family and the nurse. The participants mention the benefit to the child. *'It brings bonding between the child and health care providers(nurses)' (P8).*

Nurses' benefits were not left out as participants stated them.

'It makes us (nurses) stand tall among our peers and this way it goes a long way too to improve the health system, I think. Eieh it reduces stress on us as nurses because maybe something you would have been doing if you explain it well to the child and parents, they can easily do with your guidance so it makes the work less stressful for us. It improves our job satisfaction we feel fulfilled about doing the work' (P7).

Participants were also aware the benefit of PFCC to the family and revealed as stated below. *'The family knows much about the child. The anxiety level goes down. They may be aware of what is actually going to happen' (P7).*

3.2.4 Determinants of PFCC practice among nurses

This talks about the enablers and challenges that affect the implementation of PFCC. The participant enumerated the key reasons the successful implementation or otherwise of PFCC.

Nurses attitude towards parent in the care of their child.

Most of the participants demonstrated a good-will but described the relation between the child, family and the nurses not friendly enough all the time. Participants revealed that the child and family are key stake holder to the child's health care.

'It's not a kind of very friendly one I know because erh! Because we don't actually know what's going on and even asking questions sometimes, we don't even have the time to explain to them. So, it's kind of them not complying to what we actually want them to do' (P1).

3.2.5 Support for implementation of PFCC

Only one participant mentioned of getting some form of support from parents, colleagues and management for the practice of PFCC.

'Yeah! We do get some of these (support) from the bosses or in-charges. We do get some (support) from the in-charges or the bosses, encouraging us to even involve them the more in the care. Even in our other-fellow colleagues (nurses) also, because sometimes when you do involve them it makes our work even simple in some ways, where they even work and do some of the things for us so that is where they have that support from then to say that let's implement or let's do more of the PFCC. Once in a while we may get somebody a relative or a nurse or another relative or somebody who may speak (translate language barrier) but others in fact when they come there barely, we can barely exchange sometimes we have to involve or call somebody and they speak to' (P4).

Even though some participants obtained support, the majority of the participants reported not getting support anywhere for the practice.

A participant narrated;

'Noor I have not seen any support from anybody. No! Actually, hardly do management speak about it'. (P8)

3.2.6 Nurses' perception about families involving in the care of the child

Most of the participants described the family involvement in the practice of PFCC as useful.

They also stated that family role-play to augment their work and seeks to facilitate health care delivery process for them. Nurses perceived the family involvement as important to the care of the child.

Some participants said;

'Family involvement aids in early recovery as well as coming up with good results as in the outcome of whatever the child came with' (P5).

'When we involve them, it makes our work even faster' (P4).

On the other hand, most participants felt involving the family waste their time at times and does not help deliver optimum service to children. Participants also stated that some parents are rude in making demands, asking questions trying to challenge the authority nurses have in the ward.

Actually, is not that offended as in a way but sometimes it depends also, any way it depends on whoever that is asking the question, sometimes they (parents) act as if they want to prove that they know much than you do. They don't actually come on a mutual ground to just for us to talk about it. But like (puf) erh a bit harsh when they ask a question (P6).

It is like am not getting the optimum from them it is like ... we needed not to be involving them (P4).

Nurses' awareness on the role family play in the care of the child

All participants stated the family play key role in the care of the child. Most participants narrated the specific roles families play for the speedy recovery of their children. The nurses described of guiding the parents to carry out some nursing procedures.

'Yeah! So just like you know especially something like even tepid sponging is practical example that usually they even do or help us in those kinds of things if we are even to tepid sponge (P4).

'Yeah! I do see them, they clean their children at times, sometimes too they give them food eehnn sometimes they bath them too errh sometimes they tell things that we don't know about the child yes' (P3)

3.2.7 Nurses' perception on impact of family involvement in the care of the child

All the participants admitted that, families make impact in the care of the child in many ways. They elaborated that the involvement of family makes children feel at home, the family also feel being part of the care of the child hence leads to commitment in the care of the child. The participants stated that, the family becomes more educated on the child's health conditions and this ensures proper continuity of care at home then prevent relapse of illness.

Some participants narrated;

'Yeah! Usually, you see they are like being fulfilled because they (families) were part of the care given to the child so they don't feel like aww neglected. They were doing this, they were doing that, they feel even they know how some of the things are happening. They feel fulfilled and happy, they were taking part in the care of the child. Yeah! it also speeds up the care we give to them. They (family) willingly-cowardly fast provide the things that we need. when they are involved, they know that this is very much needed so it makes the care and the things you need for taking care of the child being getting faster.'

