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Original Article

Thai nurses' perceptions and practices of family-centered care: The implementation gap

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ABSTRACT

Objectives: This study was conducted to examine the differences between perceptions and practices of family-centered care among Thai pediatric nurses.

Methods: This mixed-methods study consisted of two phases. In the first phase, a descriptive comparative design using the Family-Centered Care Questionnaire – Revised (FCCQ-R) was administered to 142 pediatric nurses from a university hospital in Bangkok, Thailand. In the second phase, qualitative interviews were conducted with 16 pediatric nurses to gather complementary information regarding the major findings from the first phase.

Results: The results revealed that family strengths and individuality were rated the highest as the most important elements and the most frequent practices. Parent/professional collaboration was perceived as the least important element, while the design of the health care delivery system was rated as the least frequent practice. The qualitative data revealed that the major reasons for suboptimal implementation included a common perception that family-centered care is a Western concept, nurses' weak attitudes towards their roles, and a shortage of nurses.

Conclusions: Nurses agreed that the identified elements of family-centered care were necessary but that they did not incorporate the concepts into their daily nursing practice to maintain their endorsement of the family-centered care model. Further study is needed to explore how family-centered care is understood and operationalized by Thai nurses and how hospital administration and environments can be modified to support this care model.

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What is known?

- Family-centered care is associated with improved outcomes for the care of hospitalized children and has received a widespread endorsement in Western developed countries.
- Nurses believed in the value of family-centered care but could not execute the elements of this care model consistently in their everyday practice.

What is known?

- A mixed-methods approach was used to identify differences between perceptions and practices of family-centered care among Thai pediatric nurses.

- While the quantitative findings were consistent with those of previous studies, the qualitative findings implied significant challenges related to the shortage of nurses, the nurses' attitudes towards their role as a change agent, and the parents' role as a member of the healthcare team.
- Certain components of family-centered care may not fit within the Thai context of healthcare delivery, as this care model was originally rooted in Western, developed countries.

1. Introduction

Family-centered care has been widely accepted as an ideal way to care for children in hospitals. According to this philosophy of care, the psychological and developmental needs of the child and the family's well-being are best achieved when the healthcare system supports the pivotal role of the family in partnership with healthcare providers to provide care for their child [1]. To

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effectively practice family-centered care, nurses must understand and advocate the nine elements of this philosophy of care: family as the constant, parent/professional collaboration, sharing information with family, family strengths and individuality, parent-to-parent support, child's and family's developmental needs, emotional and financial support, design of health care delivery system, and staff support [2,3]. The results from an integrative review of international literature related to the integration of family-centered care into the care of hospitalized children support the benefits of this approach in reducing parental anxiety, resulting in increased parent confidence in the involvement of care and improving communication between parents and healthcare professionals [4].

Although family-centered care has been adopted as the basis of pediatric nursing, its effective implementation into nursing practice has not been without difficulty. A previous qualitative study indicated that nurses viewed family-centered care as an ideal philosophy of care; however, its implementation into practice has been very challenging and problematic due in part to organizational and managerial factors [5]. Several studies also addressed the problems that arose from healthcare providers when utilizing a family-centered care approach: a lack of understanding of what specific actions constitute family-centered care and a lack of skills for integrating the principles of family-centered care into practice [3,6]; nurses' conflicting beliefs about their role as the care experts for children [7,8]; and poor communication between parents and nurses [8]. Such problems cause inconsistent practice of family-centered care even though nurses believe in the value of this philosophy [3,9]. The gaps between the perceptions of current practice and the necessary elements of family-centered care result in doubts about the feasibility and appropriateness of its implementation in nursing clinics [10]. However, there is unequivocal theoretical support that family-centered care best meets the healthcare needs of children and their families. Thus, efforts still exist to promote and encourage this care approach in nursing practice, as seen in hospital policy and mission statements and the number of studies related to how to operationalize the principles of family-centered care.

