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Family-Centred Care Practice, Implementation and Barriers in Paediatric Hospitals in Delta State

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ABSTRACT

This study examined family-centred care (FCC) practice, implementation and barriers among nurses working in paediatric units of public general hospitals in Delta State, Nigeria. A cross-sectional survey design was adopted to obtain a one-time measurement of prevailing practices and perceived constraints within a dispersed hospital system. The target population comprised 406 nurses across 52 public general hospitals, and Yamane's formula produced a minimum sample of 202, which was increased to 210 to improve representativeness; of 210 questionnaires distributed, 206 valid copies were analysed. Data were collected using a structured researcher-designed instrument, the Family Centred Care Practice and Implementation Barriers Among Nurses Questionnaire, which contained demographic items and 16 Likert-type items measuring practice and barriers. Face and content validity were established through expert review, while pilot reliability testing yielded Cronbach's alpha coefficients of 0.72 and 0.81 for the two variable clusters. Data analysis was conducted with mean, standard deviation, and independent samples t-test at the 0.05 significance level, using Statistical Product and Services Solution (SPSS) version 27. Findings showed that nurses engaged considerably in family involvement practices across educational cohorts, with a statistically significant difference between diploma-prepared and BSc-prepared nurses in the reported practice. The barrier profile indicated that structural and contextual constraints impede the practice of family-centred care, with resource limitations, conflicts between family preferences and clinical protocols, cultural beliefs, time constraints, and difficulties in balancing medical care with family needs identified as major impediments, whereas language barriers and insufficient training were found as unsubstantial obstacles. The study concludes that family-centred care implementation in paediatric settings in Delta State is ongoing but uneven, and that organisational conditions exert a major influence on the practical depth of family involvement.

Keywords: Family-centred care, paediatric nursing, implementation barriers, nurses, general hospitals, Delta State.

INTRODUCTION

Family-centred care (FCC) has solidified its position as the prevailing paradigm in paediatric nursing globally, marking a profound transition from traditional, clinician-dominated models to those that prioritise the child and family as central actors in the healthcare process. As articulated by the Institute for Patient- and Family-Centred Care (2012), FCC constitutes a synergistic alliance among healthcare providers, patients, and families, one that fosters mutual advantages through joint planning, delivery, and assessment of care services; this characterisation is pivotal, for it elevates the family from a mere observer to an essential collaborator whose insights, principles, and caregiving expertise underpin the provision of secure, efficacious, and empathetic care. Jung and Tak (2017) expanded upon this by positing families as

authoritative figures on their children's needs, thus rooting FCC in the ethical axiom that familial understanding of the child surpasses what any professional can independently acquire. This framework has garnered heightened interest in both affluent and resource-constrained nations, propelled by robust empirical support indicating that familial engagement enhances patient safety, contentment, and clinical results (Lim & Bang, 2023). Consequently, the adoption of FCC implies a reconfiguration of nursing roles, wherein practitioners must integrate family dynamics into therapeutic strategies, thereby yielding implications for training, policy, and resource allocation that extend beyond individual encounters to systemic healthcare improvements.

The foundational structure of FCC encompasses four interrelated pillars, namely, participation, collaboration, information sharing, and dignity and respect. Each of these components entails a distinct ramification for nursing conduct and institutional practices in pediatric care setting. Participation entails the proactive facilitation of family involvement in decision-making and hands on care for the admitted child, which requires nurses to provide targeted support that helps families to navigate care options while remaining attentive to caregivers' affective and cognitive needs (Johnson et al., 2008). This domain, when effectively enacted, can transform passive recipients into empowered agents, though its success hinges on nurses' sensitivity to familial stressors. Collaboration advances this by establishing parity among families, clinicians, and administrators in shaping programmes, policies, and evaluations, compelling nurses to view family members as integral co-designers of care protocols rather than ancillary figures (Lim & Bang, 2023). Information sharing demands the prompt, impartial, and sufficient dissemination of data to enable informed family contributions, whereas dignity and respect mandate the validation of family viewpoints, cultural heritages, and experiential knowledge within care frameworks (Mikkelsen & Frederiksen, 2011). Collectively, these elements forge a robust ethical and operational scaffold that, upon full implementation, demonstrably elevates nursing standards, boosts satisfaction levels, and optimises outcomes for children and their kin (Seniwati et al., 2023). The implication is that FCC's efficacy resides not in isolated adherence but in the synergistic interplay of these domains, which challenges nurses to cultivate relational competencies alongside clinical acumen.

