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Obstacles Associated with Considering Family as Client (Family Centered Care)

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Abstract

Family-centered care is commonly used to describe optimal health care as experienced by families. The main aim of this paper is to recognize the obstacles associated with considering family as client in Saudi Arabia. It is clear that the elements "Recognition of family individuality", "Developmental needs", "Parent/professional collaboration", "Design of the health care system" and "Emotional support for staff" were strongly present in Saudi participants' practice of family-centered care. The major obstacles of considering family as client are: Lack of staff, limited time to build trust and form relationships, and limited time to negotiate care. Moreover, Saudi participants said that language barriers limited their abilities to communicate with families, which in turn hindered their ability to practice family-centered care. This paper recommends that the approach of family-centered care within the context of nursing education in Saudi Arabia should be included.

Keywords

Family, Care, Obstacles, Client

1. Introduction

Family-centered care (FCC) has been regarded as a partnership approach to health care decision-making [1]. FCC and patient-centered care have been identified as a philosophy of care by several medical communities, health care systems, state and federal legislative bodies, the Institute of Medicine, and Healthy People 2020 as significant to patient health, satisfaction, and health care quality [2]. Furthermore, optimal health care experienced by families is described by FCC. The term is mainly used with other terms: "partnership", "collaboration", and families as "experts" to represent the process of care delivery [3].

FCC asserts the profound bond between the family, patient member and needs to keep the normality of the family unit to diminish stress for the sick member [4] [5]. Family-centered care is expected to enhance patient outcomes, degree of family satisfaction, raise families' awareness about the care needed, establish family and child strengths, help use healthcare resources and get staff more satisfied [6]. Thus, FCC is conducted to enhance the optimal environment for interaction between children, families and nurses. As a model of care in western health care contexts, family-centered care has been upgraded; whether and to what extent adaptation is necessary to ensure its cultural suitability in non-western contexts is not clear [7]. Any aspect of pediatric care in non-westernized countries has minimal literature.

However, the study might be the cornerstone for improving the quality of FCC in the hospitals in Saudi Arabia including holding parents' support programs for the families who have babies admitted to the hospitals. Therefore, target needs ought to be identified to develop and conduct these programs effectively [6]. There are no studies on family-centered care found from Middle Eastern countries, where religious and cultural norms, together with the structure of the health care service, have remarkable impact on health care practices. This paper aims to define the hindrances concerning considering family as client in Saudi Arabia

The significant agreement has been accomplished on FCC principles, developed by groups like family voices, the Maternal and Child Health Bureau, the American Academy of Pediatrics, and the Institute for Patient- and Family-Centered Care [8] (**Table 1**).

2. The FCC Scheme in Saudi Arabia

When it comes to Saudi Arabia, they accept a female relative (usually but not exclusively the mother) to stay in the hospital with a child during medication

Table 1. The principles of family-centered care [9].

Principle	Explanation
Information Sharing	Exchanging information is allowed, objective, and unbiased.
Respect and Honoring Differences	The working relationship is defined by respect for diversity, cultural and linguistic customs, and care priorities.
Partnership and Collaboration	Medically suitable decisions ideally meet the needs, strengths, values, and abilities of all involved are made together by inviting parties, including families at the level they choose.
Negotiation	The outcomes of medical care plans are flexible and not necessarily absolute.
Care in Context of Family and Community	Direct medical care and decision-making reflect the child within the context of his/her family, home, school, daily activities, and quality of life within the community.
Respect and Honoring Differences	The working relationship is defined with relation to diversity, cultural and linguistic traditions, and care priorities.

processes. Women are required in Saudi culture to be covered in the presence of males, and hospitals have instituted several policies to accommodate this. Male relatives can't accompany and room in with the child, male nurses are not allowed to work in pediatric areas, and male doctors are required to be attended by female nurses [10]. Unthankfully, these policies would increase a passive role of male family members in taking care of patient children. That is by not effectively engaging them in taking care and not getting them allowed to accompany their children in the period of hospitalization [9].

Additionally, there are main sociocultural aspects that should be taken into consideration when it comes to the Saudi context in relation to pediatric nursing. Pediatric nurses are basically non-Saudi nationals predominantly from India and the Philippines [11], and their English is a foreign language. They have miscellaneous religious, language and cultural backgrounds to families and patients. It's not required for nurses to speak Arabic; however, it is expected that they can use and understand basic Arabic terms. Interpretation is not available for everyday nursing communications with patients and families. This leads to rising issues in giving care and communicating with patients and families. Nurses are required to communicate in English with the healthcare team as it is the official language within hospitals; however, No any specific English test is required for being employed [10].