The family-centered approach to healthcare services and its original elements were first introduced in 1987 for children with special healthcare needs in the United States [2]. Since then, this approach of care has been recognized by medical societies, healthcare systems, and state and federal legislative organizations [6]. Whereas the practice of family-centered care for hospitalized children within Western countries has evolved based on increased scientific knowledge and practice outcomes, little is known about family-centered care in Thailand. Although this philosophy of care has long been recognized in pediatric nursing in Thailand, it has not been embedded well into current practice. Three Thai master's theses were found that focused on outcomes of nursing interventions structured on the family-centered care philosophy [11–13]. In conversation with two nurses (S. Kuntharos and P. Damrongrak, 2016 Sep 22) who completed the thesis projects, they revealed feeling that in spite of the positive outcomes, these interventions had not been consistently adopted into the nurses' daily practice. In addition, according to Thai literature, sharing information with the family, a significant element of family-centered care, has always been reported as a deficit [14,15]. An integrative review reveals that the practice of information sharing between parents and healthcare professionals was less likely to happen in a Thai clinical context; that is, Thai parents had to seek out needed information about their child's condition, treatment and care needs rather than the information being given to them as a standard policy [16]. Consistent with a qualitative study of Thai families' care practices for infants with congenital heart disease, caregivers

reported that nurses were busy with their routine work and did not provide needed information about the illness of and care for the infants [17].

While Thai nurses have positive attitudes towards family-centered care and support integrating this philosophy of care into their practice [18], there is a gap between their support of family-centered care and what actually occurs in practice. Only two Thai studies reported that nurses in tertiary-care hospitals highly perceived the importance of family-centered care but did not implement this philosophy of care into their daily nursing practice to the extent of their perceptions [19,20]. It is anticipated that this "implementation gap" in family-centered care is significant, and the results of these two studies reinforce our claim. However, the findings of these studies, which were collected only from a self-administered questionnaire, could not provide an in-depth understanding of why certain elements of family-centered care were perceived as less important in nurses' views and thus were less likely to be incorporated into nursing practice. For this reason, an investigation of pediatric nurses' perceptions and practice of family-centered care using both quantitative and qualitative methods can help nurses and other healthcare professionals better understand the current phenomenon of family-centered care practice in a Thai healthcare setting. In addition, this data can also serve to support the development of system-wide educational and environmental support to enable improved implementation. Thus, the aim of the current study was to address the following research questions: (1) What are the differences between Thai pediatric nurses' perceptions of the necessity of family-centered care and their current practices? And (2) Why do any of these identified differences continue to exist?

2. Materials and methods

2.1. Design

A mixed-methods study was conducted in two phases. In the first phase, a descriptive comparative design using a standardized questionnaire was administered to study the differences between nurses' perceptions and practices of family-centered care. In the second phase, qualitative interviews were conducted in a subset of the participants from the first phase. The interview questions were constructed based on the findings from the first phase; thus, the information gathered from the second phase was used to provide supplementary data and a deeper understanding of the findings from the first phase.

2.2. Ethical considerations

Ethical approval was obtained from the institutional review board of the participating hospital (COA no. Si191/2015). For the first phase, each potential participant was approached by a research assistant (a master's student) and provided with a participant information sheet together with the questionnaire. Written consent was waived, as the returned questionnaire implied the participants' consent to participate in the study. For the second phase, written informed consent for the face-to-face interview was required.

2.3. The first phase

2.3.1. Participants

The study inclusion criteria were as follows: having at least 2 years of pediatric nursing experience and not holding a position of nurse supervisor or higher. Based on the inclusion criteria, 254 pediatric nurses from a university hospital located in Bangkok were invited to participate in the study and were sent a survey, and 142

nurses (56%) voluntarily participated in the first phase of the study.

2.3.2. Data collection procedure

All eligible pediatric nurses from inpatient wards were approached during January and February 2016 by a research assistant and were given a questionnaire. They were asked to return the questionnaires in a prepared box.