Notwithstanding the conceptual lucidity of FCC, a recurrent disparity still persists between nurses' espoused beliefs in its principles and their tangible enactment in practice, a phenomenon substantiated across varied international and clinical circles. Lim and Bang (2023) observed that perception ratings averaged 4.07 on a five-point scale, surpassing performance metrics at 3.77, while collaboration emerged as the weakest area in both. This pattern is an indication of entrenched systemic constraints rather than personal shortcomings. Thungjaroenkul et al. (2025) corroborated this through the result of a comparative analysis of Thai nurses working in general paediatric wards and paediatric intensive care units. Their study findings showed a generally high level of FCC implementation across both groups; however, nurses in intensive care demonstrated a stronger relational competence, whereas participatory components showed no significant between-group difference. Such evidence underscores that FCC's translation into routine practice is modulated by environmental factors, workforce structures, and organisational backing, implying thus that bridging the perception-practice chasm demands multifaceted reforms that transcend mere attitudinal shifts or solitary educational efforts to encompass institutional overhauls that fortify supportive family-centred care infrastructures.

Obstacles to FCC's comprehensive adoption in paediatric environments are systematically grouped into organisational, nursing staff, familial, and patient-centric categories, with their aggregate influence dictating the extent of principle integration into everyday care. Jafari et al. (2024), via qualitative exploration in a Tehran neonatal intensive care unit, delineated parental hurdles under themes of role limitations, encompassing emotional unease, apprehension about infant harm, and participation hesitancy, and involvement constraints, such as communication deficits with providers and procedural disruptions. Thungjaroenkul et al. (2025) highlighted organizational and personnel factors as predominant impediments for paediatric ward nurses, pinpointing workload-induced exhaustion and familial interaction deficiencies as key staff-level issues. Aljawad et al. (2025) observed that staff shortages, visitation restrictions, suboptimal facilities, and absent institutional frameworks across cultures constituted implantation obstacles. This multi-tiered barrier profile requires prioritization of

organisational strategies over individualistic fixes, implying thus that sustainable FCC advancement requires policy-driven resource enhancements to mitigate these interlinked challenges effectively.

An evolving facet of FCC scholarship concerns the linkage between nurses' academic credentials and their proficiency in embodying its tenets, especially in settings where diploma holders dominate the workforce. Phiri et al. (2022), in a Malawian cross-sectional survey, ascertained that baccalaureate-educated nurses exhibited markedly superior FCC practices compared to diploma counterparts, ascribing this to curricular emphases on family-oriented philosophies in advanced programmes. This association stems from FCC's demand for advanced communicative, collaborative, and strength-recognition skills – essential attributes honed through reflective, and theoretically rich education usually available at higher degree paths (Coyne et al., 2018). In Nigeria, where diploma routes like the Registered Nurse Midwife or Basic Nursing programmes prevail, exposure to FCC may prove sporadic or superficial (Okunola et al., 2017). Okunola et al. (2017) in South West Nigeria reported that both parents and nurses acknowledged knowledge gaps and contextual barriers that constrained FCC, adding that nurses tended to prioritise biomedical tasks over partnership with families, a tendency that reflected training approaches that gave limited emphasis to relational competence. Consequently, the evidence establishes the need for curricular revision that integrates FCC more explicitly, as this will garner support for the development of practitioners who can sustain technical care demands while also meeting family participation expectations.

