WWW.IJRPR.COM

International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

Perception and Practice of Family-Centred Care Among Nurses in Paediatric Hospitals: A Systematic Review of Global Evidence

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ABSTRACT

Background: Family-Centred Care (FCC) is a crucial method in paediatric healthcare that focuses on involving families in the care of children. Despite its importance, there is limited understanding of how nurses perceive and implement FCC in practice.

Purpose: This study aimed to examine the perceptions and practice of family-centred care among nurses in paediatric hospitals worldwide.

Methods: This study adopted systematic review technique by following PRISMA guidelines, the review analysed studies published from 2013 to 2024. Articles reviewed were sourced from six databases: PubMed, Scopus, ProQuest, Google Scholar, SAGE Journals, and EBSCOhost. After screening 4074 articles, 15 studies from 13 countries were selected for analysis, covering various research methods, including cross-sectional, qualitative, and mixed-methods studies. The data were thoroughly evaluated by critically reviewing the quality of the articles using the JBI and CASP checklists. The information extracted from the articles was then analysed using a narrative synthesis approach.

Results: The findings of the study reveal a gap between nurses' positive perceptions of FCC and their actual practices. Key barriers hindering the implementation of FCC include staffing shortages, heavy workloads, and restrictive hospital policies. Cultural differences further complicate the practice of FCC, as traditional healthcare structures in some regions limit family involvement in childcare. Educational interventions were shown to improve nurses' attitudes and behaviours toward FCC, but challenges like compassion fatigue and resource limitations still persist.

Conclusion: This review highlights the need for various healthcare systems to address these barriers. This can be achieved by improving nurses training, increasing staff support, and implementing policies that strongly encourage family participation in childcare. By closing the gap between nurse's perception and practice, FCC can better enhance patient care and family satisfaction in paediatric settings.

Keywords: Perception, Practice, Family-Centred -Care, Nurses, Paediatric Hospitals, Systematic Review.

1. Introduction

Family-Centred Care (FCC) is a progressive approach to health care that has gained widespread attention, particularly in paediatric settings. Its roots date back to the early 1980s when the progressive shift from conventional healthcare traditions started moving towards more inclusive care models that emphasised family involvement (Shelton et al., 2019). FCC aims to create partnerships between families and healthcare providers. It recognises the family as a crucial component of a child's care. The philosophy behind FCC holds that the well-being of a child is closely linked to the well-being, and more importantly, the involvement of the family members of the patient (Kuo et al., 2012). This philosophy is now widely recognized and encouraged by healthcare authorities (World Health Organization [WHO), 2015), particularly in paediatric hospitals, where healthcare provision often involves complex emotional and medical needs (Schmollgruber, 2024; Smith et al., 2015; Zimmerman et al., 2000). The principles of FCC are simple: respect for the family's role, sharing information freely, encouraging family participation in care decisions, and fostering collaboration between healthcare providers and families (Institute for Patient- and Family-Centered Care [IPFCC], 2010). These principles are theoretically sound but can be difficult to implement in practice, particularly in settings with limited resources or insufficiently trained staff (Malepe et al., 2022; Hodgson et al., 2024).

Nurses play a pivotal role in the successful implementation of FCC, especially in paediatric hospitals where they are expected to interact with families on a daily basis (Coyne et al., 2011). Nurses serve as primary caregivers, educators, and advocates for both the child and the family. Their perceptions and beliefs about FCC can have a significantly effect on how well the principles of FCC are implemented. Perception is the process by which individuals interpret sensory information, and this is shaped by personal experiences and cultural factors that influence their decision-making and behaviour (Schacter et al., 2011). Nurses' perceptions of their role in family-centred care (FCC) are crucial to effective practice (Lim & Bang, 2023; Mariyam et al., 2022; Kuo et al., 2012). Nurses with a positive outlook on FCC are more inclined to actively engage families in care. Conversely, those who perceive FCC as

an additional workload may implement it less consistently (Kuo et al., 2012). Lack of institutional support and policies, combined with high nurse-to-patient ratios, significantly hinders the implementation of family-centred care (FCC), particularly in resource-limited settings (Vasli, 2021; Shields et al., 2015). However, these barriers are also evident in well-resourced settings, where systemic and organisational challenges persist (Wojnar et al., 2023; Coyne et al., 2013). A study by Shields et al. (2012) highlighted the critical role of nurses' buy-in for the effective implementation of FCC interventions. The authors noted that nurses who recognised the value and benefits of family involvement were more likely to engage families in care. This suggests that fostering a positive perception of FCC among nursing staff through education and awareness initiatives could enhance their commitment to family-centred practices, ultimately improving patient and family outcomes.

Numerous studies have shown that FCC can lead to shorter hospital stays, improved patient outcomes, and higher parental satisfaction (Prasopkittikun et al., 2020; Coyne et al., 2013). In fact, a recent systematic review found that 75% of studies reported significant reductions in hospital stays when FCC models were applied. Furthermore, 100% of studies in the same review indicated increased levels of parental satisfaction with their involvement in care-decision-making. Despite this evidence, many hospitals, especially in low-resource settings, are unable to implement FCC fully (Seniwati et al., 2023). Training and education are vital to ensuring that nurses are equipped to engage and collaborate with families effectively. However, the availability of FCC-focused training varies significantly across healthcare systems. In some high-income countries, FCC is integrated as a formal and essential component of nursing education. Conversely, in many low- and middle-income countries, the emphasis on FCC training is often limited or entirely absent, reflecting disparities in healthcare priorities and resources (Rostami et al., 2019; Kuo et al., 2012).Furthermore, even in settings where FCC-focused training is available, the emphasis often leans more towards theoretical knowledge than practical application. This imbalance can leave many nurses uncertain about how to incorporate FCC principles into their daily practice (Smith et al., 2015).Observations indicate that while some nurses naturally gravitate towards FCC, others face significant challenges in its implementation. This disparity often stems from variations in personal experiences, professional competencies, and the pressure of competing demands. A case study by Coyne et al. (2013) revealed that nurses working in highly stressful environments with heavy patient loads frequently struggled to fully engage with families, as the demands of patient care often left little time or energy for meaningful family involvement.This was not merely due to a lack of appreciation for what FCC stands for but rather because they lacked the time and resources required to implement it effectively (Coyne et al., 2013; Trajkovski et al., 2012).

