Instructor Guide Chapter 2: Moving to Family Focused Care

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Chapter Objectives

1. Differentiate between individual care and family-focused care.
2. Define key terms involved in family-focused care.
3. Describe differences between family as the context of care and family as the unit of care.
4. Compare and contrast a systems model and an ecological model.
5. Discuss some of the ecological dimensions of family health.
6. Introduce some ways family-focused care influences individual and family health.

Key Concepts

Ecological Model
Family
Family-as-the-context of care
Family-as-the unit of care
Family-centered care
Family focused care
Family health
Family Health Model
Healthy family
Individual care
Patient
Patient-centered care
Systems Model

Introduction

Most will agree that nursing is both an art and a science. This textbook explores ideas pertinent to both the art and science of nursing. The scope of nursing practice must be considered and important concepts needed to build upon must be identified. Clear statements about desired program and student outcomes to achieve must be stated. While undergraduate education lays a
foundation of knowledge, this must be accompanied with adaptable skills and values for lifelong learning. Students need to learn and practice tenets critical to the work they will do (e.g., communication skills, civic professionalism, clinical judgment, ethical comportment) before they become graduate nurses. Nursing has been evolving and changes will continue over time. Many nurses work in acute care settings, trends suggest many will also be employed in ambulatory, clinic, home health, community, and long term care settings during their career. Global trends described in the first textbook chapter also indicate that methods of student education must be adapted to address changing needs.

Some seminal scholarly works linked with family focused care are referred to throughout this chapter. The older literature references cited demonstrate that while ideas have been long recommended, little action or change has occurred. Research evidence from family science and family therapy was a foundation for earlier nurses engaged in thinking family. They established programs of research and have built a body of family nursing scholarship. As you teach concepts from this textbook, notify students that it is generally best to use recent literature as evidence to support ideas. However, when little evidence exists in fields of interest or if gaps of knowledge seem to exist, then reference to seminal work has a place for consideration. Many early ideas about family care came from outside of nursing, but nurses saw their value. In the last three a body of research about family nursing care has evolved. You will see references to both seminal work and the most recent evidence about family nursing threaded throughout the book.

Chapter two of the textbook introduces ideas that are more fully developed and explored throughout the textbook. Ideas about individual and family focused care are introduced and compared. The term patient is replaced with the idea of individual and person throughout the book. Concepts linked with family, individual health, family health, healthy family, patient-
centered care, family-centered care, and family focused care are defined and explained. Terms relevant to thinking family and clarify ideas about directions for considering ways family focused care can be part of nursing practice. The background information provided for this chapter includes some things about theory as the authors believe that a firm theoretical framework is a needed to assist students ways theory guides nursing practice. Throughout the book, references to theory will be identified but the greater focus is on application. Thus, it becomes the teacher role to describe ways theory is linked with practice and research. Remember, things provided in this accompanying instructor guide are supplementary materials for use in preparing for teaching materials. However, the full of the textbook chapters is not discussed.

Family Nursing

How should family nursing be defined? A family health nurse focuses on families and their home settings where health problems are addressed and endeavors to create a healthy family are targeted (World Health Organization, 2000). This textbook offers several definitions and suggests various ways to think about family nursing. We define family nursing as practice that always views the family as the unit of care even when individuals appear alone seeking care and when family members are not present. The family nurse assists family units to manage illness, chronic disabilities, lifestyle, behavioral risks, promote health factors, and other things. Family nurses have knowledge that extends beyond what is usually expected of a competent nurse. This knowledge goes beyond skills and includes a think family attitude. Family nurses are prepared to consider ways things like family functioning, social issues and policies, community agencies, and socioeconomic factors influence family health and illness. Family nurses act intentionally to form collaborative individual-nurse-family partnerships that promote health and manage illness or disease using a coordinated perspective that values the lived family experience. The family
nurse is a generalist, but possesses knowledge about family households, ecological perspectives, and cultural needs. Family nurses are prepared to work with family units in acute, chronic, community, and home settings and manage a variety of health or illness conditions.