Delta State, situated in Nigeria's South-South region, affords a compelling locus for scrutinising FCC in paediatric nursing, as its oil-derived prosperity coexists with entrenched public health deficiencies that amplify barrier persistence. Paediatric facilities here grapple with enduring nurse shortages, infrastructural inadequacies, and scant policy endorsement for FCC, as evidenced by regional data revealing suboptimal family integration in child hospitalisation (Iweriebor et al., 2025). Without codified FCC guidelines in most state-run children's hospitals, nurses will continue to improvise family engagement based on personal education, inclinations, and capacity thresholds, thereby engendering practice inconsistencies wherein diploma and BSc nurses may diverge in partnership systematisation (Bello et al., 2023). Bello et al. (2023) further noted that the Nigerian families' sense of exclusion as a result of perceived inadequate consultations and involvement in care decision-making, - a sentiment that is resonant with critiques that domestic paediatric nursing clings to provider-centric modes amid worldwide FCC momentum. In this light, the need for a localised inquiry into how nurses involve caregivers in the provision of care to the child is essential, because such evidence can inform targeted interventions that harmonise global standards with regional realities.

The preceding exposition illuminates a critical lacuna in the evidence base, because existing research has established worldwide perception–practice incongruities, delineated recurrent barrier categories, and clarified the moderating role of education. No study has yet examined differences in family-centred care practice and the specific implementation hurdles experienced by diploma and BSc nurses within children's hospitals in Delta State. Butler et al. (2025) emphasised that contextual determinants, including institutional capacity, sociocultural expectations, and pedagogical conditions, remained underexplored in low-resource settings, which constrained the effective adaptation of strategies derived from more affluent contexts. This inquiry fills an important evidence gap by providing a comparison of how family-centred care is practised and what obstacles nurses face across different education levels in Delta State. This focus has become important, because some nurses appear not to be adequately prepared to translate family-centred care principles into daily practice, and challenges such as limited communication skills, uneven compassion and patience under pressure, and weak practical competence can reduce meaningful family participation and weaken care quality. This implies that if these gaps persist across nurse education strata, hospitals will continue to struggle with effective family involvement, and child health goals will be harder to achieve. Consequently, the study generates evidence that can strengthen nurse training, guide hospital policy improvement, and protect families' right to participate in their child's care, while also supporting paediatric nursing that better meets children's developmental needs and uses families' caregiving strengths.

1.2 Objectives of the Study

The objectives guided the study.

1. determine the extent diploma and BSc prepared nurses practice family-involvement in providing family-centred care in children hospitals in Delta State.
2. identify the barriers to practice of family-centred care by diploma and BSc prepared nurses in children's hospitals in Delta State.

1.3 Research Questions

The following research questions guided the study.

1. To what extent do diploma and BSc prepared nurses practice family-involvement in providing family-centred care in children hospitals in Delta State?
2. What are the barriers to practice of family-centred care by diploma and BSc prepared nurses in children's hospitals in Delta State?

1.4. Hypotheses

The following hypotheses were tested at 0.05 significance level in the study

- H₀₃:** There is no significant difference between the opinion of diploma and BSc prepared nurses on the extent they practice family-involvement in providing family-centred care in children hospitals in Delta State.
- H₀₆:** There is no significant difference between the opinion of diploma and BSc prepared nurses on the barriers to practice of family-centred care by nurses in children's hospitals in Delta State.

2.0 METHODOLOGY

A cross-sectional survey design was adopted to examine family centred care practice, implementation and barriers among nurses working in paediatric units of public general hospitals in Delta State, Nigeria. The design enabled a onetime measurement of prevailing perceptions and routine practices, which suited a dispersed hospital system and reduced the logistical demands associated with repeated follow up. The study was carried out in general hospitals across the state, facilities that provide primary and secondary services with limited tertiary capacity, and function as key referral points for surrounding communities. The target population comprised 406 nurses practising in paediatric units within the 52 public general hospitals in the state. Eligibility was limited to nurses posted to paediatric units, present during data collection, and willing to participate. Nurses working in private facilities, those outside paediatric units, and those on any form of leave were excluded. Sample size determination followed Yamane's 1967 formula at a five percent margin of error, producing a minimum sample of 202, which was increased to 210 to improve representativeness. A bi stage sampling technique was used. Hospitals were first stratified by the three senatorial districts, after which ten general hospitals were selected from each district. Within each selected hospital, seven nurses were randomly drawn from the paediatric unit to achieve the planned sample.

