Esc Anna Nery 2018;22(4):e20180207

Self-assessment of family inclusion in institutional policies and practices: nursing team perspective[a]

Autoavaliação da inclusão das famílias em políticas e práticas institucionais: perspectiva da equipe de enfermagem

Autoavaliação da inclusão das famílias em políticas e práticas institucionais: perspectiva da equipe de enfermagem

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Abstract

Objective: To compare the evaluation carried out by the nursing teams of pediatric and maternal-infant with adult patient wards on the inclusion of families in institutional policies and practices. **Method:** A cross-sectional and descriptive study carried out in a university hospital with 148 professionals from the nursing team of the maternal and pediatric units and 43 from adult units. The data were analyzed by the program Statistical Package for the Social Sciences 22, using the chi-square test and Fisher's exact test. **Results:** The groups presented distinct perceptions about the differentiation between families and visitors in policies and practices; similar perceptions related to the policies and practices are not favorable to the presence of siblings and children, and to the non-inclusion of the families in aspects related to daily care. **Conclusion and implications for practice:** The perception of nursing teams indicates that families are not included in institutional policies and practices. The results of an organizational self-assessment about families' inclusion subsidize a way to improve organizational policies and practices, making it possible to draw up an action plan to implementing Patient and Family Centered Care at the institutional level.

Keywords: Family Nursing; Organizational Culture; Professional-Family Relations; Nursing team.

Resumo

Objetivo: Comparar a avaliação efetuada pelas equipes de enfermagem de unidades pediátricas e materno-infantis com as de unidades de pacientes adultos acerca da inclusão das famílias nas políticas e práticas institucionais. **Método:** Estudo transversal e descritivo, realizado em um hospital universitário com 148 profissionais da equipe de enfermagem das unidades pediátricas e materno-infantis e 43 das unidades de adulto. Os dados foram analisados pelo programa SPSS 22, sendo utilizado o teste Qui-quadrado e teste Exato de Fisher. **Resultados:** Os grupos apresentaram percepções discordantes acerca da inclusão das famílias nas políticas e práticas institucionais, sobretudo, acerca da diferenciação entre famílias e visitantes nas políticas e práticas; percepções semelhantes relacionaram-se às políticas e práticas não serem favoráveis à presença de irmãos e crianças, e à não inclusão das famílias em aspectos relacionados ao cotidiano assistencial. **Conclusão e implicações para a prática:** A percepção das equipes de enfermagem indica que as famílias não estão incluídas nas políticas e práticas institucionais. Os resultados de uma autoavaliação organizacional acerca da inclusão das famílias subsidiam a construção de um caminho para melhoria das políticas e práticas organizacionais, possibilitando traçar um plano de ação para implementar o Cuidado Centrado no Paciente e na Família em âmbito institucional.

Palavras-chave: Enfermagem familiar; Cultura Organizacional; Relações profissional-família; Equipe de Enfermagem.

Resumen

Objetivo: Comparar la evaluación efectuada por los equipos de enfermería de unidades pediátricas y materno-infantiles con las de pacientes adultos acerca de la inclusión de las familias en las políticas y prácticas institucionales. **Método:** Estudio transversal y descriptivo, realizado en un hospital universitario con 148 profesionales del equipo de enfermería de las unidades pediátricas y materno-infantiles y 43 de las unidades de adulto. Los datos fueron analizados por el programa Statistical Package for the Social Sciences 22, utilizando el test Qui-cuadrado y la prueba Exacto de Fisher. **Resultados:** Los grupos presentaron percepciones distintas acerca de la diferenciación entre familias y visitantes en las políticas y prácticas; las percepciones similares se relacionaron a las políticas y prácticas no ser favorables a la presencia de hermanos y niños, y la no inclusión de las familias en aspectos relacionados al cotidiano asistencial. **Conclusión e implicaciones para la práctica:** La percepción de los equipos de enfermería indica que las familias no están incluidas en las políticas y prácticas institucionales. Los resultados de una autoevaluación organizacional acerca de la inclusión de las familias subsidian un camino para mejorar las políticas y prácticas organizativas, posibilitando trazar un plan de acción para implementar el Cuidado Centrado en el Paciente y en la Familia en el ámbito institucional.