'What I observe about the child when this thing (PFCC) is being done is that I see that they (child and family) feel at home sometimes when you involve their parents and make them part of the treatment. Sometime there is commitment to take the drugs and I see sometime back we were not doing some of these things (PFCC) but there were lots of relapse but this day we don't see some of those things (relapses)' (P3).

3.2.8 Nurses' involving family in the care of the child

All participants said they involve families in the care of the child. They seek the family views and consent. They sometimes negotiate roles together.

'Very much involving the parents! This may work at, especially sometime the pricing (medication, services) may come in, we tell them this. Then, they come on board to bring their suggestions, oh no yeah, we can even get this, don't worry we can even get this one. So, we have involved them in the thing and their decision are taken

that oh yes, their decision is taken that, we can't afford let's take the minimum one we have. We also seek their view and they input into the care We show them (families) how to do it (procedures) and they are able to do it for us' (P7).

'Just as we talk with them (parents), there are sometimes, there are things that we may not know but sometimes they approach us with health issues or health status of the child. We talk with the parents, like ohn-ohn in the language we both understand on the equal grounds (P5)'

However, all participants stated it is not all the time they involve the family in the care of the child as it is supposed to be. They sometimes finished what they are supposed to do before explaining to families or not at all. *'It's not all the time though but we do sometimes involve them'(P6). It is just that certain decisions in any way, to some extent we don't involve them that much'(P4).*

3.2.9 Nurses' perception on the availability of structures in practicing PFCC

Another theme identified in the data was nurses' perception on the available structures in practicing PFCC. Proper structures in place serve as one of the fundamental factors to successful implementation of PFCC. Here, participants responded to both physical and non-physical structures required for practicing PFCC.

3.2.10 Nurses' perception on laydown structures

All participants stated that there were no laydown structures in the ward for effective implementation of PFCC. There were no documented models for them in the hospital.

'Erh I think for now there are no laydown rules probably in the near future, something good will come up. (puf) not that I know (P2).

'Uuhh! (then sniffs) I will say some of the things are not written down but when you practice something for a while, it becomes like a norm. It is not like codified is not written! The support from the nursing staff is there to say, yes, lets continue it this way' (P4).

Also, most participants mentioned that there was inadequate physical infrastructure for an effective implementation of PFCC.

'Umm I have not. About the structures some few are there some too are not errh we... there are chairs for family to sit at times but at times too we don't even have chairs for and there are no places for the, for the family to put their heads when the night comes and sometimes even some of them food so when you watch an ideal situation for PFCC I have not seen any as far as this place is concern it's just some few other things that I can we can talk of (P3).

Only one participant stated the structures were there and whenever they wanted to implement the PFCC, they can do.

'Oh that one I believe it's there. That is why there is a saying that whenever there is a will there is a way. So, ones we want to do it, the structures are there we can implement it. Erh like! Where parents to sit to get access to their babies or children to get involve. And even if it should be isolated place or a conducive environment for, like interviewing or taking history or whatever it is, there are places you can isolate to interview parents' (P1).

3.2.11 Nurses' perception on hindrances of PFCC

All participants stated of willing to practice PFCC. However, they are not left with the challenges that is bedeviling them in the attempt to practice PFCC. The participants stated of human factors to resources.

'Yeah! Even though we do PFCC over there, I see that we would have needed to improve upon it. Euurhp! typical example is even our spacing over there sometimes urrh we cannot involve the family in certain things sometimes we do. We are crowded over there and if it was not that, like things would have improved, you are explaining something to somebody and other family is also over there.

'Layout in the ward itself is not even conducive for PFCC and errh some of the children especially the ones we have like, under six, where especially we have a place called under six where under 6months, we have cots for almost all of them. If I'm to apply-practicing PFCC then, some of these things, the mother does not have where to ideally lie those kinds of things' (P4).

All participants identified lack of documented policies or models serve as a big challenge to the practice of PFCC.

We have not written certain things down also makes some of the things we do and may skip certain things over there.

What makes, arh especially our place sometimes also being difficult too is, we have different languages over there. You cannot involve relatives in most of the things, due language differences. You cannot communicate well with them. So, you cannot explain things to them. So, language barrier is the problem even though I would have wished they can understand this's why I am doing this (P3).

3.2.12 Nurses' perception on the level of practice of PFCC

Most participants rated three (3) out of 5 being the highest as the level of practice of PFCC. all participants said they do not practice PFCC to the fullest.

