Original Research Article

EXPLORATORY STUDY ON THE MINDSET OF NURSES IN PRACTICING PATIENT AND FAMILY CENTERED CARE AT PAEDITRIC WARD OF TAMALE TEACHING HOSPITAL

ABSTRACT

Background: Patient and Family Centred Care (PFCC) is one of the fundamentals in paediatrics nursing which is struggling to gain roots in practicing of nursing worldwide due to inadequate exploratory studies in the area. Hence, others in paediatric world call Patient and Family Centred Care as Child and Family Centred Care (CFC). Nurses admitted of 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 Patient and Family Centred Care deserves.

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

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 patient and family centred care, patient and family Centred Care 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 Patient and family centred care should be given to nurses, the general public should be sensitized on PFCC and more nursing research should be carried on it.

Key Words: *Patient, Child and Family Centred Care, Paediatric Ward, Paediatric Nursing, Mindset, Tamale Teaching Hospital*

BACKGROUND

The Institute for Patient and Family Centered Care (IPFCC) defines family-centered care (FCC) as "an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families". In simple terms it is a way to provide healthcare that recognizes the importance of family for a hospitalized child (Hostler SL., 2009). FCC became necessary in the 20th century when mothers-were physically separated from their sick children and being "substituted" by healthcare professionals, who took on parents' caring functions. This did not support fully the child recovery pathway as the child needed both physical and emotional support (Festini, 2014). The admission of children is mostly an overwhelming moment for caregivers. This process involves so much emotional intensity and also medical complexity while care is being provided to the child. Families may experience some anxiety and uncertainty of a poor outcome or the death of the child. It therefore became imperative to involve families in their children's recovery plan, for the efficiency and effectiveness of their recovery pathway.

Patient and Family Centered Care is built on essential elements. This includes getting to know the family, discussing issues pertaining to their child's health needs, developing effective relationship, including parents as part of the team, having specialized knowledge to support family (Davies, Baird & Gudmundsdottir, 2013). In the developing world, there is scarce documentation on the approaches used in the management of hospitalized children. Evidence has also proven that most healthcare providers in Ghana do not take care of sick children holistically, but rather treat them only for the presenting illness and given that PFCC concept is one of the core principles in paediatric health care practice (Costello et al., 2002). It became prudent to explore the practice of PFCC in the Pediatric Ward (PW) of the Tamale Teaching Hospital (TTH) through this study following the successful training and graduation of pediatric nurses in Ghana since 2011.

MATERIALS AND METHODS

Study Design: This study was a cross sectional exploratory design facility-based study involving the collection of qualitative data among professional nurses working in the Tamale Teaching Hospital Paediatric unit, Ghana.

Study Population: The care of sick child and family involves a mix of interwoven activities and procedures performed by many different experts. This understanding was applied in determining the research participants. All nurses who give direct care to children admitted to The Tamale Teaching Hospital Pediatric Ward were included.

Setting: The study was conducted at the Pediatric Ward (PW) of Tamale Teaching Hospital (TTH), Ghana. TTH is the only tertiary hospital located in northern part of Ghana. It is the major referral site for specialist consultation and management of chronic conditions. The paediatric ward receives referrals of children age one month to 14 years of age from the northern part of Ghana including some part of the Oti region and neighbouring countries.

Inclusion Criteria: Nurses, who worked in Pediatric ward for at least 1 year post qualification. Must have worked at the children ward a minimum of six months.

Exclusion Criteria:

Mothers with birth complications and parents, who had healthy babies were excluded. This was because they could not have provided the needed information for the study. Doctors, Pharmacists, Orderlies, General administrative staff and Nutrition Officers were as well excluded from the study because the study was meant to assess only the nurses' perspective on PFCC. Nurses who worked in paediatric ward less than one year they may not have enough practical knowledge about the practice of PFCC to give the paediatric ward.

Sampling: A purposive sampling technique was used in selecting study participants. According to coyne, (1997), Purposive sampling is a basic tenet of qualitative research and study participants must be well vest and experienced in the area of study to provide relevant and accurate data. Based on this assumption that, this method of sampling was used.

Sample Size Determination: The determination of final sample size was based on data saturation, where no new dimension to the categories identified was forthcoming. Therefore, a total of 52 nurses of the paediatric ward of the Tamale Teaching Hospital who met the inclusion criteria could not participate in the study.