Palabras clave: Enfermería de la Familia; Cultura Organizacional; Relaciones Profesional-Familia; Equipo de enfermería.

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Submitted on 07/20/2018.
Accepted on 09/27/2018.

DOI: 10.1590/2177-9465-EAN-2018-0207

INTRODUCTION

Patient-and family-Centered Care (PFCC) is an approach for planning, the provision and the evaluation of health care, based on mutually beneficial partnership between the health care providers, patients and families. In agreement with this prospect, family is defined as two or more persons that are related in some way, biologically, legally or emotionally, and are the individuals/patients and family member that indicate who is part of the family and the level of involvement that each member shall have in aspects related to the care.[1] It is important to note that the advent and the PFCC evolution are rooted in the pediatric area, and its incorporation into other specialties is recent and has been gradually occurring.

The promising results evidenced given the PFCC incorporation into the organizational culture are related to the improvement in the client, family and health professionals satisfaction, in the families' communication with the health professionals and the commitment of families in caring, reducing anxiety, stress and depression of the family members, hospitalization time, costs and conflicts between family members and health team.[1-4] Based on that, this model has been endorsed as ideal for the care by large professionals as well as non-professional organizations, such as Institute for Patient and Family-Centered Care (IPFCC),[5] Institute of Medicine (IOM), American College of Critical Care Medicine (ACCM), American Academy of Pediatrics (AAP) and Joint Commission International (JCI)[6] contributing so principles and PFCC strategies can be incorporated into the health policies, national and international guidelines, health research and the clinical practice.

In the search for institutions in which the PFCC is implemented,[5] some examples are given on the North-American territory and absence recording of Brazilian institutions, except for brief indications on websites of few institutions, without details of the application of the PFCC principles. However, although records of implementation consolidated of this approach in an institutional framework have not occurred yet, the evidence shows actions related to the application of the PFCC principles[7-9] or implementation of the referred model in the context of specific care,[10] indicating a trend to incorporate the PFCC in the national health scenarios.

The PFCC is practiced by healthcare professionals when families are treated with dignity and respect, their members are truly heard, receive necessary information for decision-making, are actively involved in the care, in the way and in the level they wish, and they are supported seeking necessary resources for the functioning of the family system.[11] In the national context studies indicate that nurses are in favor of families' inclusion in the care,[12,13] evidence has shown that families really have been little include in the practice, and also of the lack of knowledge by the health professionals about this care approach.[14,15]

In order to assist in the PFCC implementation in the practice the literature indicates the creation of standardized documents, the use of institutional protocols to address the health teams' practices, the professionals' continuous education about this model, workshops focused in skills development to enable interaction of professionals with families, adequate organizational resources and the support of the institutional leaders.[1,16-19]

Despite the recommendations and promising results, the authors highlight that the PFCC implementation is challenging.[20,21] Identifying the institutional challenges for its implementation is the first step to overcome the barriers and to build an organizational culture care-based -approach.[22] The PFCC' s description in the institutional policies constitutes an important step of its implementation, as it guides the professional practices. Therefore, it is important that standardized documentations, on policies and practices guiding care, would be available and inserted into the professionals' teaching, current and newly contracted for the institutions, in a such way they would support the presence and participation of the families in clinical practice.[16,19]

Given the gap in the knowledge production about the policies and institutional actions towards the implementation of the PFCC,[8] motivate us to perform the organizational evaluation of an university hospital which, at the initiative of the nursing team, has been developing strategies for the implementation of the PFCC, having the following questions as the research guides: how does the nursing team evaluates the inclusion of the families in the written policies and in the health team practices in the institution in which they work? Is there any difference in the nursing professional' perception who works in pediatric and maternal child units and those who works in adult patients units?

The objective of this study was: Compare the evaluation carried out by the nursing teams of pediatric and maternal child units with those of adult patients units about the families' inclusion in the institutional policies and practices.

METHOD

Cross sectional and descriptive study carried out in a university hospital located in the city of São Paulo, during the period from October 2016 to February 2017. In this study, nurses, residents, nursing technicians and nursing assistants of pediatric and maternal child units (named Group I) and units of adult patients (named Group II) were included as participants. It was a non-probabilistic sample for convenience, which eligible population was comprised of 231 of the nursing team professionals (Group I) and 418 nursing team professionals (Group II). All the eligible patients were invited to participate in the study. Nursing professionals on holidays or sickness absence during the data collection period were excluded from the study.

