

Attitudes of nurses towards families: validation of the scale Families' Importance in Nursing Care - Nurses Attitudes*

ATITUDES DOS ENFERMEIROS FACE À FAMÍLIA: VALIDAÇÃO DA ESCALA FAMILIES' IMPORTANCE IN NURSING CARE - NURSES ATTITUDES

ACTITUDES DE LOS ENFERMEROS FRENTE A LA FAMILIA: VALIDACIÓN DE LA ESCALA FAMILIES IMPORTANCE IN NURSING CARE – NURSES ATTITUDES

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ABSTRACT

The attitudes of nurses towards families determine the care process. With this study, we aimed to obtain an instrument that would allow us to learn about this variable. Hence, our purpose was to perform the cross-cultural adaptation and evaluate the psychometric features of the Portuguese version of the instrument Families' Importance in Nursing Care – Nurses Attitudes (FINC-NA), which aims to evaluate the attitudes of nurses towards the importance of involving the patient's family in the nursing care. The method recommended by the literature was followed. The sample consisted of 136 nurses working in primary health care. The results obtained in the reliability tests showed good internal consistency (Cronbach's Alpha=0.87). The psychometric study permits us to state that the Portuguese version of the FINC-NA, which in Portuguese is referred to as *A importância das famílias nos cuidados de enfermagem – atitudes dos enfermeiros (IFCE-AE)*, is a reliable and valid tool.

DESCRIPTORS

Family nursing
Attitude of health personnel
Cross-cultural comparison
Psychometrics
Validation studies

RESUMO

As atitudes que os enfermeiros adotam em relação à família condicionam o processo de cuidar. Nosso propósito com este estudo foi nesse sentido: dispor de um instrumento que nos permitisse conhecer esta variável. Assim, nossa proposta foi efetuar a adaptação transcultural e avaliar as propriedades psicométricas da versão portuguesa do instrumento Families' Importance in Nursing Care – Nurses Attitudes (FINC-NA), que visa avaliar as atitudes dos enfermeiros acerca da importância de envolver a família nos cuidados de enfermagem. Foi seguido o método preconizado pela literatura. A amostra foi constituída por 136 enfermeiros dos Cuidados de Saúde Primários. Os resultados obtidos nos testes de confiabilidade revelam uma boa consistência interna para o total dos itens (Alpha de Cronbach = 0,87). O estudo psicométrico permite-nos afirmar que a versão em português da FINC-NA, que denominamos *A importância das famílias nos cuidados de enfermagem – atitudes dos enfermeiros (IFCE-AE)*, é um instrumento fidedigno e válido.

DESCRITORES

Enfermagem familiar
Atitude do pessoal de saúde
Comparação transcultural
Psicometria
Estudos de validação

RESUMEN

Las actitudes adoptadas por enfermeros en relación a la familia condicionan el proceso de cuidar. En tal sentido, nos propusimos con este estudio, disponer de un instrumento que nos permita conocer esta variable. Así, nos propusimos efectuar la adaptación transcultural y evaluar las propiedades psicométricas de la versión portuguesa del instrumento *Families Importance in Nursing Care – Nurses Attitudes (FINC-NA)*, que apunta a evaluar actitudes de enfermeros acerca de involucrar a la familia en los cuidados de enfermería. Se siguió el método sugerido por la literatura. Muestra constituida por 136 Enfermeros de Atención Primaria de Salud. Los resultados obtenidos en pruebas de fiabilidad revelan buena consistencia interna para el total de ítems (Alpha de Cronbach=0,87). El estudio psicométrico nos permite afirmar que la versión en Portugués del FINC-NA, que denominamos *La importancia de las familias en el cuidado de enfermería – actitudes de los enfermeros (IFCE-AE)* es un instrumento fidedigno y válido.

DESCRIPTORES

Enfermería de la familia
Actitud del personal de salud
Comparación transcultural
Psicometría
Estudios de validación

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INTRODUCTION

The family as a unit is essentially characterized by inter-relationships established among its members, in a specific context of organization, structure and functionality.

As a social dynamic system, it incorporates a set of values, beliefs, knowledge and practices that confer unity on it. Its network of multiple relationships transforms it constantly and it develops through co-construction processes inherent to its complexity and multidimensionality⁽¹⁾.

From this bio-ecological approach to the family system emerge systemic characteristics of a global nature and reciprocity. Based on these assumptions, we understand that health problems influence the family's perceptions and behaviors in the same way its perceptions and behaviors influence the health of its members. The interdependency between the family's health, as a functional unit, and the health of its members, assumes that health care will be more efficient as more emphasis is given to the family system as a target and unit of care⁽²⁾.