2.3.3. Measures

The questionnaire consisted of two parts: the demographic information form developed by the researchers and the Family-Centered Care Questionnaire-Revised (FCCQ-R), which was first developed by Bruce in 1992 and revised for use in a further study in 2002 [3]. The demographic information form contained items regarding participants' sex, age, educational degree, years of experience in pediatric nursing, types of pediatric units currently working at, and attendance at an academic conference or training on family-centered care.

The FCCQ-R, of which the permission for use in the current study was obtained, consists of a practice scale and necessity scale. Both scales use a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree), with higher scores indicating more implementation (practice scale) and more importance (necessity scale). There are 45 items distributed over nine subscales: family as the constant, parent/professional collaboration, family strengths and individuality, sharing information, parent-to-parent support, developmental needs, emotional/financial support, design of the health care delivery system, and staff support. Content and construct validity was previously established for the FCCQ-R, and the internal consistency reliability was established with Cronbach's α of 0.89 and 0.90 for the practice and necessity scales, respectively [3].

The FCCQ-R had previously been translated into Thai with a 4-point rating scale for previous studies [19,20]; however, there were conceptual challenges. We retranslated the FCCQ-R into Thai using a back-translation technique, and the adequacy/appropriateness of the translation was checked by a panel of three experts. For the practice scale, nurses were asked to indicate on a 4-point rating scale (1 = definitely not true to 4 = absolutely true) which activities they perceived to be currently present in their practice. Similarly, nurses were also asked which activities they perceived to be necessary for family-centered care practice by using a 4-point rating scale ranging from 1 = strongly disagree to 4 = strongly agree. In the current study, an internal consistency analysis using the Cronbach's α revealed very good reliability coefficients of 0.92 for each scale when tested with 25 pediatric nurses whose eligibility was similar to the study sample. It is worth noting that this forced-choice scale was used in the Thai version for both previous studies and this study. The middle option of 'neutral' was removed because it was considered an easy option to choose when a respondent was unsure, and thus, whether it was a true neutral option was doubtful. Thus, the scale forced the respondent to select the option that was closest to their perceptions and clearly indicated a decisive opinion. Survey research studies generally indicate that including or not including the 'neutral' option has been shown to not significantly affect the results [21,22].

2.3.4. Data analysis

The Predictive Analytics Software (PASW) version 18 (SPSS, Chicago, IL, USA) was used for data analysis. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to describe the sample and the study variables. The difference between nurses' perceptions and practices of family-centered care was analyzed using a paired *t*-test with the level of significance set at 0.05.

2.4. The second phase

2.4.1. Participants

Interviews were conducted in April 2016 with pediatric nurses ($n = 16$) who also participated in the first phase of this study. To achieve variation in terms of years of experience and inpatient wards, one nurse from each ward was purposively sampled by age.

2.4.2. Data collection procedure

Interviews were recorded via audiotape and occurred at convenient times and locations. All interviews were conducted by AS and lasted between 30 and 45 min. Interview questions moved from general to specific with prompts used to encourage further dialogue. We shared the aggregated results from Phase I with the participants. Three major questions were asked: To your understanding, (1) Why did pediatric nurses in the hospital view family strengths and individuality as the most necessary elements of family-centered care and practice? (2) Why did pediatric nurses in the hospital view the parent/professional collaboration as the least necessary element of family-centered care? and (3) Why was the design of a hospital system that was flexible, accessible, and responsive to family needs ranked least in the current practice of pediatric nurses in the hospital? Participants were given a small gift (valued at five US dollars) for their time.

2.4.3. Data analysis

Data were analyzed using thematic analysis [23]. After the interview was transcribed verbatim, two researchers read the transcribed data several times to gain an overall understanding and coded the transcribed data independently. Then, the coding was checked for agreement. The potential themes were identified based on the codes and then defined and named by the researchers. Rigor for this phase of the study included the concepts of credibility, transferability, and dependability. The inclusion of participants who were currently in pediatric practice (and thus had the lived experience) addressed credibility issues. Recruiting nurse informants from various pediatric wards and with varying years of experience supported that the findings were likely applicable to other similar pediatric practice settings. Finally, the process of data collection and data analysis could be examined through the audit trails used, that is, verbatim transcription, field notes created by the interviewers and the coding documents used in the process of thematic analysis.