Data were collected using a structured researcher designed questionnaire titled Family Centred Care Practice and Implementation Barriers Among Nurses Questionnaire (FCCPIBANQ). Section A captured demographic characteristics, while Section B comprised 16 items measuring the study variables through a four-point Likert format. Response anchors covered Strongly Agreed to Strongly Disagreed for the first research question and Very High Extent to Very Low Extent for the second. Content and face validity of the questionnaire were established through expert review. Reliability was confirmed through a pilot test with 30 paediatric nurses in Port Harcourt, Rivers State, and this yielded Cronbach's alpha coefficients of 0.72 and 0.81 for the two variable clusters, which indicated satisfactory internal consistency. Data collection followed institutional permission in each selected hospital, after which questionnaires were administered to eligible respondents. Completed copies were returned immediately on site where feasible, or deposited with designated unit desk officers for later retrieval. Of 210 questionnaires distributed, 208 were retrieved, and 206 valid copies were used for analysis. Data analysis used Statistical Product and Services Solution (SPSS) version 27. Mean and standard deviation were used to answer the research questions, while t-tests was used to examine the hypotheses at 0.05 level of significance. Ethical approval

was obtained from the University of Port Harcourt Ethics Committee, and confidentiality and voluntary participation were maintained through anonymisation and secure handling of data.

3.0 RESULTS AND DISCUSSION

Table 1: Socio-Demographic data of respondents (n=206)

Variables	Options	Frequency (n = 206)	Percentage (%)
Gender	Male	54	26.21
	Female	152	73.79
Years of Experience	Less Experienced (1-5 Years)	117	56.8
	Experienced (5-above Years)	89	43.20
Educational Level	Diploma-prepared Nurses	86	41.75
	BSc-prepared Nurses	120	58.25

Table 1 presents the socio-demographic characteristics of the 206 respondents who participated in the study. The sample comprised predominantly female nurses (n = 152, 73.79%), with male nurses constituting approximately one-quarter of the respondents (n = 54, 26.21%). In terms of professional experience, the majority were classified as less experienced, having practiced for one to five years (n = 117, 56.8%), whilst the remaining 43.20% (n = 89) had accumulated more than five years of nursing practice. Regarding educational qualifications, more than half of the participants held Bachelor of Science degrees in nursing (n = 120, 58.25%), whereas 41.75% (n = 86) possessed diploma-level nursing credentials, reflecting the dual-track training pathway that characterises nursing education in Nigeria.

Table 2: Mean and Standard Deviation of responses on the extent diploma and BSc prepared nurses practice family-involvement in providing family-centred care in children hospitals.

S/N	Questionnaire items	Diploma-prepared Nurses		BSc-prepared Nurses		Average Mean	Remarks
		\bar{x}	SD	\bar{x}	SD		
1.	I actively involve family members in taking care decisions of paediatric patients.	2.61	0.65	3.30	0.67	2.96	High Extent
2.	I encourage family participation in developing care plans for children in our hospital.	2.70	0.85	2.90	0.66	2.80	High Extent
3.	I collaborate closely with families to ensure that their input is valued in the care process.	2.75	0.74	3.05	0.68	2.90	High Extent
4.	I communicate regularly with families to keep them informed and involved in their child's treatment.	2.72	0.78	3.20	0.64	2.96	High Extent
5.	I support families with information for understanding medical procedures and treatments for their children.	2.90	0.80	3.10	0.76	3.00	High Extent
6.	I seek for feedback from families to improve our approach to family-centred care.	2.85	0.63	2.99	0.56	2.92	High Extent
7.	I value active involvement of families in their child's daily care activities.	2.72	0.62	2.95	0.59	2.84	High Extent
8.	I consider family preferences and values when developing care plans for paediatric patients.	2.65	0.82	2.67	0.55	2.66	High Extent
	Aggregate mean	2.74	0.74	3.02	0.64	2.89	High extent