**Family Identity**

Family identity is established as individual members find their places or form attachments within the household and then separate or go their different ways. Normative life experiences call for forming close family attachments to nurture, socialize, and support purposes. Identity pertains to the dynamic ways developing members collectively make meaning of relationships, affiliations, and attachments to persons, places, and things. Family household members share present and past memories of joy, grief, struggles, and triumphs. Individuals often retain their family identity throughout youth and into adult life where it might be reconfigured as new family constellations are formed.

Family identity can be closely tied to shared traditions and celebrations. Memories of family household experiences are often retained or almost imprinted on one’s psyche. Recollection of at least some activities, ideals, and behaviors remain throughout lives. Family traditions are things like vacations, weekend getaways, reunions, shared evening meals, and unique events tied to particular families. Traditions can be tied to events or ways celebrations occur. Traditions differ even when families live in the same neighborhood or share similar race, age, and ethnicity. Family celebrations often commemorate meaningful events, such as birthdays, anniversaries, weddings, holidays, and religious days or events. Celebrations often include extended family members and close friends, require commitment, involve planning, and have some time oriented regularity. Ceremonial practices might be part of the event (e.g., baptism, marriage practices, fasts, clinking glasses). Traditions and celebrations are often
behavioral patterns handed down or passed from one generation to the next. Patterned behaviors are often tied to a family’s cultural beliefs, faith or religion, and time ordered practices. Celebrations and traditions can be costly in member resources (e.g., time, finances, planning, commitments) and often have associated member roles and expectations. Traditions and celebrations are recognized as customary practices of families are closely tied with family identification. Many take ethnocentric perspectives to their traditions or celebrations and fail to identify that others might have different practices.

Growing Knowledge about Family Nursing

Ideas about family nursing have been evolving over time. Drs. Catherine Gilliss and Suzanne Feetham, both recognized nationally and internationally for their leadership and family nursing scholarship, were strong family nursing advocates in the early 1980s. They have continued to advocate for viewing family as the unit of care in practice and analysis in research throughout their careers. Here is a list of events in moving family nursing forward:

• In 1988, the First International Family Nursing Conference occurred in Calgary, Alberta, Canada. It recognized the importance of a focus that viewed family as the unit of care. A total of 400 participants from 15 nations participated.
• Interest in family nursing grew, and some nurses began to view themselves as family nurses with section groups formed in the National Council on Family Relations (NCFR) and the Midwest Nursing Research Society (MNRS).
• The Journal of Family Nursing, established in 1995, with Dr. Janice Bell as the editor has provided a place for scholarship linked with family nursing.
• Several nursing textbooks with reprinted editions have been available since the 1980s and many schools of nursing across the nation and world use them in courses.
The 5th International Family Research Conference in Chicago in 2000, family nursing
scholars had made significant headway.

In 2009, at the 9th International Family Nursing Conference was held in Reykjavik,
Iceland, the decision was made to begin what is now known as the International Family
Nursing Association (IFNA).

In 2011, the 10th International Family Nursing Conference occurred in Kyoto, Japan; it
was a celebration of the combined efforts of the fledgling IFNA group and the Japanese
Association for Research in Family Nursing (JARFN) with 1,007 participants from 34
nations in attendance.

In 2011, a two-volume *Encyclopedia of Family Health* was published (Craft-Rosenberg
& Pehler, 2011).

In June 2013, the first family nursing conference sponsored by IFNA occurred in
Minneapolis, Minnesota. The continuance of this work and growing international interest
indicates that family nursing is not merely a western perspective, but a global concern.

Over the last three decades, a growing core group of national and international nursing
scholars have contributed to a growing body of literature about family nursing practice
and evidence from family nursing research studies.

**Models for Understanding Family Nursing**

Teachers that appreciate the value of theory for guiding, describing, and explaining nursing
practice are important student models. Students need to be taught to appreciate what is meant by
the scope of nursing practice and value the ways theory can steer their unique practice approach.

In nursing, a variety of theories and models suggest different ways to characterize nursing
practice, organize nursing actions, and deliver care. Grand nursing theories have been generated
by nurses to arrange ideas about the scope of nursing practice and delivery of care. Some highly respected grand nursing theories include:

- Johnson’s Behavioral System Model
- King’s General System Framework
- Levine’s Conservation Model
- Neuman’s Systems Model
- Orem’s Self-Care Framework
- Roger’s Science of Unitary Human Beings
- Roy’s Adaptation Model
- Watson’s Philosophy of Caring

Many frameworks have had several revisions and been updated to be more inclusive of family and individual perspectives. Familiarity with nursing theories can help students understand different approaches to care. Nurses also use non-nursing theories in clinical practice, things such as developmental theory, communication theories, cultural theories, interaction theories, change theories, systems theory, and behavioral or psycho-social theories all have relevance. Many nursing and non-nursing grand and middle range theories are applicable to nursing practice.