3. Results

3.1. The first phase

One hundred forty-two pediatric nurses completed the survey. The age of the respondents was between 24 and 60 years, with an average age of 37.0 ± 10.0 years. Of these, 90% had obtained a bachelor's degree in nursing, while the remaining respondents had a master's degree. Approximately half of them were from general pediatric units (with large rooms to accommodate several patients), 33% were from intensive care units, and 16% were from special units (with single rooms to accommodate one patient). Years of experience in pediatric nursing varied from 2 years to 40 years, with an average of 13.8 ± 10.0 years. More than half of the nurses (57%) reported attending at least one academic conference on the topic of family-centered care.

The nurses perceived the importance of all family-centered care elements with average ratings between 3.02 and 3.38 (the possible range: 1.00 to 4.00). Based on the ratings, the most necessary elements for family-centered care were family strengths and individuality, followed closely by sharing information. In contrast, the

Table 1Differences between pediatric nurses' perceptions of the necessity of family-centered care key elements and the current practices ($n = 142$, Mean \pm SD).

Element of Family-Centered Care	Perceptions	Practices	Mean difference	t
Family as the constant	3.25 \pm 0.49	2.86 \pm 0.52	-0.39 \pm 0.47	-9.85
Parent/professional collaboration	3.02 \pm 0.46	2.51 \pm 0.43	-0.51 \pm 0.45	-13.59
Family Strengths and individuality	3.38 \pm 0.44	2.94 \pm 0.45	-0.44 \pm 0.48	-10.98
Sharing information	3.35 \pm 0.40	2.67 \pm 0.46	-0.68 \pm 0.51	-15.92
Parent-to-parent support	3.22 \pm 0.49	2.38 \pm 0.57	-0.84 \pm 0.60	-16.66
Developmental needs	3.23 \pm 0.44	2.58 \pm 0.52	-0.66 \pm 0.56	-13.98
Emotional/financial support	3.23 \pm 0.44	2.66 \pm 0.43	-0.56 \pm 0.52	-12.94
Design of health care delivery system	3.15 \pm 0.44	2.20 \pm 0.47	-0.95 \pm 0.54	-20.82
Staff support	3.24 \pm 0.41	2.49 \pm 0.52	-0.74 \pm 0.60	-14.84
Total	3.22 \pm 0.36	2.56 \pm 0.35	-0.66 \pm 0.41	-19.20

Note: all $P < 0.001$.

least necessary element was the parent and professional collaboration (Table 1). For current practice, recognition of family strengths and individuality was the most frequent practice of family-centered care, while the design of the health care delivery system was rated as the least frequent. Scores for the necessity of each of the elements were significantly higher than the scores for the use of the elements in current practices, indicating that nurses perceived each family-centered care element as more necessary than implemented. The gap (mean difference) between the perception of necessity and current practice was highest in the design of the health care system.

3.2. The second phase

Sixteen nurses (mean age 44.0 ± 9.0 years, range 24–57 years; mean years of pediatric nursing experience 20.0 ± 9.0 years, range 3–33 years) participated in the interview. Three selected elements of family-centered care that showed 'the most' and 'the least' as endorsed by the nurses of the first phase were explored through the interview. Interestingly, their responses to the interview questions were very similar to each other, as described below.

3.2.1. Views of the nurses concerning family strengths and individuality

All nurses agreed that family strengths and individuality were the most important components of family-centered care. The nurses realized the importance of parents as a part of medical and nursing care, as they were major caregivers who knew their children best. According to the nurses' opinion, each family had different strengths, in particular to the readiness for the provision of care for the sick children. Two themes were identified from the data analysis.

