

Mini Review**Family-Centered Care: A Philosophy to be Developed**Antonio Vázquez Sellán, PhD, RN^{1*}; María Carmen Sellán Soto, PhD, RN²; María Luisa Díaz Martínez, BSc-BA, RN²¹San Rafael-Nebrija Health Sciences University Center, Antonio de Nebrija University, Madrid, Spain²School of Medicine, Autonomous University of Madrid, Madrid, Spain***Corresponding author**

Antonio Vázquez Sellán, PhD, RN

Professor, San Rafael-Nebrija Health Sciences University Center, Antonio de Nebrija University, Madrid, Spain; Tel. (+34) 91 564 1868; E-mail: avazquez@nebrija.es**Article information****Received:** March 24th, 2017; **Accepted:** June 23rd, 2017; **Published:** June 23rd, 2017**Cite this article**Vázquez Sellán A, Sellán Soto MC, Díaz Martínez ML. Family-centered care: A philosophy to be developed. *Pediatr Neonatal Nurs Open J.* 2017; 5(1): 1-5. doi: [10.17140/PNNOJ-5-126](https://doi.org/10.17140/PNNOJ-5-126)**ABSTRACT**

This article focuses on the philosophy of care such as family-centered care, which is considered beneficial, but their implementation in pediatric units can be clearly improved for the better. Throughout this work, the main difficulties identified in the literature, as well as the important benefits of its implementation involves both the family (children and parents) and the healthcare system have been discussed.

Keywords

Family-centered care (FCC); Pediatric intensive care units (PICU); Neonatal intensive care units (NICU); Healthcare system.

INTRODUCTION

The aim of this paper is to point out how, despite the fact that family-centered care (FCC) is considered to be beneficial, its implementation is far from optimal.

FCC is a philosophy of care that recognizes that the family is a constant in the lives of children and that professionals only act at specific moments. It is the parents and not the professionals who really know the child and their needs.^{1,2} This situation is especially relevant in the case of children with chronic health issues. We will begin this work with a brief review of the evolution of childcare.

A BRIEF HISTORICAL REVIEW

The United Kingdom (UK) was the first country in which the mother was able to accompany her child during hospitalization. Thus, Sir James Spence, a doctor at the Children's Hospital in Newcastle-upon-Tyne, inaugurated in 1925 the first clinical service to which mothers could accompany their sick children. Two years later in New Zealand, Pickerill and Pickerill let the mother accompany the child to reduce cross-infection. This experience was presented at the end of the 1940s and the results published in 1954. These early attempts at participation were followed by Craig and

McKay, pediatricians at the Royal Aberdeen Hospital for Sick Children in Scotland in 1952. Others would follow suit, culminating with the Platt Report in 1959, drawn up by a multidisciplinary team from the UK. This Report recommended unrestricted visits during child hospitalization; mothers with children under five should have the opportunity to stay in the hospital and that health team training should be improved to include psycho-affective aspects of children and their families.

This gave an important impetus to improving the deplorable conditions of hospitalization in Britain and Europe at that time, introducing innovations in aspects of medical education, planning and architectural design of new hospitals and the creation, in 1961, of Mother Care for Children in Hospital, later known as the National Association for the Welfare of Children in Hospital (NAWCH), which is currently called Action for Sick Children, whose Quality Standard for Care of the Sick Child, established in 1990, is now fully in force in the UK.³

In the case of Spain, the first children's hospital dedicated exclusively to care for poor children was the *Hospital del Niño Jesús*, opened in 1877. The precariousness of that district of Madrid at the end of the 19th century, with a mortality rate of 34%, made this the obvious choice for the location of a hospital for poor children. In this way, children's hospitals were gradually being opened,

although the real expansion of infant care would take place in the 1960s when the *Instituto Nacional de Previsión* expanded throughout Spain.

Thus, in each province a hospital, which included a unit of pediatrics and also neonatology, was opened. Although initially only for adults, *La Paz*, a true hospital complex, was opened in 1964. The following year this hospital added its Children's Hospital and Maternity Hospital, the latter becoming one of the largest maternity hospitals in Europe, with an average of 100 births per day in the 1970s. The Children's Hospital initially had 337 beds and cots, 42 beds for older children and 32 for the mothers of admitted children. Here we find a history of parents' being able to stay with their children. The clear evolution from these first beginnings to the current way of treating and caring for children and their families, suggest that a new philosophy must permeate professional praxis.

So since the second half of the 20th century, child care has undergone a number of significant changes, began to understand that parents were the defenders of their children's rights, and also with the gradual understanding that the child was able to make decisions for herself/himself and that these should be heard.