From this perspective, family nursing is directed to how the family responds to real or potential health problems and is centered on its functional ability in the face of its transition problems⁽¹⁻³⁾. For nursing care to be centered on the family as the object of intervention, it is essential to recognize its multidimensional nature and its competencies as a self-organizing unit in the face of transition processes.

The development of the nursing discipline and profession increasingly points to the need for recognizing the family as the object and target of care and also as a proactive element in this process; the family is an essential part of the care process⁽⁴⁾. In the definition of their strategies described in the National Health Plan 2004-2010⁽⁵⁾, the health policies in Portugal integrate and emphasize the importance of health care centered on the family and the life cycle.

In this context, the attitudes of nurses in situations of therapeutic interaction with families translate their understanding concerning the importance of integrating their attitudes into care processes, generating practices more or less conducive to the functional empowerment of families.

Attitude (from Latin aptitudine, and French attitude) means a purpose, a way to proceed with an organized and coherent manner to think, feel, and react⁽⁶⁾. It links opinion and conduct and indicates what we are willing to do in our hearts. Attitudes are favorable or unfavorable tendencies related to objects, people and events or in relation to some of our qualities, and are composed of three components: a cognitive component (thoughts and beliefs), an affective component (feelings and emotions) and a behavioral component (tendencies to react).

Various concepts attempt to explicate the cognition, affection and behavior of nurses toward families⁽⁷⁻⁸⁾ and have been used in studies addressing interactions between nurses and families in health care such as: perceptions, experiences, points of view, attitudes, beliefs and perspectives.

Studies addressing the attitudes of nurses toward families⁽⁹⁻¹⁰⁾ provide evidence that, despite the fact that nurses' own narratives express the importance of care being centered on the family, their practices are not congruent with their representations. Nurses consider families to be a resource in the care process based on collaborative principles, highlighting the importance of establishing a good relationship.

Factors identified as hindering factors⁽¹¹⁾ include the follow-up of families with diverse ethnic characteristics or living transitions that generate suffering. Some studies acknowledged attitudes and behaviors that minimize family involvement in care^(9,12-14). Such attitudes are manifested through restricting the presence of families during the performance of nursing activities and also restricting

their presence in services such as Intensive Care Units (ICU)⁽¹³⁾, based on the belief that the family is unable to care for its sick member⁽¹⁴⁾ and on the conviction that the family negatively influences their work. There are various instruments and questionnaires that enable the identification of the attitudes of nurses toward families when evaluating their needs, perceptions and experiences⁽¹⁵⁾ and also in relation to the family participating in care delivery⁽¹⁶⁻¹⁷⁾. These instruments are directed to the attitudes of nurses in specific contexts (especially in intensive care and pediatric units) and basically seek to evaluate the needs and participation of families in care provided to their members.

Studies addressing the attitudes of nurses toward families provide evidence that, despite the fact that nurses' own narratives express the importance of care being centered on the family, their practices are not congruent with their representations.

The scale *Families' Importance in Nursing Care – Nurses Attitudes* (FINC-NA) was developed in Sweden based on a systematic review of literature initiated in 2003 by a group of nurses who surveyed the reality of the situation in Sweden. It takes as a fundamental principle that the family is an important resource both for the sick individual and for the nurse delivering care⁽³⁾. The items that compose it integrate the cognitive *I think...*, affective *I feel...* and behavioral dimensions *In my work...* and consider that the concept *family* used in the scale encompasses all its members, friends, neighbors, and other significant people⁽⁷⁾.

Considering the results of the studies mentioned and also the fact that no instrument was found in Portuguese to measure the attitudes of nurses toward the involvement of the family in nursing care, we considered it extremely important to adapt and validate the instrument *Families' Importance in Nursing Care – Nurses Attitudes* (FINC-NA). We expect this study will contribute to improving nursing care based on the identification of effective needs in the scope of collaborative intervention with families.

OBJECTIVE

To complete the cultural adaptation and validation of the instrument *Families' Importance in Nursing Care – Nurses Attitudes* (FINC-NA) in Portugal.

METHOD

The process of cultural adaptation and validation of the instrument followed recommendations provided in the literature, guiding the strategy of implementation through an operational proposal⁽¹⁸⁾.