The implementation of FCC varies significantly between high-and low-income countries. In wealthier nations, FCC is more common, though disparities still exist within different institutions (Shields, 2015). In contrast, the low- and middle-income countries face greater challenges due to limited resources and cultural barriers. For instance, in most collectivist societies in Asia and Africa, decision-making is exclusive prerogative of senior family members or healthcare providers, which in some cases, can complicate the challenges to adoption of FCC principles (Coyne et al., 2013; Shields et al., 2012). The rationale for this study therefore, is grounded on the pressing need to explore the perceptions and practices of Paediatric nurses on FCC. By virtue of their regular close interactions with both children and families, and as key agents in the implementation of FCC intervention. Much of the existing research on FCC focused on broader institutional practices or family experiences, leaving the critical role of nurses somewhat underexplored (Kuo et al., 2012). Even a systematic review by Seniwati et al. (2023), which examined the effects of FCC on the quality of care in paediatric settings, largely overlooked nurses' perceptions and the practical implementation of FCC in everyday practice.A review that synthesises existing studies on nurses' perceptions and practices of FCC can provide valuable insights into its implementation and the barriers that hinder its effectiveness, thus justifying the need for this study

2. Research Methods

2.1 Research design

This researcher adopted systematic review to carry out the study. The research question used were determined using population, intervention, comparison, outcome and time (PICOT) framework to structure the result question. The PICOT framework is a commonly employed tool for formulating research questions in systematic reviews (Moher et al., 2009). In this study, the research question was "What are the global perceptions and practices of family-centred care among nurses in paediatric hospitals?"

Table 1. Description of PICOT

Population	Nurses working in paediatric hospital globally.
Intervention	Implementation of family centred care, which involves incorporating or involving the family of the patient in the child's care. Interventions also include the components of family centred care (collaboration, information sharing, involvement, and respect for patients while providing care).
Comparison	Comparative perceptions and practices of family centred care in paediatric hospitals across the different regions (for hospitals with formal FCC programmes).
Outcome	Nurses attitudes, beliefs, and understanding of the concept of FCC, and their practices resulting from the implementation of FCC.
Time	Articles published in the last 11 years (2013-2024)

2.2 Search methods

The literature search was carried out across six databases, specifically, they are PubMed, Scopus, ProQuest, Google Scholar, SAGE Journal and EBSCOhost, focusing on articles published between 2013 and 2023.In developing the search strategy, Boolean operators were employed to combine keywords effectively to ensure comprehensive coverage of the literature related to the topic. The key concepts identified in the research question were combined using the operators "AND," "OR," and "NOT." The search string used to capture studies that addressed the perceptions and practices of family-centred care among nurses working in paediatric hospitals include "family-centered care" AND (nurses OR "nursing staff") AND (perception OR practice) AND ("paediatric hospital" OR "children's hospital").

2.3 Inclusion and exclusion criteria

The inclusion criteria encompassed (1) studies published between 2013 and 2024, (2) published articles written in English Language, (3) researches focusing on nurses in paediatric hospitals, (4) studies from any country, and (5) relevant qualitative and quantitative studies. Conversely, the exclusion criteria eliminated (1) studies published outside the 2013-2024 timeframe, (2) non-English publications, (3) research focused on healthcare professionals other than nurses, (4) studies carried out in non-paediatric settings, (5) editorials, opinion pieces, conference proceedings, thesis, and studies, and articles that were not accessible/downloadable.

2.4 Screening of articles

The screening process for the articles began with a thorough search across the cited databases. Initially, all identified articles were subjected to a title and abstract screening. Articles that did not meet the inclusion criteria were excluded. The full-text access and screening phase was undertaken. Articles that did not offer sufficient detail, relevance, or focused on different healthcare settings were further excluded. Articles were also evaluated based on their methodological rigor, including the design, sample size, data collection methods, and analysis. Studies with significant methodological limitations were also excluded. After completing the screening process, a final set of 15 articles were selected for inclusion in the study in line with Gough et al. (2017).