'Errh I will rate three (3) because, we don't most of the time involve them (parents), most of the time we finish with whatever we want to do before and even ask them for their suggestions. We just go ahead and think whatever we're doing is ok for the child. Sometimes when they even approach us for explanations erh sometimes we get offended' (P1).

Only two participants rated the practice of PFCC below three.

'I think I will say it's medium. Let's say 2. eerh because sometimes, what I know is that, I read about PFCC and errh I tried to compare whether we actually do something and I realize we are doing some of them but some of them we are not doing. So, most at times what we just do is to explain the procedure to them and I can say that we are no really doing to the maximum' (P2).

3.2.13 Nurses' perception of routine practice of PFCC

Most participants stated PFCC is a routine practice in the ward. They always do one thing or other with child and the family. Also, there is local undocumented policy that does not allow them to admit the child without relative(s).

'Yes, routine yes! In the children's ward, we don't admit the child alone, it is child then another family member so even in that there is some sort of PFCC over there. The consultations we ask them some of the few questions so basically, the things we do almost on routine bases (P4).

On the other side, only one participant said PFCC was not a routine practice in the ward.

'Noor it is not a routine thing. I don't know the right word to really use but it is some kind of errh when you wish because we don't make it a routine practice. It is when a nurse wishes to do it and he does' (P3).

One participant could not tell whether it is a routine practice. The participant stated that it was commonly practice when necessary.

'I can't say it is a routine and I can't say it is not a routine thing because sometimes we even forget to involve them before you realise you are doing your things and don't even know the family are around. Sometime that when it occurs to you again, you try to at least explain things to them' (P2).

4. DISCUSSION

4.1 Knowledge of Nurses on Child and Family Centered Care

The Institute of Family-Centred Care [1] describes PFCC as a method of planning, delivering, and appraising health care that is rooted in communally helpful alliances among care providers, patients, and families. The results of this study showed that some of the respondents did not have a complete understanding of the definition of PFCC as many participants had different definitions of PFCC. Many respondents misplaced or omitted important items in the definition. Some participants did not acknowledge in their definitions the mutual benefit between the child, family as well as the nurse. Also, other participants ignored evaluation in care delivered to child and the family in their attempt to define PFCC. Majority of the participants mentioned 'involving' child and family in the health care which is not the only key term for the definition of PFCC. A similar finding was also noted by Shields [6] as many nurses could not give a vivid definition for PFCC but had an understanding of what PFCC entailed. Different definitions in his study were attributed to the multiple descriptions

of child and family centered care by different participants. A study conducted in Ghana by Ohene, Power & Rhagu [7] also reported that many nurses recognized family centered as family participation. Shield [6] further found that, some nurses use elements of PFCC as a guide without even knowing. The present study similarly found that, most of the participants were guided by the elements of PFCC in their practice without being aware of its elements.

Most of the participants in this study understand that PFCC is important to the child, the family and the nurse. The participants did not illustrate the importance of PFCC to the health institution as well as the country. Effective practice of PFCC will automatically improve both physical and none physical structures in the health institutions. Prognosis of children will be good when PFCC is effectively practiced. This will reduce child morbidity and mortality in the country. Effective implementation of PFCC will reduce heavy financial burden on health to the state because many parents will have knowledge on how to care for their children's health needs. It is advisable for the state to take a leading role in implementation of PFCC. A study by Neff [8] is consistent with the finding of this study that, nurses ignored the importance of PFCC to the country during the exploratory study on the knowledge of nurses on PFCC. This is attributed to the fact that the state has not taken keen interest in ensuring that PFCC is practiced in health institutions to the fullest.

4.2 Determinants of PFCC among Nurses

In this study, most of the participants expressed their frustration about the unavailability of established guidelines or policies regarding PFCC for nurses to follow. Most participants mentioned that due to unavailability of guidelines, they often forget to put to practice some protocols of PFCC they read about. Also, majority of participants attributed their frustration in practicing PFCC to inadequate spacing in the ward. Inadequate spacing makes it difficult for nurses to express themselves in an attempt to discuss health needs and solutions with child and family with the concern that other family members will hear sensitive information about the child health. In simple terms, if care is not taking in practicing PFCC, confidentiality of the child's health issues will be broken. A similar finding was revealed by Bruce and Ritchie [9] who observed that "there were no established guidelines or standards for its practice or

provisions to provide nurses with education and opportunities to practice family-centred care,” and that “simply espousing a philosophy of family-centred care does not ensure that the philosophy will be practiced. However, a study in Ireland by Coyne [10] found a contrary view, that spacious environment facilitated nurses to practice PFCC. Children, families could interact without interference.