(1) Different readiness for participation in care

In the nurses' view, each family has different demographics and cultural backgrounds as well as methods of coping. Such differences make them different in readiness for participation in care. As two nurses said:

"If they (parents) are ready to listen and learn, they will be able to take over

more parts of the care. Their readiness is their strength."[P7]

"Some families could easily understand what has happened to their children

and they are well adapted but some could not and are not ready to fully

cooperate with us."[P11]

(2) Different help is needed

Due to the difference in the family's readiness to participate in the care for their children, it was important for nurses to assess the family's needs and readiness. The assessment would help nurses approach them appropriately, provide advice, and coach necessary care skills. As nurses said:

"They are not alike. So how we advise them and the language we use depend on their backgrounds and understanding." [P14]

"To assess the parents' readiness is the first important thing we do before giving information and teaching. Some parents are too afraid to care for tracheostomy tubes, while others are not. Then, we have to think of which teaching method is right for each one." [P16]

3.2.2. Views of the nurses concerning the parent/professional collaboration

The nurses participating in the interview were not surprised that parent/professional collaboration was perceived as the least necessary element for family-centered care. They thought that collaboration in the perspective of family-centered care (that is, viewing families and professionals as partners in the development, review, and implementation of the care plan, hospital facilities and policies) did not match with Thai healthcare delivery. Nurses also viewed themselves as experts in caring for sick children. The description of the two themes identified was as follows:

(1) Parent/professional collaboration does not fit within the Thai context

According to the concept of family-centered care, the collaboration between parents and professionals involves many activities that seem to be unpractical in the Thai healthcare delivery system. Nurses in this interview thought that Thai people were respectful to healthcare professionals and were characteristically harmonious and passive. Thus, it was difficult for them to play an active role in collaboration with those in a very respectful position. In addition, some nurses believed that only well-educated parents could collaborate with healthcare professionals and make a medically appropriate decision that best fit their needs, strengths, and values.

"It is impossible to ask Thai parents to take part in determining the information needed for families and to contribute to such activities as the development and review of hospital facilities, policies, and program development. This idea is for Western countries. Thai people are too humble to doctors and nurses to share their thoughts comfortably." [P15]

“General parents are not well educated, so how could they contribute to health care teams? This could be practical in other countries but not in Thailand. Thai families feel uneasy to share ideas and advice with a healthcare team consisting of doctors, nurses, and other care professionals even though we allow them to do it.” [P8]

“Nurses don’t think parents will be able to share significant ideas to improve care. In fact, they come here for help.” [P12]

(2) Nurses did it better and faster

Even though the hospital in this study allowed parents to stay with and take care of their children, their involvement in providing care was limited. The nurses worried that most families do not understand the medical terms, treatments, and procedures. Consequently, parent involvement was viewed as an obstacle to nursing care. The nurses in this study thought that they were more knowledgeable and skillful in caring for sick children. Instead of collaboratively working with families to develop the best plan for their children, the nurses assumed much more active roles in determining and providing care for the children.

“Letting them wait outside the treatment room would be better. If they are inside, a child would be fussier and difficult to handle.” [P2]

“Yes, of course, we always encourage their involvement but only in easy-care tasks. Most parents have little knowledge of diseases, medical terms, and medical treatment. They cannot be of much assistance in care for their hospitalized children. I did it better and faster.” [P8]

3.2.3. Views of the nurses concerning the design of the health care delivery system

The nurses realized the importance of the design of health care delivery systems; however, in their view, the hospital system was already established, and their job was to follow the traditions of that established system. The nurses did not have official responsibility or authority to set or change the health care delivery systems. Thus, the provision of flexible care delivery to be more accessible seemed to be impossible, as described in the following two themes.

(1) Designing health care delivery systems is beyond nurses’ authority

The nurses did not think they could assure the families that the design of the hospital system was flexible, accessible and responsive to family needs. As the hospital system was already established, all practices should comply with the policies, regulations, and procedures. The nurses thought that they did not have much authority in designing the services system, even at the level of wards.

“We do not have much authority to change or adjust the hospital system. It has already been established, and we have to follow.” [P2]

“If you allow one family to have a fast track of service for a certain reason, the others would request that too. I can’t imagine how chaotic it would be.” [P12]

Flexibility was an important focus for nurses, as they perceived it as a high priority for families. They tried to be flexible for the

families as much as possible. Flexibility for the visiting time duration and the number of visitors might be the best that the nurses could do.