The Group I included the units of Pediatric Emergency, Pediatric Clinic, Pediatric Intensive Care Unit, Neonatal Intermediate Care Unit, Rooming-In-services and Obstetric Center, and the Group II was comprised of the Adult Emergency, Medical Clinic, Surgical Clinic and Adult Intensive Care Unit sectors.

The data were collected through a formulary elaborated by the researchers based on an instrument "Better Together - Partnering with Families: Organizational Self-assessment", made available for use with free access on the IPFCC website.[23] The instrument makes possible the organizational self-assessment on the families' inclusion in different institutional elements, such as written policies, site, information materials and health team practices, helping to determine initial priorities and action steps to start the process of change. For use of the instrument the IPFCC policies were followed for reproduction and utilization of documents. After the translation and adaptation of questions to the research objective, the formulary was validated by two investigators experts in the area; then, a pilot test was performed for language and content validation with ten participants of the study population, that did not result in modifications in the instrument initially elaborated. Considering that the instrument is not intended to measure concepts, but to guide a reflection on the organizational culture, psychometry techniques were not used.

The formulary used, of self-completion type, was composed by sociodemographic variables for characterization of the sample, and contained 42 closed questions distributed in eight blocks, with a Likert scale that offered three response options (yes, no and I don't know). In this study, results concerning three blocks of questions (18 questions in total) will be presented: (1) policies written in the hospital documents; (2) nursing team practices in the work unit and (3) health team practices as a whole in the work unit.

The place where the study was carried out had not institutional documents to describe the PFCC as a model or care concept to guide the organizational processes and the assistance practice. However, since 2014, pediatric and maternal-infant units (Group I) have been going through an internal process for inclusion of the families in the care, with actions of awareness of the nursing team of the theme, as part of a managerial goal to the PFCC implementation in a consolidated way. Therefore, it has been made a comparison of perceptions between the Groups I and II in the data analysis.

The eligible professionals to participate in the study received personally explanations about the aim of the investigation and procedures for data collection. After this step, upon previous agreement with the nurse managers of each sector, formularies and Free and Informed Consent Forms were made available on envelopes in the nursing manager rooms in each assistance unit so that nursing professionals of all shifts could participate and e respond, at their best convenient time.

In order to guarantee the participants' anonymity, two different ballots were made possible and identified to allow the participant to deposit the FICF in a ballot and the formulary in the other, separately. After two weeks the envelopes and the ballots of the Group I were collected and after 5 weeks those of the Group II, due to the low number of documents returned, totaling a sample of 148 nursing team professionals of the Group I and 43 of the Group II.

The data from the formularies were organized on Microsoft Excel 2010 program, and exported later to the data bank of the Statistical Package for the Social Sciences (SPSS) 22 program, statistics analysis made based on the chi-square test and Fisher's exact test, adopting a level of significance of 0.05.

The study was conducted taking into account the ethical aspects described in the Resolution 466/2012 of the Health National Council, approved by the Ethics Research Committee of the Escola de Enfermagem da USP (protocol no. 1.780.925) and by the participant Hospital (protocol no. 1.801.215).

RESULTS

The sample was composed of 191 nursing professionals, of which, 148 (77.5%) belonging to the Group I and 43 (22.5%) to the Group II (Table 1), in that the most belonging to the category of nursing assistants or nursing technicians. The participants presented a median of 41 (±9.7) years old, 16 (±8.3) years of profession and 15 (±8.9) years of experience in the institution (Table 2).

The participants' perception about the content regarding families that was described in the institution policies is shown in the Table 3, and there was a significant discrepancy among the groups (p = 0.006) when questioned about the families being considered as visitors in which the most (46.3%) of the Group I declared that the institutional written policies did not consider the families as visitors and the most (59.5%) of the Group II that the written policies considered the families as visitors.

From a perspective of the most of both groups, the written policies recognized the importance of the families in the patient's attention, comfort and safety (p = 0.018), and it is important to

Table 1. Distribution of sample by professional category and groups. São Paulo, SP, Brazil, 2017.