This study also revealed supportive attitude of nursing staff as an enabler to the practice of PFCC. Some of the participants reported obtaining support and encouragement from their in-charges and colleagues. It is therefore recommended for nurses to consciously educate child and family about PFCC practice in the ward to establish a conducive rapport with them. That will make the parents to be conscious and comply with the implementation of elements of PFCC for its successful outcome. This finding is not consistent with previous studies conducted by Lloyd, [11] & Esmaeili [12] where they identified unsupportive attitudes of nursing staff as one of the barriers to the practice of PFCC. The study explained that, Nurse Managers did not have full understanding of the concept of PFCC hence tempted to misapply nursing staff distribution in PW.

In this study, some of the participants mentioned that parents or caretakers being unfriendly and time constraints as some of the challenges to the effective implementation of PFCC in the ward. The nursing staff in the ward is not proportional to the work load on a nurse. The work load makes the nurse feel that there is no time to attend to the patient and family effectively. A similar finding was reported in a study carried out by Baird [11] where they found out that nurses labeled parents who advocated and asked questions as “difficult” with negative impacts on subsequent interactions. Nurses felt care takers or parents were trying to rock shoulders with them and were trying their knowledge instead of looking for solution for their children’s health needs.

4.3 Nurses’ Perception on the Practice of PFCC

This study results shows that nurses do not practice PFCC to its fullest. When the participants were asked to rate the practice of PFCC in their ward from one (1) to five (5), with one being low and five being excellent, majority of the participants chose three (3) as the level of

practicing PFCC and most of the participants stated the practice by just involving the parents. Also, most participants indicated of not given all information about the child health issue to the child and family. Some participants claimed they did not want to provoke the child and family emotions for given them unpleasant information hence chose not to give them all the information. A Davies, Baird, & Gudmundsdottir (2013) study also agreed that elements of child and family centered care were not implemented consistently, which could result in sub-optimal care for the child. However, a study in Ireland by Coyne identified PFCC as identifying family needs, information sharing, shared decision making, facilitating parents to participate in care and inter-disciplinary collaboration.

The participants in this study also stated the child and family are key stake holders to the child’s health care and that the family remains a constant figure in the care of the child. Many participants mentioned that major decisions about the child’s health issue must involve the family. This finding is supported by studies which discovered that nurses who practice child and family-centered care recognized the vital role that relatives play to ensure the health and welfare of children [12]. However, a study conducted in America by DeLemos, [13] had a contrary view that, nurses do not involve minority ethnic groups parents about the child health care needs. This is because minority ethnic groups are not respected in the country and the behaviour is imported into the health care setting.

5. CONCLUSION

The study focused on PFCC as a transformational approach to care requiring transformational leadership and an organizational culture that supports learning, research, and the implementation of new and innovative approaches to patient care. The aim of the study was to explore the practice of PFCC in the Paediatric Ward of TTH. It was observed that participants did not have adequate knowledge on PFCC. Also, Socio-demographic characteristics of the respondents had a significant influence on knowledge and practice of PFCC. Participants with paediatric background has good knowledge on PFCC. Most of the participants had some amount of knowledge on the benefit of practicing PFCC and this had influence on their care of the sick child and the family. This translated into majority of the participants rated three out of one (1) to five (5)

as the level of practice of PFCC in TTH PW. A few participants rated below three in terms of practicing PFCC. Also, almost all the participants stated of inadequate availability of structures for practicing PFCC. The study also identified some challenges which hinders the practice of PFCC. In conclusion, PFCC is partially practiced in TTH PW.

Although existing evidence that quantifies the impact of PFCC on outcomes is limited, review of this evidence provides preliminary support for the benefits of this approach. Before implementing PFCC, it is important to clarify the key elements and characteristics that comprise PFCC approach to care and to identify the mechanisms or phases of its development.

DISCLAIMER

The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

CONSENT AND ETHICAL APPROVAL

The University for Development Studies/Tamale Teaching Hospital Ethics Review Board was consulted for ethical approval. Permission to conduct the research was also sought from TTH's Chief Executive Officer (CEO). The study's goal, significance, and related risk were explained to the participants before they signed a consent form. Participants were advised that their participation in the study was fully voluntary, and that they could withdraw at any time with no repercussions. Participants were also given a unique code to ensure that their comments and study participants remained anonymous and confidential. Researchers assured that no participant suffered any physical, psychological, or emotional impairment as a result of their participation in this study.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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