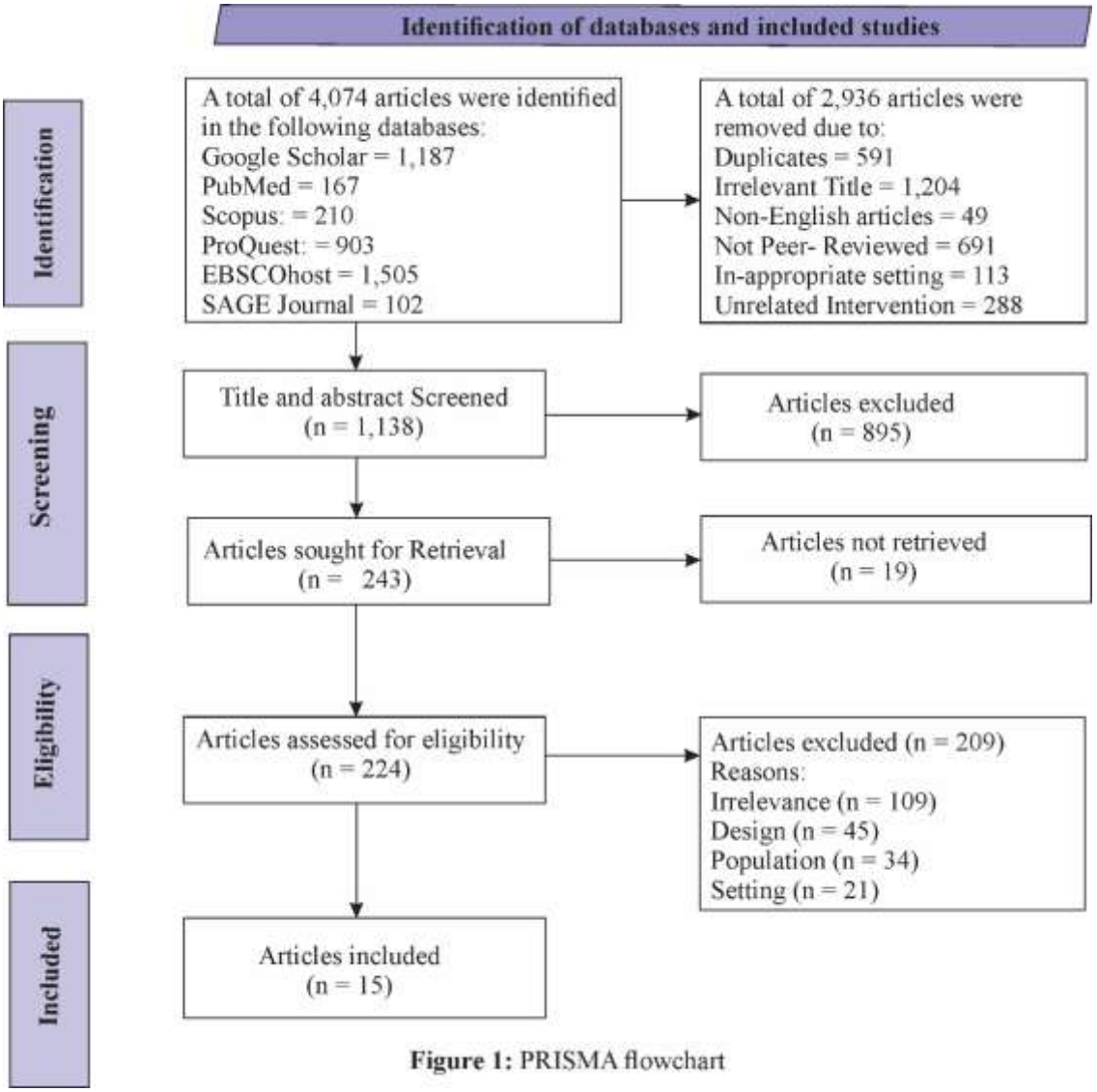

Figure 1: PRISMA flowchart

Figure 1 displays the processes in this systematic review, in line with PRISMA flowchart. It began with the identification of 4,074 articles from six databases, including Google Scholar (1,187), PubMed (167), Scopus (210), ProQuest (903), EBSCOhost (1,505), and SAGE Journal (102). After removing 2,936 articles due to duplicates (591), irrelevant titles (1,204), non-English language (49), non-peer-reviewed sources (691), inappropriate settings (113), and unrelated interventions (288), a total of 1,138 articles were screened based on the content of their titles and abstracts. Of these, 895 were excluded, and 243 articles were identified for full-text retrieval. However, 19 articles could not be accessed. Consequently, 224 full-text articles were assessed for eligibility, with 209 excluded for the following reasons: irrelevance (109), inappropriate study design (45), wrong population (34), and inappropriate setting (21).Finally, 15 studies met the inclusion criteria and were included in the review. This rigorous selection process ensured that only articles that were directly relevant to the topic of family-centred care in paediatric nursing were considered.

2.5 Data extraction

Data extraction was conducted using a structured grid format that consistently captured key details from the 15 included studies. This format documented information such as the authors, publication year, country of research, study design, setting, and sample size. Also, the researcher focused on extracting findings related to the practice and perception of FCC by nurses in paediatric settings. Specific FCC components like family involvement, collaboration with parents, emotional and financial support, and healthcare system design were highlighted. By independently extracting data from each study, the researcher ensured a systematic summary of FCC practices, thereby ensuring easier and quick comparison across the included studies (See table 3).

2.6 Quality assessment, risk and bias

Fifteen articles were assessed using three risk assessment tools. The JBI Critical Appraisal Checklist for Randomized Controlled Trials (RCT) was used to assess Rostami (2019) (See appendix 1). The assessment yielded 73%, which indicated a low risk of bias, as it surpassed the 70% threshold. In the JBI Critical Appraisal Checklist for Prevalence Studies, Coyne et al. (2013) achieved 88%, while Prasopkittikun et al. (2020), Al-Oran et al. (2023),

Kutahyalioglu et al. (2021), and Vasli et al. (2021) scored between 72% and 78%, all of which indicated low risk of bias according to Higgins et al. (2011). Pasha et al. (2020) had a moderate risk with 68%. Other studies, such as Okunola et al. (2017), Wojnar et al. (2023), Mariyam et al. (2022), Lim & Bang (2023), and Done et al. (2020), scored between 75% and 88%, suggesting low risk. The Critical Appraisal Skills Programme (CASP) was used to appraise three qualitative studies (Abukari & Schmollgruber, 2024; Malepe et al., 2022; and Nematifard et al., 2023), with resultsrevealing that the studies have clear aims, methodology, design, recruitment, and data collection methods. Ethical issues were alsoaddressed, and data analysis processes were rigorous, although the relationship between researchers and participants was unclear in all the three studies (See appendix 2).