Table 2 reveals the extent to which diploma-prepared and BSc-prepared nurses engage families in paediatric care delivery. Both groups demonstrated considerable caregiver involvement across all eight practice dimensions, though BSc-prepared nurses consistently reported higher engagement levels, achieving an aggregate mean of 3.02 compared to 2.74 for their diploma-prepared counterparts, with an overall mean of 2.89. BSc-prepared nurses particularly excelled in actively involving families in care decisions (M = 3.30) and maintaining regular communication regarding treatment progress (M = 3.20), whilst diploma-prepared nurses recorded their strongest performance in providing informational support to help families understand medical procedures (M = 2.90). These scores collectively indicate that family-centred care principles permeate clinical practice substantially across both educational backgrounds within the studied hospitals.

Table 3: Independent Samples Test analysis on the opinion of diploma-prepared nurses and BSc-prepared nurses on the extent they practice family-involvement in providing family-centred care in children hospitals .

Group	n	Mean	SD	t-value	df	p-value	Cohen's d
Diploma-prepared nurses	86	2.7	.74	3.45	204	0.001	0.47
BSc-prepared nurses	120	3.02	.64				

The results presented in Table 3 revealed that the mean score of BSc-prepared nurses (M = 3.02, SD = 0.64) is higher than that of diploma-prepared nurses (M = 2.70, SD = 0.74), suggesting that nurses with a higher academic qualification tend to have a more favourable perception of family involvement in family-centred care. This difference is confirmed by the t-value (3.45, df = 204) and the p-value (0.001), which is below the significance level of 0.05, indicating that the observed variation in perceptions is statistically significant. The effect size, as measured by Cohen's d (0.47), suggests a moderate difference, implying that educational qualification plays a meaningful role in shaping nurses' perspectives on family involvement in care.

Table 4: Mean and Standard Deviation of responses on the barriers to practice of family-centred care by diploma and BSc prepared nurses in children's hospitals.

S/N	Questionnaire items	Diploma-prepared Nurses		BSc-prepared Nurses		Average	Remarks
		\bar{x}	SD	\bar{x}	SD		
1	I face challenges in communicating effectively with families due to language barriers.	2.04	0.89	2.12	0.91	2.08	Disagreed
2.	Time constraints often hinder my ability to provide comprehensive family-centred care.	3.01	0.79	2.92	0.60	2.96	Agreed
3.	Insufficient training on family-centred care practices impacts my ability to implement them effectively.	1.92	0.81	1.99	0.96	1.96	Disagreed
4.	Limited resources/support systems make it challenging to meet the needs of both patients and their families.	3.24	0.85	3.32	0.89	3.28	Agreed
5.	I find maintaining a balance between providing medical care and addressing family needs quite difficult.	2.71	0.65	3.04	0.58	2.88	Agreed
6.	Patient and family preferences sometimes conflict with medical protocols, leading to tensions in care delivery.	3.19	0.92	3.41	0.86	3.30	Agreed
7	Cultural beliefs often shape family roles and decisions, sometimes making family-centred care harder to implement.	3.05	0.87	3.13	0.82	3.09	Agreed
8	Administrative and organizational policies are	2.15	0.88	2.18	0.88	2.16	Disagreed