In this sense, the European Parliament established, on 13 May 1986, the "Rights of the Hospitalized Child", recommendations which were adopted at the United Nations General Assembly on 20 November 1989 (International Convention on the Rights of the Child) and also by United Nations International Children's Emergency Fund (UNICEF).^{4,5}

FAMILY-CENTERED CARE (FCC)

We fully subscribe to the consideration that the family is the basic unit of society. From this starting point, the family's role is set out and constitutes a specification of what we mean by care. Its functions are those of the upbringing and socialization of children, and providing assistance to all members of the family for particular needs such as illness or disability.⁶

The central approach of this care philosophy is to understand that family and child form an indivisible unit in which families play a vital role in ensuring the health and well-being of their children. There are different approaches to FCC that slightly modify some of the principles. These can be summarized as follows:^{2,7,8}

1. Listen and respect each child and family, taking into account social, cultural, ethnic differences, etc.
2. Ensure that, within health organizations, flexible policies, procedures and practices can be adapted to the needs, beliefs and values of each child and family. Favoring the choice of the child and his/her family on approaches to care.
3. Share the information in a complete, honest and impartial way to allow facilitate decision-making by the families.
4. Recognize and harness the strengths of children and families and enable them to discover their own strengths. Collaborate with them at all levels of healthcare.

This movement arose from the recognition that the separation of parents and children during hospitalization generates significant harm in children, so that, among other modifications, shared decision-making, joint hospitalizations, open doors (free 24 hours visits), visits by siblings, pain management, lactation and breastfeeding support were gradually allowed.

All these changes in the healthcare of the sick child and his family have resulted in several benefits (Table 1) as improve patient outcomes, increase family satisfaction and knowledge of health, reduced unmet healthcare needs, reduced cost, or increase staff satisfaction.⁹⁻¹⁶

Most progress has taken place in the pediatric intensive care units (PICU) and, especially, in the neonatal intensive care units (NICU), due to the development-centered care and linked to the newborn individualized developmental care and assessment program (NIDCAP).¹⁷⁻²⁴ Within these units, we have been working to eliminate visiting schedules, promote breastfeeding, implement the Kangaroo Mother Method, promote parent contact with other parents, create parent schools, etc.

For instance, the NICU at *Hospital La Paz* has an open-door policy for parents for more than 10 years, and has been promoting breastfeeding for 15 years, and its parents school was set up about ten years ago. Although, Lopez Maestro et al²⁵ shows that there had been an improvement in Spanish public NICUs since his previous research in 2006, there is still ample room for improvement such as in the implementation of the Kangaroo Mother Method, the availability of rest areas for parents, an open-door policy, or in the use of non-pharmacological methods of pain relief.²⁶ Furthermore, it is necessary to bear in mind that Lopez Maestro's research only studied 27 of the 90 NICUs in Spain.

Table 1. Main Benefits of FCC

For child	Improved patient outcomes
	Stress reduction
For parents	Increased family satisfaction
	Increased families' awareness about the care required
	Build on family and child strengths
For health system	Reduced costs
	Effective use of healthcare resources
	Increased staff satisfaction

Table 2. Main Barriers to FCC

Source	Problems
Nurses	Cultural issues
	Communication problems
	Reduced ability to meet the physical and psychological needs of the patient and family
	Parent-professional collaboration
	Limited time
Healthcare system	Organizational support
	Financial issues
	Continuing education and mentoring programs

Although, the majority of scientific societies, including World Health Organization (WHO), support FCC, the reality is that the implementation of this philosophy of care is far from ideal.^{2,27-29} Thus, there are still significant barriers to the implementation of FCC (Table 2).^{10,30-38}

CONCLUSIONS

The literature show that, in general, nurses are aware of the theoretical elements of FCC, but have problems applying them, probably due to a lack of cultural and communication skills. But these issues must be verified in each concrete situation. No research was obtained that addresses the barriers of the health care system identified by nurses, so it's a field that must be studied and explored.

So to generalize FCC practice, it is important to determine the primary obstacles in each case to address the challenges. Therefore, to implement this care model, nurses should not only understand the model conceptually but should also understand the rights, roles, and responsibilities of parents and the potential benefits of providing FCC to families. For us, its important to note that no negative effect has been found for children's health with the implementation of FCC.

Despite the enormous advances in hospitalized children's care and the undoubted advantages, we still have a long way to go in order to achieve an optimal implementation of FCC, at least in Spain.

CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest.

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