Table 2: JBI Critical Appraisal Checklist for Prevalence Studies

Authors	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	% (Yes)	Interpretation
Coyne et at. 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	88	Low risk of bias
Prasopkittikun et al. 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	72	Low risk of bias
Al-Oran et al., 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	78	Low risk of bias
Vasli et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	75	Low risk of bias
Kutahyalioglu et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	78	Low risk of bias
Pasha et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	68	Moderate Risk of bias
Okunola et al., 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	88	Low risk of bias
Wojnar et al., 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	88	Low risk of bias
Mariyam et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	78	Low risk of bias
Lim & Bang, 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	75	Low risk of bias
Done et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	78	Low risk of bias

Questions 1 to 10 refer to the JBI risk assessment tool. The risk of bias was classified as high if the study achieved up to 49% of "yes" responses, moderate if it achieved between 50% and 69% of "yes" responses, and low if it achieved more than 70% of "yes" responses.

In the above table 3, studies were evaluated based on 10 criteria from the JBI Critical Appraisal Checklist for Prevalence Studies. Coyne et al. (2013) achieved 88% "yes" responses, indicating a low risk of bias across all 10 questions. Prasopkittikun et al. (2020) had 72%, with an unclear response for Q9, also suggesting a low risk of bias. Similarly, Al-Oran et al. (2023) and Vasli et al. (2021) had 78% and 75%, respectively, with unclear responses for Q9, both were classified as low risk. Kutahyalioglu et al. (2021) also scored 78%, with Q9 being unclear, indicating a low risk. Pasha et al. (2020), however, had a moderate risk of bias with 68%. Both Okunola et al. (2017) and Wojnar et al. (2023) scored 88%, indicating a low risk, whereas Mariyam et al. (2022), Lim & Bang (2023), and Done et al. (2020) had 75% to 78% scores, with Q9 remaining unclear, and all were classified as low risk of bias.

3 Results

3.1 Characteristics of the Included Studies

The systematic review identified and included 15 studies that explored the perception and practice of FCC among nurses in paediatric and neonatal settings. These studies were selected after rigorous screening of 4,074 articles identified in various databases, including Google Scholar, PubMed, and ProQuest. The review included studies from 13 countries. The countries include Ireland (Coyne et al., 2013), Thailand (Prasopkittikun et al., 2020), Ghana (Abukari & Schmollgruber, 2024), Jordan (Al-Oran et al., 2023), Iran (Vasli, 2021; Nematifard et al., 2023; Rostami et al., 2019), U.S.A. (Kutahyalioglu et al., 2022), Pakistan (Pasha et al., 2020), Nigeria (Okunola et al., 2017), South Africa (Malepe et al., 2022), Poland (Wojnar et al., 2023), Sri Lanka (Done et al., 2020), South Korea (Lim & Bang, 2023), and Indonesia (Mariyam et al., 2022). The study designs of all 15 articles are as follows:

Non-experimental survey designs were used by Coyne et al. (2013) and Wojnar et al. (2023). Cross-sectional designs were employed by Al-Oran et al. (2023), Vasli (2021), and Pasha et al. (2020). Mixed-methods designs featured in Prasopkittikun et al. (2020) and Done et al. (2020). Descriptive qualitative studies were conducted by Abukari & Schmollgruber (2024), Nematifard et al. (2023), and Malepe et al. (2022). Rostami et al. (2019) used a quasi-experimental design, while Kutahyalioglu et al. (2022) employed a descriptive and correlational mixed-methods design. Lim & Bang (2023) and Mariyam et al. (2022) used a descriptive survey design, while Okunola et al. (2017) used a descriptive cross-sectional design.

Table 3: Characteristics and data extraction of included articles

S/n	Authors, year and country	Design	Setting	Sample Size	Findings	Components of FCC
1	Coyne et at. 2013, Ireland	Non-experimental survey	Paediatric Units	250	Nurses' practices of FCC were significantly lower than their perceptions. Current practices scored 32.20 (SD = 5.06), while necessary practices scored 39.55 (SD = 3.67) ($t(249) = -20.38$, $p < .0001$). The least practised aspect was healthcare system design (M = 2.82, SD = 0.92), while emotional and financial support was the most practised (M = 4.04, SD = 0.69).	Family involvement and parent collaboration often fell short in practice. Parent support and developmental needs were neglected, while emotional support was commonly provided. Healthcare design remained the least implemented.
2	Prasopkittikun et al. 2020, Thailand	Mixed methods	Paediatric Unit	142	Nurses showed a clear gap between their perception of FCC and their actual practices. Perceived necessity scored 3.22 (SD = 0.36), while current practices were lower at 2.56 (SD = 0.35) ($t = -19.20$, $p < 0.001$). Family strengths and individuality were the most practised aspects, but parent/professional collaboration and healthcare system design lagged behind. Barriers to FCC included cultural mismatches, nurses' traditional roles, and system constraints like staff shortages.	Family as the constant, parent collaboration, family strengths, sharing information, parent support, developmental needs, emotional support, healthcare design, and staff support.
3	Abukari & Schmollgruber, 2024, Ghana.	Descriptive qualitative survey	Neonatal intensive care units	33	Nurses in NICUs faced overwhelming workloads and staffing shortages, limiting family engagement. Negative staff attitudes, lack of resources, and restricted family access further strained relationships.	Workload, staff attitudes, and resource limits were key issues.
4	Al-Oran et al., 2023, Jordan.	Cross-sectional study	Paediatric Units	102	Jordanian paediatric nurses had modest views and practices of FCC. "Family is the constant" scored highest (M = 3.56, SD = 0.78), while "Parent-to-parent support" was lowest (M = 3.26, SD = 0.86). Age and academic level did not affect FCC practices, except older nurses valued emotional support more ($\beta = 0.24$, $p = 0.02$).	Family as the constant and individuality were key. Collaboration, information sharing, and support were less practised. Healthcare design and staff support were the least implemented.
5.	Vasli, 2021, Iran.	Cross-sectional study	Paediatric Wards	233	Nurses viewed FCC positively, with an overall score of 3.05 (SD = 0.39). Collaboration rated highest (M = 3.28, SD = 0.46), followed by support (M = 3.10, SD = 0.51). Respect for family diversity and privacy scored lowest (M = 2.64, SD = 0.50), showing gaps in these areas.	Respect, collaboration, and support.
6	Kutahyaliogl u et al., 2022, and U.S.A.	Descriptive and correlational	Neonatal intensi	176	The study found nurse empowerment improved FCC practices, while compassion fatigue reduced them. Nurses in Magnet hospitals and with web cameras had better FCC engagement. Empowerment explained 35.1% of FCC	Parental involvement, open communication, and support systems for both parents and healthcare professionals.