Data collection instrument: Data collection started from March 2020 and ended in April, 2020; through individual face-face in-depth interviews using a semi-structured interview guide. Data was collected by the three principal researchers of this study. The interview tool consisted of four thematic areas, section A captured data on the sociodemographic characteristics of each study participant (Biodata), section B solicited the study participants level of knowledge regarding PFCC, Section C covered practices of nurses with reference to PFCC and section D was about availability of structures for PFCC implementation at the facility level.

Data collection procedure: With the aid of the semi-structured interview guide, a face-to-face interview was conducted among eligible staffs of the PW. Responses were probed or redirected where necessary to ensure full understanding of questions, and to ensure that interviewee responds were within the study objectives. All interviews were conducted in English and audios recorded and comments were noted down copiously. After every interview the audio recordings were transcribed and analysed thematically. Each interview lasted approximately 30–45 minutes.

Data quality control: Data was collected by the principal investigators since we understand the objectives, basic and the data collection techniques. A pilot study was conducted among nurses of a different facility and corrections or adjustments made to the interview guide. Main study interviews were recorded and initially saved on a digital voice recorder. These recordings were later transferred onto our personal computer for safety

Data Processing and Analysis: Transcribed data was cleaned of incomplete and inconsistent sentences. It was further cross-checked for accuracy of interpretation and coherent conveyance of the participant’s narrative contributions. Under each thematic area, content

analysis was done by reading through the transcripts, and emerging codes were derived and merged.

Ethical Consideration: Ethical approval was sought from the University for Development Studies/Tamale Teaching Hospital Ethics Review Board. Permission was further sought from the Chief Executive Officer (CEO) of TTH to undertake the research. The objective, relevance and associated risk were outlined to the study participants after which written consent was obtained. Participants were liable informed that their participation is entirely voluntary and they can withdraw from the study anytime without consequences to them. Also, Participants were assigned a unique code for anonymity and confidentiality of responses and study participants. Researchers ensured that this study did not cause any physical, psychological or emotional harm to any participant.

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 are presented and verbatim quotations used to back the claims.

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 35years. 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 4years. 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 own view on the definition of PFCC. Majority of participants defined the PFCC.

Definition of PFCC

All the participants admitted of having heard of PFCC. Participants stated that, PFCC meant including and caring for the whole family, and most of the participants indicated that it was important to let the family identify who constituted their members. All of 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).

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 see it 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)*

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, they.. 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 given 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).

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 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).*

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).

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;

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

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 …then 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)

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 fill 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 become 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 erh 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 errh when this thing (PFCC) is being done is that I see that they (child and family) feel at home sometimes errrh when you involve their parents and make them part of the treatment. Sometime there is commitment to take the drugs and I see ooo 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).

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 (of 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 arh 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).

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.

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 erh 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 a 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 just the 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 say. 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 whatever to get it'* (P1).

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 almost cot for 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.

One thing which makes, arh especially our place sometimes also being tough too is, we have diverse language thing over there. That one sometimes we cannot do much about it again because there is diverse language, somebody comes even you want to involve, you want to explain certain things but you are not getting, erh there is this barrier over there you cannot get to communicate that much with the person and it seems tough over there even though I would have wished they can understand this why I am doing this (P3).

Nurses' perception on the practice of PFCC

The participants' level of on the practice of PFCC is stated. Also, whether PFCC is a routine practice is as well analysed.

Nurses' perception on the level of practice of PFCC

Most participants rated three (3) out of 5 being the highest as the level 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, most of the time we finish with whatever we want to do before 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).

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, there 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.

'Nooor it is not a routine thing. Is 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 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).

RESULT AND DISCUSSION

Knowledge of nurses on child and family centered care

According to the Institute of Family Centred Care (2017), PFCC is defined as an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. The results of this study showed that some of the participants did not completely understand the definition of PFCC as many participants had varied definitions of PFCC. Most of the participants omitted key items in the definition. Some participants did not appreciate in their definition 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. The 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 (2010), 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 centred care by different participants. A study conducted in Accra-Ghana by Ohene, Power & Rhagu (2020), also found that most nurses knew family centred care to mean family involvement.

Shield (2010) 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 it as 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 as a whole. 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 (2003), is consistent with the finding of the 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.

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 (2007), 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 (2011) 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 Lioyd, (2018) & Esmaeili (2014) 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 stated 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 (2015) 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/parents were trying to rock

shoulders with them and were trying their knowledge instead of looking for solution for their children's health needs.

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 (2011) 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 Ccollins (2007) and America Academy of Paediatrics (2012) study which revealed that nurses who practice child and family-centered care recognized the vital role that families play in ensuring the health and well-being of children.

However, a study conducted in America by DeLemos, (2010) 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.

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.

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