Instrument

The scale used was the self-applied *Families' Importance in Nursing Care – Nurses Attitudes* (FINC-NA)⁽⁷⁾ composed of 26 items that embody each statement. These statements are similar among them and the sequence does not follow a particular order. Similar to the original scale, we used an Likert agreement scale (4 options) that varies from completely disagree(1) to completely agree(4) that measures the following dimensions: family as a resource in nursing care (10 items); family as a conversational partner (8 items); family as a burden (4 items) and family as own resource (4 items). The scores obtained in the scale range from 26 to 104, considering that the higher the score, the more supportive the attitudes of nurses toward the family⁽⁷⁾. The data collection instruments also included a set of questions to obtain demographic and professional data on nurses.

Procedures

After the authors of the original scale approved its adaptation, authorization to contact the nurses of the Health Centers in the Eastern and Western Port was provided by the North Regional Health Administration (Protocol 22,033 on April 23rd 2009). In Portugal, health institutions authorizing studies request ethical advice from committees whenever ethical issues related to human protection, dignity and integrity, emerge. Most of these institutions are based on the Helsinki Declaration that recommends that written informed consent be obtained when the participants are members of the health team. Therefore, after the study was approved, the researchers contacted the nurses through the head nurses of the different Health Centers and Family Health Units (FHU) inviting them to participate and collaborate with the study. All the participants filled out an informed consent form according to the provided in the Helsinki Declaration and data collection was conducted between April 27th and May 22 2009.

The Statistical Package for the Social Sciences (SPSS) for Windows version 17.0 was used in data processing.

Participants

A non-probabilistic convenience sample was used taking into account the requirements to proceed with the

statistical analysis inherent to scale validation. Hence, a total of 136 (64.76%) nurses from a population of 210 participated in the study. Most were women (88.2%; n=120), aged between 23 and 65 years old (A=35.8; SD=10.1). Time of professional experience ranged from one to 41 years (A=12.9; SD=10.0), experience in Primary Health Care ranged from less than one year to 36 years (A=8.3; SD=7.5). Most had a Nursing Teaching Diploma (83.8%; n=114), 8.2% (n=11) had a Bachelor's degree, and three had a Master's degree (2.2%).

In relation to their positions, 50% (n=68) of the participants were nurses, 38.2% (n=52), senior nurses and the remaining 11.8% (n=16) included: head nurse (n=5) and specialist nurse (n=11); 17 (14.1%) nurses who worked in FHU. In relation to work methodology, the functional method was the most used (45.6%), while the family nurse method (43.4%) and the team method (25%) were also reported. A total of 59.6% (n=75) of the participants attended family nursing training, 23.5% of which were in an academic context, and 29.4% in continuing education programs promoted by the North Regional Health Administration, 19.9% in self-training processes and 6.6 % in other contexts.

Development of the Portuguese Version

The scale's cultural adaptation and validation was performed as presented in Figure 1.

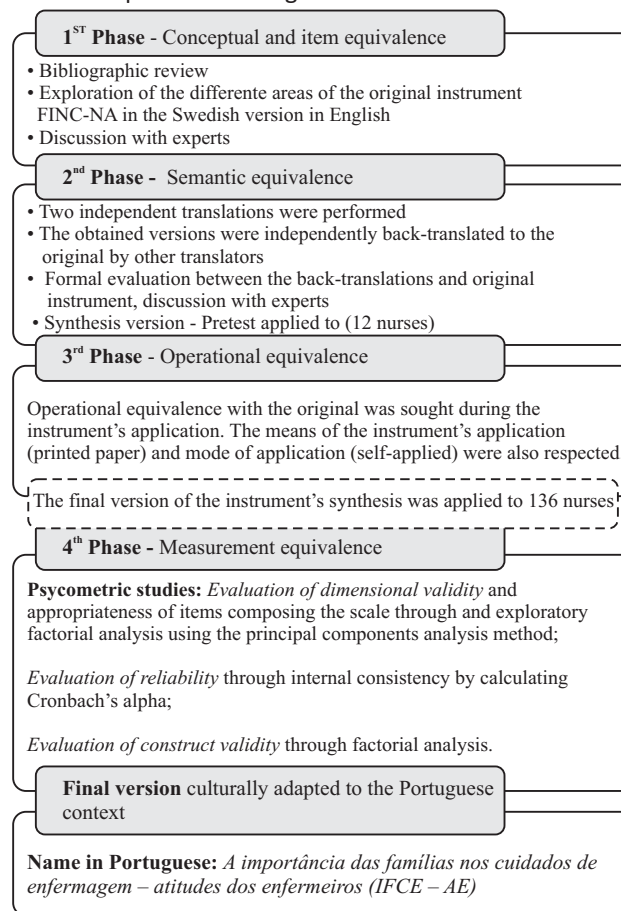


Figure 1 – FINC-NA's cultural adaptation and validation process

RESULTS

In addition to the descriptive analysis, construction validity analysis was also performed through factorial analysis and internal consistency was verified through Cronbach's alpha. The maximum error probability was set at 5%.