Professional category	Group I N	Group I %	Group II N	Group II %
TE/AE*	82	55.4	26	60.5
Residents	12	8.1	0	0
Nurses	54	36.5	17	39.5
TOTAL	148	77.5	43	22.5

* TE/AE: Nursing Technicians/Nursing Assistants.

Table 2. Distribution of the professional participating in the study regarding age, time of profession and time of service in the Institution. São Paulo, SP, Brazil, 2017.

	Unit	Professional category	N*	Mean	DP*	Median	Minimum	Maximum
Age	Group I	TE/AE*	82	44.35	8.860	44.00	25	63
		Residents	12	23.83	1.642	23.50	22	28
		Nurses	54	41.63	8.090	38.00	30	56
		Total	148	41.70	9.851	41.00	22	63
	Group II	NT/NA	26	44.15	9.242	42.50	28	60
		Nurses	17	39.35	9.340	35.00	30	56
		Total	43	42.26	9.472	41.00	28	60
	Total	NT/NA	108	44.31	8.910	44.00	25	63
		Residents	12	23.83	1.642	23.50	22	28
		Nurses	71	41.08	8.393	38.00	30	56
		Total	191	41.82	9.745	41.00	22	63
Time of profession	Group I	NT/NA	82	19.01	7.075	19.00	7	36
		Residents	12	0.72	0.205	0.58	1	1
		Nurses	54	17.52	7.966	15.00	6	32
		Total	148	16.98	8.629	16.00	1	36
	Group II	NT/NA	26	17.88	6.599	17.50	6	32
		Nurses	17	15.06	7.846	12.00	5	29
		Total	43	16.77	7.164	16.00	5	32
	Total	NT/NA	108	18.74	6.950	18.50	6	36
		Residents	12	0.72	0.205	0.58	1	1
		Nurses	71	16.93	7.952	15.00	5	32
		Total	191	16.94	8.304	16.00	1	36
Time of occupation in the institution	Group I	NT/NA	82	16.98	8.477	17.00	3	35
		Residents	12	0.72	0.205	0.58	1	1
		Nurses	54	16.22	8.469	15.00	4	32
		Total	148	15.38	9.202	15.00	1	35
	Group II	NT/NA	26	14.73	8.619	12.50	4	32
		Nurses	17	12.29	7.192	10.00	5	26
		Total	43	13.77	8.085	12.00	4	32
	Total	NT/NA	108	16.44	8.525	16.50	3	35
		Residents	12	0.72	0.205	0.58	1	1
		Nurses	71	15.28	8.305	13.00	4	32
		Total	191	15.02	8.968	15.00	1	35

* N: Absolute number. SD: Standard Deviation; NT/NA: Nursing Technicians/Nursing Assistants.

Table 3. Nursing team's perception about the families' inclusion in the institutional written policies. São Paulo, SP, Brasil, 2017.

The written policies (in documents) of the hospital:		Group I		Group II		
	Answer	N	%	N	%	P-value
a) Recognize the importance of the families in the patients' assistance, comfort and safety?	Yes	110	74.3%	26	61.9%	0.018
	No	24	16.2%	5	11.9%	
	Don't know	14	9,5%	11	26,2%	
b) Refer to the families as essential partners and not as visitors?	Yes	85	57.4%	19	45.2%	0.015
	No	45	30.4%	10	23.8%	
	Don't know	18	12.2%	13	31.0%	
c) Encourage the patients and their families to define who will be involved in the care and in the decision making?	Yes	97	65.5%	24	57.1%	0.005
	No	32	21.6%	4	9.5%	
	Don't know	19	12.8%	14	33.3%	
d) Encourage the patients and their families to declare their preferences of how will be involved in the care, care planning and in the decision making?	Yes	70	47.9%	20	47.6%	0.002
	No	52	35.6%	6	14.3%	
	Don't know	24	16.4%	16	38.1%	
e) Make distinction between families and visitants?	Yes	70	47.6%	9	21.4%	0.001
	No	58	39.5%	19	45.2%	
	Don't know	19	12.9%	14	33.3%	
f) Consider the families as visitors?	Yes	57	38.8%	25	59.5%	0.006
	No	68	46.3%	8	19.0%	
	Don't know	22	15.0%	9	21.4%	
g) Consider the families as companions?	Yes	116	78.9%	28	66.7%	0.217
	No	16	10.9%	7	16.7%	
	Don't know	15	10.2%	7	16.7%	
h) Are favorable to the presence of brothers and children of all the ages in accordance with the preferences of the patient and the family?	Yes	37	25.2%	5	11.9%	0.074
	No	96	65.3%	29	69.0%	
	Don't know	14	9.5%	8	19.0%	