		(Mixed)	ve care units		outcomes. More research is needed on how fatigue affects FCC.	
7	Pasha et al. , 2020, and Pakistan	Cross-sectional	Paediatric Departments	120	Nurses had a positive view of their FCC practices, scoring 3.02 for respect, 3.18 for collaboration, and 3.13 for support. They felt they welcomed families, respected privacy, provided honest information, involved parents in decisions, and addressed emotional needs. Nurses rated higher than parents in respect, collaboration, and support, as shown by paired t-tests.	Respect meant welcoming families and maintaining privacy. Collaboration involved including parents in decisions and sharing information and support,
8	Okunola et al., 2017, Nigeria.	Descriptive cross-sectional	Paediatric Units	176	Nurses rated their family-centred care highly, with detailed explanations (mean = 4.48), treating parents as team members (mean = 4.33), and helping parents (mean = 4.31). There was no major difference between nurses' and parents' views, but experience shaped nurses' positive perceptions. More experienced nurses likely implemented FCC better.	Respect, collaboration, and support from nurses' perspectives.
9	Malepe et at., 2022, and South Africa	Descriptive survey (qualitative)	Paediatric Units	11	The study found that nurses face major barriers to implementing family-centred care, including caregiver mistrust, limited involvement in decisions, and restrictive hospital policies. The lack of space and privacy in wards further complicates effective FCC practice.	Barriers to family-centred care.
10	Wojnar et al., 2023, and Poland.	Descriptive cross-sectional survey	Paediatric Units	289	Nurses strongly supported daytime parental presence (95.2%), but only 46.4% supported it at night, and 39.4% agreed under special circumstances. Parental presence increased workload for 50.5% of nurses, especially those with specialisation (59.1% vs. 41.3%, $p < 0.02$). While 77.1% acknowledged parental involvement in care, specialised nurses often saw it as a burden. Hospital rules were introduced to parents by 95.2% of nurses, though only 46% believed they were consistently followed, with compliance linked to the child's age ($p < 0.02$).	Nurses' perceptions of parental involvement, with focus on its impact on workload, necessity, and adherence to hospital regulations.
11	Nematifard et al., 2023, and Iran	Descriptive survey (qualitative)	Paediatric Unit	5	The study identified key barriers toFCC among nurses: limited knowledge from personal experience, ethical challenges reducing motivation, and poor teamwork morale. These issues were tied to a lack of structured FCC education and the chronic demands of paediatric rehabilitation, leading to burnout and lower motivation.	Barriers to FCC, focusing on nurses' challenges with knowledge, ethics, and teamwork.
12	Mariyam et al., 2022, and Indonesia	Descriptive survey	Paediatric and Neonatal Units	52	The study found that 90.4% of nurses had a positive view of FCC in paediatric settings. Key elements were rated highly, with 100% valuing information-sharing, 98% emphasizing listening to parents, and 96% supporting collaborative decision-making. Additionally, 94% highlighted individual communication,	Information sharing, listening, decision-making, individual communication, and role negotiation.

					while 63% recognised the importance of role negotiation in FCC.	
13	Rostami et al., 2019, and Iran	Quasi-experimental (Randomized Control Trial, Intervention)	Paediatric Units	196 (99:97)	The study found no significant link between socio-demographic factors and nurses' attitudes towards FCC. However, an educational intervention improved behaviour and attitudes by 1.571 and 0.619 units, respectively ($p < 0.05$). Analysis confirmed significant differences between the intervention and control groups over time, with a strong correlation between attitude and intention, supporting the Theory of Planned Behaviour.	Educational intervention's impact on paediatric nurses' attitudes, intentions, and behaviours towards implementing FCC.
14	Lim & Bang, 2023, and South Korea.	Descriptive survey (Intervention)	Paediatric Unit	162	The study found that nurses' perceptions of FCC were higher (mean = 4.07) than their actual performance (mean = 3.77). Collaboration scored the lowest in both areas. Perceptions varied by career length and FCC familiarity, while performance only varied with career length. Barriers included staff shortages, lack of time, and no systematic FCC approach. A strong positive correlation ($r = .594$, $p < .001$) showed that better perceptions led to improved performance.	Perceptions and performance across four FCC components: family respect, collaboration, information sharing, and family support.
15	Done et al., 2020, and Sri Lanka.	Mixed methods	Paediatric Unit	157	The study showed nurses perceived FCC more positively (mean score = 4.02) than their actual performance (mean score = 3.38). Family participation had the highest perception score (4.09), and information-sharing led in performance (3.54), while collaboration scored lowest in both. Nurses valued family roles in child care but faced barriers like poor communication, staff shortages, and cultural issues, such as excluding fathers. They recommended integrating FCC into education, improving infrastructure, and creating supportive policies.	Respect and dignity, information sharing, collaboration, and family participation.