An exploratory factorial analysis was performed to confirm the scale's structure using the Principal Component Analysis method with orthogonal rotation through the Varimax method with Kaiser normalization, previously defining four factors similarly as did the original scale, selecting the items with factorial load above 0.3. The KMO index of sampling adequacy (measure of variables homogeneity) was computed in 0.89, thus the conclusion is that the data matrix is appropriate to proceed with the factorial analysis⁽¹⁹⁾. We considered the minimum number of valid answers to be five times the number of variables. The obtained factorial solution is reproduced in Table 1.

Table 1 – Principal components of the IFCE-AE scale – Porto, Portugal - 2009

Item	Factor 1	Factor 2	Factor 3	Factor 4
4	0.344		0.389	
6	0.747			
9	0.632		0.487	
12	0.512	0.545		
14	0.656	0.351		
15	0.784			
16	0.638	0.479		
17	0.575	0.335		
18	0.667			
19	0.678	0.467		
24	0.720			
25	0.430	0.434		
1		0.456		0.301
3		0.665	0.379	
5		0.445	0.653	
7		0.314	0.584	
10	0.415		0.371	
11	0.564	0.417		
13		0.366	0.310	
20		0.650		
21		0.601	0.305	
22		0.693		
2			-0.637	0.343
8				0.620
23				0.647
26				0.697

Note: Orthogonal rotation by Varimax method with Kaiser normalization; Items with factorial load > 0.3; four factors; Rotation converged in 11 interactions.

After analyzing the obtained results, we verified that they diverged a little from the original version's dimensions. We made some changes in the composition of the FINC-NA scale considering the theoretical content inherent to each item, the factorial load and an internal consistency evaluation of each factor/dimension. The Portuguese scale then became represented by three, instead of four factors. The items, which in the original scale composed the dimension *Family as a resource in nursing care* saturated all in our factor 2 with the exception of item 1. The items that composed the dimensions *Family as a conversational partner* and *Family as own resource* in the original scale came to constitute the adapted scale factor 1, with the exception of item 4. The items that composed the *Family as a burden* saturated all our items in factor 3, with the exception of item 2, which also joined the four items of this dimension in the original scale. After rebuilding the scale in three dimensions, we verified that Cronbach's alpha kept virtually unaltered and satisfactory values, meaning they contribute to the internal consistency of each factor, thus, three factors were then kept with reframed items.

The original scale can be compared to the adapted one in Table 2 as well as the computation of the accuracy of the various dimensions.

Discriminant validity was obtained through Person's coefficient of correlation (r) among the 26 items that compose the global scale and the different factors obtained by the analysis of principal components. The internal consistency of each of the dimensions as well as of the total scale was computed.

The internal consistency of the total scale is good (Cronbach's alpha of 0.87), very close to the original scale, which confirms the Portuguese version's accuracy. The items are correlated with the results of the dimensions to which they belong and with the total scale with acceptable values. High values are found in the dimensions *Family: conversational partner and coping resource* and *Family: resource in nursing care*. Internal consistency was considered reasonable in the dimension *Family: burden* considering this subscale has a small number of items, similar to the Swedish study⁽⁷⁻⁸⁾.

Table 2 – Analysis of accuracy of the scale’s results (IFCE-AE) and comparison with the original version (FINC-NA) – Porto, Portugal - 2009

Scales	Components	Nº Items	Cronbach’s α
Original	Family as a resource in nursing care	10	0.81
	Family as a conversational partner	8	0.79
	Family as a burden	4	0.69
	Family as own resource	4	0.70
		Cronbach’s α Total	0.88
		Explained Variance	52.74%
Adapted	Family: conversational partner and coping resource (factor 1)	12	0.90
	Family: resource in nursing care (factor 2)	10	0.84
	Family: burden (factor 3)	4	0.49
		Cronbach’s α Total	0.87
		Explained Variance	47.79