“Flexibility is good and everyone needs it, but not everything can be flexible. Nurses will get into trouble if such flexibility causes an unexpected worse consequence.” [P16]

“What we can do is to allow flexible visitation. Although the hospital has determined the visiting time, we pretend to forget that their visiting time was already over.” [P11]

(2) Shortage of nurses as a barrier for being responsive to family needs

With a sense of being overwhelmed with heavy workload due to staff shortages, the nurses accepted that they had to primarily focus on helping patients improve the acute health condition that brought them into the practice settings. Thus, other family needs that would have helped them to get more accessible or responsive services were left unmet.

“A shortage of nurses is serious here; thus, saving a patient’s life is first prioritized, while responding to the needs of developmental care comes later.” [P7]

4. Discussion

The current study was based on the nine elements of the philosophy of family-centered care [2,3] to explore the nurses’ perceptions of the importance of this philosophy and their current practice. Interestingly, the overall findings of the current study were very similar to those of the published studies [3,9,24–27]. That is, nurses in the current study were aware of the importance of each element of family-centered care; however, the nurses incorporated these elements into their daily practice to a significantly lower degree than the levels of their awareness. These findings highlight multiple individual and system challenges to implementation.

The term ‘parents’ readiness’ found in the study interview characterized family strengths as a parent’s willingness to participate in caring for their children. Thus, nurses would focus their assessment on the parents’ ability to listen and learn the specific tasks needed to care for their ill children in the context of the practice setting. It is not surprising that nurses in the current study used a strength-based approach for family assessment. This is consistent with a multicountry review of using a concept of family strengths and relating it to care tasks [28]. In a survey of nurses that graduated from a nursing college in Thailand, the nurses’ attitudes towards the importance of family in nursing care were at a ‘good’ level, and this rating was independent of the years of nursing experience, the types of wards, and the ages of patients [29]. Thai nurses, like nurses worldwide, limit their definition of family strengths to a task orientation and not to the broader issues of parents’ roles in supporting children’s age-appropriate development in providing emotional support and in understanding what is happening and why so they can interpret their child’s various hospital experiences to the child.

Enhancing parents’ contributions to the development and review of hospital policies and practices and collaborative participation in care were the least valued in this study. In the nurses’ view, this aspect of the family-centered care model (that is, parent/professional collaboration) did not match with the Thai culture of healthcare delivery. According to a study by Shields and Nixon [30], parents from developed countries (Australia and Britain) were

more likely to prefer higher involvement in hospitalized childcare than those from developing countries (Indonesia and Thailand); this could be due to medical dominance deriving from a strong social class system in developing countries that makes parents more passive and prefer less complicated involvement. Furthermore, information from the study interview highlighted that nurses were more likely to assume the roles of the controller of the care for pediatric patients and that they determined the needs and planned for the child's care from their own perspectives. The findings were consistent with a previous concept synthesis that indicated that unclear roles and boundaries between parents and healthcare professionals, as well as the rooted professional practices retaining the role of being the dominant decision-makers and caregivers, were barriers to implementing family-centered care [31]. There remain unspoken but powerful reinforcement and support for traditional views of the roles of each healthcare professional, including nurses, which are inconsistent with family-centered care. Ideally, to practice in a family-centered manner, a nurse must be an equal partner and facilitator of care, and families must be invited to participate actively in developing, implementing, and evaluating policies and programs, as well as in making decisions and adapting the care to fit their backgrounds [32]. Practically, translating the core principles of family-centered care in particular to partnership models (valuing family collaboration and participation) remains challenging due to an unclear definition and a lack of operational indicators and key strategies [33]. To ensure such involvement of parents, first and foremost, it is imperative that nurses examine, reflect and reframe their actions to be more consistent with their stated beliefs. Next, the family-professional relationship should be the focus, and efforts should be targeted at unmasking the issues around shared responsibility and mutual dependency [31]. More importantly, there must be a clear direction from hospital administrators and policymakers that family-centered care will be adopted and that a shared implementation plan will be provided to support the move in that direction. However, these high-level changes must be made in the context of ongoing and authentic consultation with all levels of healthcare professionals, as well as parental involvement as equal partners in the process. One previous study evidently supported the importance of policy in this matter. After the hospitals launched a new policy of increasing family presence to provide a safe and secure environment for patients, 87% of staff were supportive of the policy, and 70% fully and consistently adopted the policy; it was interesting that the team leaders significantly improved their perceptions of family-centered care in terms of leadership, mission, and patient and family support [34].