3.2 Participants

The studies encompassed a total sample of 2,104 participants, which primarily included nurses working in paediatric wards, and neonatal intensive care units (NICUs). The inclusion of nurses from both NICUs and paediatric wards was considered reasonable by the researcher, given that they shared similar focus on specialized paediatric care, associated challenges in family-centred practice implementation, and the valuable insights they could provide across the spectrum of early childhood healthcare settings. The respondents in some studies included parents and other healthcare personnel (Abukari et al., 2024; Nematifard et al., 2023; Wojnar et al., 2023; Malepe et al., 2022; Vasli, 2021; Pasha et al., 2020; Okunola et al., 2017). However, only data specific to nurses were extracted to maintain the integrity of the research. Among the 15 studies, staff nurses were the most commonly represented designation, with Coyne et al. (2013) reporting the highest proportion at 65%.Specialised nurses in ICU and NICU settings were featured in the studies conducted by Prasopkittikun et al. (2020) and Kutahyalioglu et al. (2021). In contrast, the lowest representation was observed in Malepe et al. (2022), which included only 11 nurses across various roles, such as registered nurses, enrolled nurses, and nursing assistants. Overall, staff nurses were the most frequently represented, while nurses in specialised roles appeared less frequently in the studies.The age distribution of nurses ranged from the mid-20s to early 40s. Specifically, Al-Oran et al. (2023) reported an age range of 22 to 45 years. The average ages were 37 years in Prasopkittikun et al. (2020), and 42 years as per Kutahyalioglu et al. (2021), which is the highest among the studies reviewed. Done et al. (2020) found that 40.8% of nurses were aged 29 or younger. While most nurses fell within the mid-20s to early 40s bracket, some reviewed studies reported participants nurses in their 50s and 60s, with Prasopkittikun et al. (2020) noting that some participants were up to 60 years old. Majority of participants were female nurses. The highest female representation was reported at 98.8% in Kutahyalioglu et al. (2021), while the lowest was 71.67% in Pasha et al. (2020), which corresponded to the highest male representation at 28.33%. Most studies reported female participation exceeding 90%, with male representation typically below 5%.

3.3 Data analysis/ synthesis

In this review, the researchers chose narrative synthesis because of the heterogeneous design of the studies, as most of the studies dealt with qualitative and quantitative data. For instance, Prasopkittikun et al. (2020) and Abukari & Schmollgruber (2024) highlighted gaps between nurses' perceptions and actual practices of family-centered care (FCC), but the barriers they encountered were quite different. Given this variety, a statistical approach would not have been suitable. Instead, narrative synthesis empowered me to explore these differences in a more descriptive way, thereby making it easier to address core principles of FCC – collaboration, information sharing, involvement, and respect for patients. I grouped both the qualitative studies and the qualitative parts of mixed-methods studies under "qualitative" to keep things simple. I also included some effect sizes and mean differences in the narrative synthesis, just as the authors presented them, and highlighted any significant findings. In the final synthesis, I looked at recurring qualitative themes and discussed how they connected with the quantitative results and intervention outcomes.

3.4 Study findings on nurses' perceptions of family-centred care

The summary of key findings from the 15 studies is presented below, focusing exclusively on nurses' perceptions of FCC. The most common perception-related themes were gaps between perceptions and practices (n = 7), followed by positive attitudes towards family involvement and collaboration (n = 5). Three studies reported specific barriers influencing perceptions, such as cultural or systemic challenges (n = 3). The most frequently observed theme was the discrepancy between nurses' perceptions of FCC and its actual practice in clinical settings. In Coyne et al. (2013), for instance, a significant gap was noted between nurses' views of what FCC should be and their reported practices, with a total mean score of 39.55 (SD = 3.67) for necessary practices compared to a much lower score of 32.20 (SD = 5.06) for current practices. A similar trend was observed in Prasopkittikun et al. (2020), where the mean score for perceived necessity (M = 3.22, SD = 0.36) was significantly higher than that for current practices (M = 2.56, SD = 0.35). Likewise, Lim and Bang (2023) reported a higher perception of FCC (with a mean score of 4.07) compared to the actual performance (mean score of 3.77), with a statistically significant positive correlation between perceptions and performance ($r = .594$, $p < .001$). In terms of positive attitudes towards family involvement, several studies highlighted the importance nurses placed on collaboration and support. Pasha et al. (2020), for example, showed that nurses rated respect, collaboration, and support highly with scores exceeding 3.0. Similarly, in Okunola et al. (2017), nurses rated their involvement in supporting families and treating them as valued team members positively, with mean scores of 4.33 and 4.31, respectively. The principle of family involvement was also reflected in Vasli (2021), where nurses perceived collaboration and support as essential, with scores of 3.28 and 3.10, respectively. However, this study also noted gaps in respecting family privacy and diversity (mean score of 2.64).

Barriers that affected nurses' perceptions of FCC were highlighted in three studies. Al-Oran et al. (2023), for instance, identified resource limitations and overwhelming workloads as key barriers, which hindered effective FCC implementation despite positive perceptions. Cultural constraints were another major theme, with Prasopkittikun et al. (2020) finding that the cultural mismatch between FCC principles and the traditional Thai healthcare system created tension for nurses, affecting their ability to practice FCC as they perceived it. Similarly, Done et al. (2020) noted that cultural constraints, such as excluding fathers from care settings, significantly influenced how FCC was perceived and practised in Sri Lanka. Despite the overall positive perceptions of FCC, nurse empowerment and experience were noted as influential factors in improving implementation. Kutahyalioglu et al. (2022) found that nurse empowerment explained 35.1% of the variance in FCC practices, suggesting that nurses who felt empowered were better equipped to implement FCC. Compassion fatigue, however, had a slight negative impact on FCC perceptions in this study. Several studies provided insights into how educational interventions could bridge the gap between perception and practice. For instance. Rostami et al. (2019) reported that an educational intervention significantly improved nurses' attitudes toward FCC, with an increase of 1.571 units ($p < 0.05$). This highlights the potential for structured training programmes to enhance nurses' understanding and application of FCC principles. While nurses generally perceived FCC positively across the reviewed studies, the consistent gaps between perception and practice highlight the need for systemic improvements and additional training. Factors such as empowerment, experience, and education played crucial roles in shaping perceptions, while cultural and systemic barriers often impeded the full realisation of FCC principles.