prioritise biomedical tasks over partnership with families, reflecting training approaches that give limited emphasis to relational competence. The overall high-extent implementation across both groups presents a departure from the recurrent perception-practice disparity documented internationally, wherein Lim and Bang (2023) observed that perception ratings surpassed performance metrics. Thungjaroenkul et al. (2025) corroborated that FCC implementation levels vary according to environmental factors and organisational backing, implying that the Delta State context may possess certain facilitative conditions despite the absence of codified FCC guidelines in most state-run children's hospitals (Bello et al., 2023). The barrier profile delineated in Tables 4 and 5 illuminates the structural and contextual constraints that impede comprehensive FCC adoption, with both educational cohorts identifying substantive obstacles that transcend individual competency deficits to implicate systemic deficiencies in resource allocation and organisational culture. The statistically significant difference between groups ($p = 0.002$), despite its small effect size, suggests that educational preparation influences nurses' perceptual sensitivity to implementation challenges. This finding resonates with Butler et al.'s (2025) emphasis that contextual determinants, including institutional capacity and sociocultural expectations, remain underexplored in low-resource settings, which constrains the effective adaptation of strategies derived from more affluent contexts.

The identification of resource limitations as the most pressing challenge aligns with Aljawad et al.'s (2025) observation that staff shortages, suboptimal facilities, and absent institutional frameworks constitute implementation obstacles demanding prioritisation of organisational strategies over individualistic fixes. The prominence of conflicts between family preferences and medical protocols, alongside cultural beliefs shaping family roles, reflects complex negotiation processes that characterise FCC implementation where biomedical paradigms intersect with indigenous health beliefs. Jafari et al. (2024) delineated parental hurdles under themes of role limitations and involvement constraints, highlighting that barriers emanate from both institutional deficiencies and the affective dimensions of family engagement. The acknowledgement of time constraints corroborates Thungjaroenkul et al.'s (2025) identification of workload-induced exhaustion as a key staff-level issue, whilst the rejection of insufficient training as a substantial obstacle presents a paradox. Nurses' dismissal of training inadequacy, despite documented educational differentials in FCC proficiency, may reflect unrecognised incompetence or a professional culture that stigmatises admission of educational needs. The similarly low endorsement of organisational policy misalignment contradicts the documented absence of codified FCC guidelines (Bello et al., 2023), implying that nurses have normalised the policy vacuum or attribute implementation challenges to proximal factors such as resource scarcity rather than distal structural determinants like regulatory frameworks.

5.0 CONCLUSION

This study has provided evidence that educational qualification significantly influences family involvement practices and barrier perceptions among paediatric nurses in Delta State children's hospitals. Based on this, the study concludes that BSc-prepared nurses demonstrate superior family-centred care implementation compared to diploma-prepared counterparts, whilst structural constraints—resource limitations, protocol conflicts, and cultural complexities—rather than training inadequacies constitute the primary impediments to comprehensive FCC adoption. These findings underscore that sustainable advancement requires coordinated policy reforms and institutional capacity enhancements alongside educational interventions.

6.0 RECOMMENDATIONS

In line with the findings, the following recommendations were made:

1. The Delta State Ministry of Health should mandate all children's hospitals to develop and implement codified family-centred care guidelines that explicitly delineate nurses' roles in family involvement, thereby standardising practice expectations across educational backgrounds and institutional settings.

2. Hospital administrators should prioritise resource allocation to address identified structural barriers, particularly staff shortages and support systems deficiencies, by advocating for increased nursing workforce capacity and establishing dedicated family liaison positions to facilitate comprehensive family-centred care delivery.
3. Nursing education institutions should revise diploma-level curricula to incorporate explicit instruction on family-centred care principles, emphasising collaborative and participatory dimensions alongside technical competencies, thereby equipping graduates with relational skills necessary for effective family partnership.
4. Hospital management should institute workload redistribution strategies that allocate protected time for nurses to engage meaningfully with families, ensuring that time constraints do not compromise the quality of family involvement in care decisions and daily activities.
5. Professional development coordinators should design and implement ongoing in-service training programmes focused on navigating cultural beliefs and protocol-preference conflicts, enabling nurses to reconcile diverse value systems whilst maintaining clinical safety standards within family-centred frameworks.

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