The design of the hospital system should be assured of its flexibility, accessibility, and responsiveness to family needs; however, this element was least practiced. According to the interviews, a shortage of nurses threatened the viability of a new service designed for patients and families. This was consistent with a study in Iran indicating that a shortage of nursing was one of the factors that led to ignoring family-centered care principles [35]. Note that the gap between the nurses' perceptions of necessity and implementation of family-centered care was largest for this element. The nurses weakly realized their potential as change agents in designing a better services system for child healthcare and prevented the move towards family-centered care. These findings were not surprising. Despite the fact that nurses represent the largest proportion of healthcare workers in Thailand, their voices in policy-making have historically been weak. The findings in the current study correspond well with those of a previous study of nurses in university hospitals in Thailand that reported that 83% of nurses never participated in policy development and that only nurses who held administrative positions (10%) had the

opportunity to be involved in policy-making processes because nurses were usually considered practitioners and not policymakers and their leadership in policy-making was not explicitly exercised [36]. From this notion, organizational support for human resources and nurse leadership is needed. Thai nurses should be armed with knowledge and understanding of their roles in the design of hospital systems as well as competent skills for being a change agent to fully deliver family-centered care.

5. Limitations

This study was implemented at a university hospital located in Bangkok, Thailand; thus, the study findings cannot be generalized to the whole country. In addition, the response scale of the FCCQ-R Thai version was adapted from 5-point to 4-point ratings. Therefore, comparison with previous studies could not be performed.

6. Conclusions and recommendations

Nurses in the current study felt concerned about essential elements of family-centered care; however, they were unable to practice it to the extent that they believed necessary. Although the current study did not aim at examining barriers to implementing family-centered care, the findings implied some significant challenges that were related to nurses' attitudes towards their role as a change agent and parents' role as one of the health care team members and the shortage of nurses. Moreover, in the nurses' view, family-centered care was originally rooted in a Western perspective from developed countries; thus, some elements of this care seem not to fit within the Thai clinical context.

Based on the study findings, future research is recommended to investigate how Thai nurses understand this philosophy of care, what constitutes family-centered care, the similarities and differences between Western and non-Western countries, and how to promote the implementation of family-centered care principles in clinical practice. The inclusion of physicians and other healthcare providers, parents and family members, as well as hospital administrators, as participants in future studies is also suggested so that comprehensive information can be obtained and can help researchers fully understand how this model of care is executed within the Thai context. It seems to be unrealistic to suggest an increase in the nurse-patient ratio to support family-centered care practice, as the shortage of nurses is a nationwide issue in Thailand that has no solution in sight. The realistic implication that we would recommend is to integrate concepts and applications of family-centered care into both nursing undergraduate education programs and in-service nursing education programs. Teaching methods that are focused more on role modeling and practice rather than knowledge per se would help refine nurses' thinking and guide their practices.

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Author contributions

Prasopkittikun conceived and designed the study, and obtained research funding. Srichantaranit and Chunyasing supervised the recruitment of the study participants and the conduct of data collection using a questionnaire. Srichantaranit conducted the interviews which were facilitated by Chunyasing. Prasopkittikun and Srichantaranit analyzed the data. Prasopkittikun drafted the manuscript and all authors contributed substantially to its revision.

Prasopkittikun took responsibility for the paper as a whole.

Declaration of competing interest

The authors declare no conflicts of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnss.2019.09.013>.

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