* Chi-square Test; Fisher's exact Test.

observe that the percentage of answers "don't know" of the Group II (26.2%) was higher than the sum of the percentage of answers "no" and "don't know" of the Group I (25.7%).

However, in relation to encourage the families to declare their preferences of how they want to be involved in the care, care planning and decision making, the sum of the percentage of answers "no and "don't know" in both groups was higher than 50%, overcoming the affirmative answers, which represented 47.9% in the Group I and 47.6% in the Group II ($p = 0.002$).

Relating to the presence of Brothers and children of all ages, according to the patient and family preferences, the most respondents in both of groups, 65.3% of the Group I and 69% of the Group II, agreed that the institutional written policies were not favorable to the presence of such members of the family. It shall be noticed that in this group of questions about the written policies, the percentage of answers "don't know" is considerably more expressive in the Group II than in the Group I, reaching a maximum value of 38.1% and 16.4%, respectively (Table 3).

Regarding the participants' perception about the families' inclusion in the nursing team practices (Table 4), in both of groups it was observed a percentage of affirmative answers higher than 80% for two questions: the first that asked about the recognition of the importance of the family in the patients' assistance, comfort and safety by the nursing team.

Table 4. Nursing team's perception about the family's inclusion in the nursing team's practices. São Paulo, SP, Brazil, 2017.

The nursing team's practices of its work unit:		Group I		Group II		
		N	%	N	%	P-value
a) Recognize the importance of the families in the patients' assistance, comfort and safety?	Yes	123	83.1%	38	88.4%	0.404
	No	25	16.9%	5	11.6%	
	Don't know	0	0.0%	0	0.0%	
b) Encourage the patients and their families to define who will be involved in the care and in the decision making?	Yes	121	81.8%	38	88.4%	0.682
	No	22	14.9%	4	9.3%	
	Don't know	5	3.4%	1	2.3%	
c) Encourage the patients and their families to declare their preferences of how will be involved in the care, assistance planning and in the decision making?	Yes	81	56.3%	29	69.0%	0.332
	No	43	29.9%	9	21.4%	
	Don't know	20	13.9%	4	9.5%	
d) Make distinction between families and visitors?	Yes	81	55.5%	15	35.7%	0.050
	No	61	41.8%	26	61.9%	
	Don't know	4	2.7%	1	2.4%	
e) Make distinction between families and companions?	Yes	67	45.3%	13	30.2%	0.121
	No	80	54.1%	29	67.4%	
	Don't know	1	0.7%	1	2.3%	
f) Are favorable to the presence of brothers and children of all the ages in accordance with the preferences of the patient and the family?	Yes	32	21.8%	9	20.9%	0.519
	No	104	70.7%	33	76.7%	
	Don't know	11	7.5%	1	2.3%	

* Chi-square Test; Fisher's exact Test.

In relation to the nursing team to encouraging the patients and their families to declare their preferences of how they want to be involved in the care, assistance planning and in the decision making, the most respondents of both groups, 56.3% of the Group I and 69% of the Group II, agreed that the team has this type of behavior. Regarding the team's practices to being favorable to the presence of brothers and children of all the ages, both of groups disagree about this declaration, which presented 70.7% of negative answers in the Group I and 76.6% in the Group II.

The only question that presented significant difference in the perception about the team's practice in the work unit (Table 4) was about having distinction between families and visitors in the assistance units, with discrepancy among the groups, where the most of the do Group I (55.5%) declared having differentiation between families and visitors and the most of the Group II (61.9%) declared not having such distinction ($p = 0.005$).