Table 3 – IFCE-AE’s dimensions and internal consistency – Porto, Portugal – 2009

Dimensions	Items	Cronbach’s α
Family: conversational partner an coping resource	4. Family members should be invited to actively take part in the patient’s nursing care.	0.90
	6. I ask family members to take part in discussions from the very first contact, when a patient comes into my care.	
	9. Discussion with family members during first care contact saves time in my future work.	
	12. I always found out what family members a patient has.	
	14. I invite family members to have a conversation at the end of the care period.	
	15. I invite family members to actively take part in the patient’s care.	
	16. I ask families how i can support them	
	17. I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves.	
	18. I consider family members as cooperating partners.	
	19. I invite family members to speak about changes in the patient’s condition.	
	24. I invite family members to speak when planning care.	
25. I see myself as a resource for families so they can cope as well as possible with their situation.		
Family: resource in nursing care	1. It is important to find out what family members a patient has.	0.84
	3. A good relationship with family members gives me job satisfaction.	
	5. The presence of family members is important to me as a nurse.	
	7. The presence of family members gives me a felling of security.	
	10. The presence of family members eases my workload.	
	11. Family members should be invited to actively take part in planning patient’s care.	
	13. The presence of family members is important for the family members themselves.	
	20. Getting involved with families gives me a feeling of being useful.	
	21. I gain a lot of worthwhile knowledge from families that I can use in my work.	
22. It is important to spend time with families.		
Family: burden	2. The presence of family members holds me back in my work.	0.49
	8. I do not have time to take care of families.	
	23. The presence of family members makes me feel that they are checking up on me.	
	26. The presence of family members makes me feel stressed	
Total scale Cronbach’s α		0.87

DISCUSSION

The Portuguese version resulted in three factors that explain 47.49% of the total variance, indicating the instru-

ment measures three domains of nurses’ attitudes concerning the importance of the family for nursing care. The

correlational analysis among the three dimensions supports this conclusion because it shows that the correlations among all the dimensions and the global scale are stronger than the correlations only between dimensions. Therefore, new applications are recommended to confirm the obtained results. The evaluation of the scale's accuracy ranged from 0.49 to 0.90 for the three dimensions, indicating good inter-correlation and homogeneity of the items composing it. No answers were not observed. The names of the dimensions adopted in the Portuguese version agree with the names of the original subscales.

We observed that the factorial solutions were not equal to those for the original version (4 dimensions) because even though most items were grouped according to the Swedish version, there were items that saturated into factors other than the initial ones, though they maintained acceptable internal consistency results. We consider the percentage of participants (65.76%) to be strength of this study since it exceeded 50%(10) and also exceeded the number recommended in the literature to proceed with factorial analysis. In relation to the demographic characteristics, as observed in the context of Primary Health Care provided in Portugal, females were predominant and the average age (35.8 years old) was close to the national average, which supports the possibility of generalizing the results.

Most of the nurses participating in this study held supportive attitudes (family: conversational partner and coping resource ($\alpha=0.90$); family: resources in nursing care ($\alpha=0.84$)) and considered it important involving the family in nursing care, which is essential to involve and interact with the family over the care process⁽⁷⁾. The fact they consider the family a support for nursing care, owner of forces and resources that allow it to collaborate in decision-making, contributes to the development of interactions based on a collaborative approach, to view it as partner, and include it as a target and unit of care. The attitudes of nurses that lead them to consider the family as a burden ($\alpha=0.50$) according to the items: *the presence of family members holds me back in my work, I don't have time to take care of families, the presence of family members makes me feel that they are checking up on me, the pres-*

ence of family members makes me feel stressed overlap the beliefs⁽²⁰⁾ mentioned as an obstacle to acknowledging the family as a competent and coherent unit. Despite this general supportive attitude, it was interesting to evaluate the differences among the subgroups in the results obtained in relation to the dimension *Family: conversational partner, a coping resource*. We verified that nurses who attended family nursing training programs and those who work in the FHU obtained a higher average compared to the remaining. Such a result corroborates current policies to reconfigure Primary Health Care as well as investments to academic education and continuing education directed to nursing professionals. No statistically significant differences were observed concerning the relationships among the remaining demographic and professional variables and the dimensions of the Portuguese scale.

CONCLUSION

The IFCE-AE scale that resulted from the cross-cultural adaptation of the Swedish scale FINC-NA met psychometric validity criteria and is a promising instrument to evaluate the attitudes of nurses about the importance of the family in nursing care in the contexts of clinical practice.

The scales' reliability indexes were considered good and very similar between versions and indicate the Portuguese adapted version is appropriate.

The instrument still needs to be adapted and tested in other countries to facilitate international comparisons and verify its relevance, reliability and validity in different contexts.

The results also provided evidence that most nurses hold supportive attitudes toward the family, hence it is expected that this reciprocity implies not only more adjusted nursing care provided to the family but also more satisfactory interactions accruing from this process. The application of the scale in diverse contexts of care will allow the development of strategies to encourage supportive attitudes in nursing care and, consequently, enhance collaborative practices to promote family health.

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