**Family Nursing Theories**

Many theories and explanatory models directly linked with family nursing and practice have emerged over the last several decades. These models not only illustrate ways individuals and family units influence health and illness, but also suggest directions for family nursing practice. For example, family systems nursing is used through the *Calgary Family Assessment Model* and the *Calgary Family Intervention Model* (Wright & Leahey, 2013). The *Trinity Model*
(Wright & Bell, 2009) describes ways nurses can employ practice to address suffering, beliefs, and spirituality to help the members formulate core beliefs about the purpose and meanings of health and illness.

This textbook uses an ecological lens to explore and understand family nursing practice. This type of model is useful for describing the great complexities of many interacting factors and forces that influence individuals’ health and illness. The Family Health Model describe family health and ties it to the family household niche and larger community (Denham, 2003). The focus moves away from acute episodic clinical care to mindful thoughts and approaches tied to the family unit relationships that occur in the daily lived in experience in household, other lived spaces, and the community. An ecological model helps one think about multiple factors relevant to health or illness such as:

- relationships of shared and separate events and contexts
- individual and collective experiences
- interactive behaviors within and outside the family household
- effects of social networks, larger communities, and environmental circumstances
- perceived meanings, beliefs, values, or interpretations tied to health and illness
- multiple personal and family interdependent factors linked with health or illness.

The Family Health Model suggests ways to identify interconnecting events and circumstances. Nurses can use these interrelated ideas as assessments are completed, complete nursing actions or interventions are planned, and outcomes are evaluated. The Family Health Model takes the perspective that family health is a socially constructed phenomena. The three domains of Family Health Model (i.e., context, function, and structure) are introduced and explained in this chapter. Each domain provides a ways to understand factors linked with
individual and family units that influence health and illness. Be sure to spend time reviewing the content on this topic in the textbook as student may not be familiar with ecological perspectives.

If you want additional information, you can go to the *Diabetes: A Family Matter* website [http://www.diabetesfamily.net/family/family-health-model/] and download book chapters for free.

**Middle Range Theories**

Theories viewed as middle-range theories are also used to understand nursing practice. Some of these theories are directly linked with family nursing. For example, concepts linked with family presence, family management, family conflict, caregiving, family routines, and many other topics are areas where middle-range theories useful in the area of family nursing have been developed. Many middle-range theories relevant to family focused nursing care are explored throughout the chapters of the book.

**Patient-Centered Care**

Much discussion is occurring in health care around the topic of patient-centered care. This term suggests that health professionals are responsive to individuals’ needs. Patient-centered care generally implies several of these things:

- honoring the dignity of the individual
- providing care in respectful ways
- sharing information in clear, unbiased, and timely ways
- involving patients in care decisions
- collaborating to evaluate influences on care delivery and outcomes.

A vision for 2020 American health care (Davis, Schoen, & Schoenbaum, 2000) suggests seven attributes of patient-centered primary care:
1. superb access to care (e.g., short waiting times, off hour service available)

2. patient engagement and partners in care (e.g., assistance with self-care, preventive care reminders)

3. clinical information systems that support high-quality care, practice-based learning, and quality improvement (e.g., easy access to lab results, monitor treatment adherence, treatment information)

4. care coordination (e.g., systems to prevent errors, follow-up, support)

5. integrated and comprehensive team care (e.g., free information flow among practitioners, avoid duplication of tests)

6. routine patient feedback to doctors (e.g., patient surveys to learn from patients)

7. publicly available information (e.g., accurate information about physicians)

Questions still remain about the extent to which power and control will truly be shifted into the hands of patients, families, and communities. The quality of care we currently have in United States health care delivery systems is far from the quality we could have (Berwick, 2009). Berwick has suggested that patient-centered care is “the experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care” (p. 560). He says this implies the inclusion of family and loved ones, ideas that some consider to be relatively radical care forms (Box 2.1). This care would reach beyond the status quo. Concerns about time, costs, and available staff are often the biggest barriers.