3.5 Study findings on core principles of family-centred care in practice

3.5.1. Family Involvement and Collaboration

The principle of involving families in their child's care, a cornerstone of FCC, appears consistently across studies, though its implementation varies. For example, Coyne et al. (2013) in Ireland found that while emotional and financial support for families was frequently practised (M = 4.04, SD = 0.69), other aspects such as collaboration and developmental needs were under-practised. Similarly, Prasopkittikun et al. (2020) in Thailand highlighted that although nurses valued family strengths and individuality, parent/professional collaboration and system design were the least practised aspects, with significant gaps between perceived necessity and actual practice ($t = -19.20$, $p < .001$). Wojnar et al. (2023) in Poland showed that while nurses supported parental presence during the day (95.2%), fewer supported it at night (46.4%), indicating limited collaboration during off-hours. This hesitation was linked to the belief that parental involvement increased workload, especially for specialised nurses ($p < .02$). Overall, while nurses recognise the importance of family participation, structural challenges such as staffing shortages and workload (Mariyam et al., 2022) limit its full realisation.

3.5.2. Respect and Dignity

Respect for families, including maintaining privacy and valuing their contributions, was another critical element of FCC, though studies suggest inconsistencies in its practice. In the study by Vasli (2021) in Iran, the respect domain received the lowest rating (M = 2.64, SD = 0.50), indicating gaps in fully respecting family diversity and privacy. Similarly, Pasha et al. (2020) in Pakistan reported that nurses rated their respect practices highly (M = 3.02), but discrepancies existed between nurses' perceptions and those of parents, with nurses consistently rating their practices higher. These findings suggest that while respect is theoretically upheld, it may not always align with family expectations.

3.5.3. Information sharing

Effective communication and information sharing are essential for FCC. Studies show that nurses acknowledge the importance of providing detailed explanations and clear communication. For example, Okunola et al. (2017) in Nigeria noted that nurses rated their ability to provide explanations highly (M = 4.48). Mariyam et al. (2022) in Indonesia also highlighted the significance of information sharing, with 100% of nurses recognising its importance in paediatric settings. However, Done et al. (2020) in Sri Lanka found that while nurses had high perceptions of FCC (M = 4.02), the actual performance, particularly in collaboration, was lower (M = 3.38), indicating room for improvement in effectively engaging families through communication.

3.5.4. Support systems

Providing emotional and practical support to both families and healthcare staff is fundamental to FCC. Several studies emphasised this principle, with emotional support being a key focus. For instance, in the study by Al-Oran et al. (2023) in Jordan, older nurses placed greater value on emotional support for staff ($\beta = 0.24$, $p = 0.02$), highlighting the interrelationship between supporting both families and the healthcare team. Similarly, Coyne et al. (2013) found that providing emotional and financial support to families was the most commonly practised element of FCC (M = 4.04, SD = 0.69), although other areas lagged behind.

3.5.5. System design and structural challenges

The healthcare system's design and structural barriers, such as staffing shortages and lack of resources, were frequently cited as obstacles to implementing FCC. Prasopkittikun et al. (2020) identified that system constraints, including a shortage of nurses and traditional roles, hindered the full implementation of FCC in Thailand. Abukari and Schmollgruber (2024) in Ghana similarly found that overwhelming workloads and inadequate staffing negatively impacted nurses' ability to engage with families effectively. These structural challenges were echoed in other studies, such as Malepe et al. (2022) in South Africa, where mistrust from caregivers and restrictive hospital policies further limited the application of FCC.

4.5.6. Educational and training gaps

Several studies identified gaps in education and training as barriers to effectively implementing FCC. Rostami et al. (2019) showed that educational interventions significantly improved nurses' attitudes, intentions, and behaviours towards FCC in Iran, confirming the importance of structured education in enhancing FCC practices ($p < .05$). Nematifard et al. (2023) also noted that reliance on personal experience rather than formal training limited nurses' knowledge of FCC, further exacerbated by the chronic nature of paediatric rehabilitation, leading to burnout and decreased motivation. While family involvement, respect, collaboration, information sharing, and support are widely acknowledged as core principles, their practical implementation often falls short due to structural barriers, lack of resources, and gaps in training. These findings suggest that improving FCC requires not only addressing these challenges but also investing in education and system redesign to better support both families and healthcare professionals in delivering comprehensive, family-centred care.

4.6 Findings on barriers to implementing family-centred care

4.6.1. Staffing shortages and heavy workloads

A recurring theme in many of the studies is the impact of staffing shortages and overwhelming workloads on the ability of nurses to implement FCC effectively. For instance, Abukari and Schmollgruber (2024) in a descriptive qualitative study in Ghana's neonatal intensive care units (NICUs) reported that nurses were often unable to engage effectively with families due to inadequate staffing and excessive workloads. These findings align with Malepe et al. (2022) in South Africa, where nurses indicated that limited caregiver involvement was due to restrictive hospital policies and insufficient nurse-to-patient ratios. This finding resonates with Wojnar et al. (2023), where the perceived increase in workload due to parental presence was noted, with specialised nurses finding this particularly burdensome. The underlying structural weaknesses in the healthcare systems prevent FCC from being effectively practised in many cases. The physical ward environment was another issue, with lack of space and privacy further straining nurse-family relationships. These structural challenges are echoed in Lim and Bang's (2023) study from South Korea, where a descriptive survey of 162 nurses revealed that a shortage of personnel and lack of time were significant barriers. These quantitative data showed a statistically significant correlation between nurses' clinical experience and their performance of FCC ($r = .594$, $p < .001$).