The last block of questions analyzed (Table 5) showed that in all the situations questioned - visits (discussion of cases), passages of duty, emergencies and realization procedures - both of groups agreed that the team's practices demonstrate that the families are unwelcome.

DISCUSSION

The self-evaluation of professionals about the family's inclusion both in the institutional policies and in the team practices enabled identifying the lack of clarity, for both groups, on the differentiation between the concept of family as partner, family as visitor and family as companion. In Brazil, the main reference used to guide the actions regarding the family's inclusion in the assistant contexts is the National Humanization Policy (PNH) in the Brazilian Health System.[24] However, the PNH document analysis allows us to verify that the same uses the terms companion and visitor obscurely, or using them in a distinct manner, referring to the companion as stays full time alongside the patient and to the visitor as has time restriction to enter and stay and remain in the assistance units, or describing the terms visitor, family member or network patient representative as synonyms. Different family concepts could determine difficulties and barriers in the in implementing inclusive practices of the family members, as those intended by the PNH.

The PFCC philosophy is emphatic when it says that family is not visit, family is considered as essential member of the team health. According to the PFCC, treating the Family members

Table 5. Nursing team's perception about the health team's practices demonstrating that the families are welcome in the care environments. São Paulo, SP, Brazil, 2017.

The families are welcome 24h a day, 7 days a week by the team's practices as a whole in:		Group I		Group II		
		N	%	N	%	P-value
a) Clinic visits (discussion of cases)	Yes	39	26.7%	11	26.2%	0.322
	No	88	60.3%	29	69.0%	
	Don't know	19	13.0%	2	4.8%	
b) Passages of duty	Yes	47	32.2%	9	21.4%	0.348
	No	93	63.7%	30	71.4%	
	Don't know	6	4.1%	3	7.1%	
c) Emergency situations	Yes	48	32.7%	18	41.9%	0.245
	No	91	61.9%	25	58.1%	
	Don't know	8	5.4%	0	0.0%	
d) Realization procedures	Yes	67	45.3%	19	45.2%	0.553
	No	75	50.7%	23	54.8%	
	Don't know	6	4.1%	0	0.0%	

* Chi-square Test; Fisher's exact Test.

as visitors restricts their participation in the care, emphasizing the importance of the change in rules that restrict the family presence in the hospital environment to enable the PFCC to be incorporated.[19]

The results presented here showed that the professionals' group which it had already undergone a process of sensitization regarding the PFCC, presented less doubtful perceptions about the family inclusion in the written than the group that was sensitive for the theme. However, such perceptions showed the lack of understanding of the nursing team professionals about the inclusion in the institutional policies, because such question was not established at the location, which suggests that the answers were made based on the perception of the organizational culture experienced by the professionals within the action units. The literature says that one of the obstacles to the PFCC implementation in the professional practice is the absence of its description in the institutional policies, as the multiprofessional team practice the approach to which it gives preference, then, those that prefer a more traditional care environment, adopt a more patient-centered and less family-centered approach.[22]

International studies showed that the family's perceptions, beliefs and rhetoric about the patient-centered care and in the family-centered care are not consonant with the daily practice, making its implementation difficult.[21,25] This corroborates our findings, as despite the most professionals have demonstrated the perception of that the nursing team recognized the importance of the families for the patients and encouraged them to define who and how would be involved in the care, care planning and decision making, demonstrated the perception of that, in practice, the families were not involved in the clinical visits, passages of duty, emergency situation and realization procedures, indicating that the families are unwelcome in situations lived in the daily.

In accordance with the PFCC, the families' participation in the passages of duty, clinic visits, emergency situations and during the realization procedures, including the invasive, is the recommended practice.[1,20,25,26] The healthcare organizations leaders should recognize that patients and families should be included in all the institutional processes and elements, since situations related to the direct care to patient, such as passages of duty, until the policies and programs planning and execution, such as teams training.[25,27]