Box 2.1 Providing Patient-Centered Care with a Family Focus*

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Patient centered care implies individuals have more autonomy, share in decision-making, and have a voice in what, where, when, and how things are done. For this care to become family-centered, then the following changes need to occur:

- Hospitals would have no visitation restrictions, except those chosen by and under the control of individuals.
- Individuals determine the food selected to eat and what clothes they wear in hospitals (to the extent health status allows).
- Individuals and family members participate in rounds and are included in reports.
- Individuals and families participate in the design of health care processes and services.
- Medical records belong to individuals. Clinicians, rather than individuals, would need to gain access to them.
- Shared decision-making technologies would be used universally.
- Operating room schedules would minimize waiting time for individuals rather than the convenience of the clinicians.
- Individuals physically capable of self-care would, in all circumstances, have the option to perform it and have family assist.

* Adapted from Berwick, D.M. (2009)

Chapter two of the textbook describes family-centered care and explores meanings and intentions associated with this term. Use of terms often occurs without clear delineation of
meanings and leads to confusion. In this textbook, we claim the term family focused nursing care for use in our discipline. We propose its use to describe nursing practice characterized by intentional actions and deliberate family unit supports aligned with the wishes and needs of individuals and their family unit. Family focused care mindfully uses relationships to satisfy holistic health and illness care needs; it is a care attitude conveyed through thinking family that purposely guides nursing actions. This care values and respects unique individual and family unit needs. The chapter lays a foundation for understanding key concepts linked with family nursing. Be sure to spend time carefully reading this chapter as it describes terms used throughout the textbook. Engage students in conversation around these various concepts and help them see how attitudes make a difference in the ways approaches to practice are made. Explain the ways an ecological theory can serve to understand family focused care.

**Integrative Care**

*Integrative care* is another term often heard when discussing patient-centered care. Integrative medicine is “patient-centered, healing-oriented, and embraces conventional and complementary therapies” (Maizes, Rakel, & Niemiec, 2009, p. 3). Integrative care is not adding more content, but wisely identifying concepts relevant to nursing (e.g., behavioral health, prevention, chronic conditions, culture, ethics) are using them as curricular threads. Much like quality, safety, and environment are threads of content often considered in pedagogy, family focused nursing practice calls for inclusion of things like relationships, communication, intentional actions, and coordinated teamwork.

Integrated care can also be care that focuses on needs for whole persons, care different from the dominant biomedical model. Integrative care affirms uses of holistic practices, conventional and alternative medicine approaches. For example, high-tech medicine is not
always successful in addressing chronic health problems and other things are needed. Consumers and professionals are realizing that health promotion and prevention are vital to a healthy society. Illnesses are often treated the same, this creates despair as it sometimes seems a hammer is the only tool available. Federal and state agencies now oversee school accreditation, licensure, and certification in complementary medicine practices such as traditional Chinese medicine, Ayurvedic medicine, midwifery, massage therapy, chiropractic, naturopathic, and acupuncture. Many consumers use complementary medicine along with conventional medical practices as holistic approaches to satisfy care needs (Box 2.2). Students need knowledge about alternative forms of care and consider these things when assessing individuals and family units. Much evidence is now available to support various therapies and treatments. Encourage active learning around holistic care and family focused practice when individuals are met in clinical settings.
Box 2.2 Principles of Integrative Medicine*

Ideas about the things involved in integrative medicine include the following principles:

· Individuals and practitioners are partners in the healing process.
· All factors that influence health, wellness, and disease are considered (e.g., body, mind, spirit, community).
· Appropriate uses of conventional and alternative methods are used to assist the body’s innate healing response.
· Natural and less invasive interventions should be used whenever possible.
· All practice should be based upon the best scientific evidence available, open to inquiry or questions, and allow for new practice forms.
· Individuals must decide on what treatments to have based on their personal values, beliefs, and available evidence.
· Treatment alone is not enough; broad ideas of health promotion and prevention must also be included.
· Integrative medicine practitioners should be exemplars of the practices they suggest and be committed to self-exploration through reflection and continued development.

* Adapted from Maizes, Rakel, & Niemiec (2009)

References