2.1. Family-Centered Care as a Model of Care in Saudi Arabian Hospitals: Analytical View

Considering FCC as an example of care giving and examining pediatric based care in Saudi Arabia, the elements: "Recognition of family individuality", "Developmental needs", "Parent/professional collaboration", "Design of the health care system" and "Emotional support for staff" were clearly found in Saudi participants' practice [9]. Other elements such as "Family is the constant", "Sharing information", "Parent-to-parent support", and "Emotional and financial support for families" were rarely found in nurses' practice. Therefore, the observed practices have been basically on achieving the daily delivery of care to patients. Surprisingly enough, there were no strategies of a working model of care such as a checklist to assist nurses to follow an anticipated model as identified in the western model of family-centered care. In fact, pediatric care elements that were practiced did not follow any approaches with relation to patient or family centeredness [11].

When observing Saudi culture and how nurses were practicing within this environment, it was clear that religious aspects and cultural contexts had a remarkable contribution in shaping the practice of pediatric nurses [10]. The important aspects to which nurses paid attention include paying attention to spaces and maintaining privacy between patients, dealing with male family members, and following the visiting policy. These aspects left an impact on Saudi nurses' practice and how they deliver care for the children being hospitalized [9].

2.2. Impediments Concerning Deeming Family as Client in Saudi Arabia

Taking the former studies in Saudi Arabia into consideration, Saudi nurses reported they wanted to deliver care depending on family-centered care [9]. However, they came up against some obstacles applying theory into practice due to reduced organizational and managerial support, inadequacy of resources and facilities, need for staff, limited time to build up trust and start relationships, and limited time to negotiate care. Besides, they consider exchanging information with families as a part of their role, nor did they have confidence in the genuineness of their knowledge and information. Moreover, language barriers weakened their abilities to communicate with families, which made them largely unable to practice family-centered care [8]. Obstacles of implementing the approach of family-centered care in general include:

2.2.1. Understanding Family-Centered Care

What specific actions forming FCC are still ambiguous, on both the level of care giver (provider) and patient. Some providers view FCC as commissioning bigger responsibility to families for caring and decision making than families desire [12]. Families have a desire for partnership and joint decision-making and not necessarily increased responsibility and autonomy [13]. However, families also may not understand what they can and should expect in a partnership. Parents constantly expect a high degree of satisfaction with a sense of partnership in a variety of child health care settings, even as subjective descriptions of care are far less satisfactory [14]. That would probably reflect a ceiling effect of expectations; a lot of parents may not know they can expect care, information, and decision-making on shared terms. Racial differences and language disparities within FCC suggest additional communication barriers that impede partnership building [15].

2.2.2. Support for Practices

Hindrances of substantive partnering include in adequacy and change of insurance coverage, and family financial burden and employment constraints. Significant time and repeated visits with providers may be required to establish family support and partnering [9]. Physician time and effort required to develop partnerships endangering enthusiastic practitioners for diminished reimbursement are not adequately supported by Reimbursement policies [16].

2.2.3. Research

Research has been hindered by lack of true validated measures and outcome measures for FCC. The lack of adequate research has formerly been mentioned [16]. Measures that evaluate family views of care fall short in related certain actions with overall health and outcomes. To measure the processes of care, a scale has been developed in the 1990s that evaluates the family-centeredness of services, has been largely implemented only for children with neurodevelopment

conditions [17]. A family-centeredness index based on the Consumer Assessment of Healthcare Providers and Systems survey has been used in national surveys [18].

3. Conclusion

Eventually, nurses are not enough aware of the theoretical concepts underlying family-centered care as a model of care. In fact, despite overall agreement on the concept, the outcomes of this paper suggest that pediatric nurses have a limited understanding of what family-centered care means and they do not constantly apply this concept in their practice. A lot of the family-centered care papers were conducted over the past two decades pointed out that nurses need to deeply understand the core elements required to practice family-centered care.

4. Recommendations

Research into what is suitable and appreciated by nurses and families is required to assess whether adopting the current westernized model of family-centered care is suitable for the Saudi context. Besides, the approach of family-centered care within the context of nursing education in Saudi Arabia should be included. Moreover, the ministry of health ought to strive to surmounting the obstacles which thwart implementing this approach in Saudi Arabia.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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