About the presence of brothers and children off all ages, in this study, the groups of professionals demonstrated the perception of that the nursing team's policies and practices was not favorable to their presence. An Irish study, carried out in children's units, showed that the nurses recognized not only the children's parents, but brothers, grandparents and other relatives as the family members, considering as important their involvement in the care.[28] Another study emphasized the lack of appropriate accommodation, both for the parents, and for the brothers and another members of the family as a negative element, which limits the integral presence of the family and makes the PFCC appropriate implementation difficult.[29] International study that explored the experiences lived by nurses in the PFCC implementation in assistance practices in the Neonatal ITU, showed that despite they wish that all the members of the family, such as brothers or grandparents visit the child, they were obliged - due to the internal policies of the unit to prevent the entry of these members of the family due to the questions related to disturbances, management and infection control.[30]

In Brazil, study which carried out the intervention for the application of a Program of Implementation of the Model of Care-Patient and Family-Centered in the Neonatal Unit, found improvements of 30% in the healthcare team professionals' perception regarding the PFCC on the widened participation of the family, the stay of the parents during the procedures, the family's inclusion in the care for the child and knowledge of the parents network. However, the team remained resilient to the presence of another person other than the parents, grandfathers and brothers.[10]

The nursing team a play fundamental role in the PCCC planning, implementation and evaluation, however, although is close to the patients and their families in their daily activities, it should assume alone and exclusively the responsibility for the PFCC implementation, as patients, family members and all the multiprofessional team should be included in all the stages, what includes the planning, the development and the evaluation of policies and guidelines related to this care approach.[30]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study revealed that the groups had distinct perceptions about the family concept in the institutional policies and practices, where the most pediatric areas and maternal child there was differentiation between families and visitors and the most that worked in the adult patients units stated there was no distinction. Similarly, while the most professionals of the first group had the perception of that families were not considered as visitors, the most of the second group showed perceptions of that the families were considered as such.

Similar perceptions were evidenced in questions related to the no inclusion of brothers and children of all the ages, both in the institutional policies and practices. The groups also agreed that the families were unwelcome in situations lived in the daily of the assistance units pointing out that they were not included during the clinic visits, passages of duty, emergency situations and realization procedures.

The results of this study showed that the lack of description of a guided care model in the institutional policies, implied different and erroneous perceptions of the nursing team about the families' inclusion in the organizational field. The misunderstandings showed among the groups' perception corroborate the idea of that the lack of definitions in the organizational written policies, about who is the family, makes it difficult and causes different perceptions and comprehension in the professionals about concepts that should guide aspects of professional practice.

It was configured as a study limitation the low return in the number of formularies filled by the nursing team professionals of adult patients units, whose reduced sample made a more accurate analysis of the groups difficult. This fact can be interpreted as an indicative element of the receptivity of these professionals to the PFCC.

Another limitation can be attributed to the fact that the study was carried out only with the nursing teams, as among several professionals that work in the institution, we focused the organizational self-evaluation from only one perspective. To carry out the organizational self-evaluation from the nursing professionals' perspective is only one of the possible lines, but of great importance, since represent the major quantitative of human resources in the hospital institutions and have a greater relational proximity with the patients and families. Subsequent studies should search the perspective of the other professional categories of the institution, as well as the impact assessment of the institutional practices related to the families in the health and satisfaction of families and professionals indicators.

Furthermore, in face of a scenario that recommends the incorporation of this care model by the health services, studies should be carried out about national policies, programs and public health strategies that are closer to the PFCC principles, such as the National Humanization Policy, the Family Health Strategy and the Single Therapeutic Project, aiming at understanding these approaches and the singularity of each initiative.

The carried out of an organizational self-evaluation about the families' inclusion can subsidize the built of a way for the review and improvement of the organizational policies and practices, enabling us to lay out a plan of action for implementing the PFCC in the institution, establishing priorities and goals for incorporating the principles of this approach in the documents, environments and assistance processes, in such a way that, gradually, the organization culture can be transformed. This plan should, among other aspects, take into account the establishment of groups to lead the organizational transformation process for implementing the PFCC in different fronts, such as the review of the documents that deals with the institutional philosophy and the policies, dissemination of knowledge by means of the teams' training and, continuous implementation and evaluation of the assistance practices.

ACKNOWLEDGEMENTS

To the Institute for Patient- and Family-Centered Care for the support given to this publication.

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[a] This article was developed as part of an educative program for the implementation of the Family - Centered Care, which have been conducted in partnership with the School of Nursing of the USP and the University Hospital of the USP - São Paulo - Brazil.