4.6.2. Cultural and institutional barriers

Cultural differences and institutional practices also pose substantial barriers to FCC. In Prasopkittikun et al. (2020), a mixed-methods study in Thailand, nurses faced a cultural mismatch between the principles of FCC and traditional healthcare delivery systems, where nurses are regarded as care experts rather than facilitators of family involvement. This perception was compounded by system constraints, such as a shortage of nursing staff, which hindered collaborative care. These barriers were further explored in Wojnar et al. (2023) in Poland, where a descriptive cross-sectional survey of 289 nurses found that while parental involvement in care was recognised as crucial, hospital regulations and nurse specialisations made it difficult to fully implement FCC, especially at night. Parental presence was supported by 95.2% of nurses during the day but dropped to 46.4% at night, indicating a tension between family participation and healthcare policies that restrict family access during certain hours. Similarly, Done et al. (2020) noted that cultural constraints, such as excluding fathers from care settings in Sri Lanka, limited the involvement of family members in the care process. Such culturally bound practices create an environment where FCC principles are difficult to reconcile with local healthcare traditions

4.6.3. Inadequate Training and Education

A lack of formal education and training in FCC is a significant barrier identified in several studies. In Nematifard et al. (2023), a descriptive survey in Iran, it was found that nurses often relied on personal experience rather than structured education in FCC, which contributed to their limited knowledge and implementation of its principles. Ethical challenges and teamwork issues also emerged as barriers, with nurses lacking the necessary support to maintain morale and motivation. The study by Done et al. (2020) also supports this finding, suggesting that the lack of formal education on FCC principles limits nurses' ability to implement these practices effectively. However, there is evidence that education can lead to significant improvements. Similarly, Rostami et al. (2019) conducted a quasi-experimental study in Iran, which showed that educational interventions had a positive impact on nurses' attitudes and behaviours toward FCC. In the intervention group, behaviours improved by 1.571 units and attitudes by 0.619 units ($p < 0.05$), accentuating the importance of formal training in overcoming associated barriers. Put together, these findingssuggest that without structured educational programmes, nurses are left to navigate FCC based on fragmented knowledge, and this could further reduce overall effectiveness of FCC intervention.

4.6.4. Emotional and Compassion Fatigue

A mixed-methods study in the United States, on the influence of emotional stress and compassion fatigue on FCC practices, showed that compassion fatigue negatively impacted FCC, as nurses experiencing high levels of emotional exhaustion were less likely to engage fully with families (Kutahyalioglu et al.,2022). This study found that nurse empowerment had a positive correlation with FCC engagement, with 35.1% explanation of the variance in FCC practices accentuating the significance of empowering nurses. Given that compassion fatigue clearly undermined nurses engagement with families, is suggests the imperatives of policy rejig to ensure that healthcare systems decisively address the issue of emotional well-being of nurses, as this has a strong bearing to enhancing FCC implementation.

4.6.5. Hospital Policies and Restrictions

Restrictive hospital policies also emerged as a barrier in several studies. Malepe et al. (2022) in South Africa found that hospital regulations limiting caregiver involvement in decision-making hindered FCC. Additionally, the physical environment of hospitals, including the lack of private spaces for family interactions, exacerbated these barriers. In Wojnar et al. (2023), despite strong support for daytime parental presence, hospital rules often limited night-time family access, with compliance linked to the child's age ($p < .02$). This illustrates how hospital policies, designed to manage workflow, may at times inadvertently reduce the potential for full family participation in care process. This inconsistency further complicates the practice of FCC, as nurses may be left with unclear and restrictive policy-frameworks as guides to navigating paediatric environment.

4.6.6. Lack of Communication and Trust

Several studies also highlighted communication issues and mistrust between healthcare staff and caregivers as barriers to FCC. In Malepe et al. (2022), nurses reported that mistrust from caregivers and limited involvement in decision-making reduced the effectiveness of FCC. Similar findings were observed in Coyne et al. (2013) in Ireland, where nurses acknowledged family involvement but often fell short in practice. The study showed a statistically significant gap between nurses' perceived and actual practices, with a total mean score for current practices at 32.20 (SD = 5.06) and necessary practices at 39.55 (SD = 3.67) ($t(249) = -20.38$, $p < .0001$). This discrepancy highlights how communication and trust between nurses and families are often insufficient, and may be undermine implementation of FCC. Overcoming these barriers will require comprehensive reforms in healthcare system design, increased support for nurses through education and training, and more flexible hospital policies that promote meaningful family involvement in paediatric settings.

4.7 Findings on facilitators of family-centred care

The studies reveal several key factors that help make FCC work in paediatric settings. Collaboration and communication between nurses and families stand out as critical. Rostami et al. (2019, Iran) found a 1.571-unit increase in nurses' collaborative behaviour after an educational intervention ($p < 0.05$), showing how training can make a real difference. Similarly, Lim and Bang (2023, South Korea) reported a strong link between nurses' perceptions and

their actual FCC performance ($r = 0.594$, $p < 0.001$), highlighting the importance of fostering positive attitudes. Information sharing also proved crucial. In Mariyam et al. (2022, Indonesia), 100% of nurses acknowledged its importance for involving families. Additionally, the role of nurse empowerment and training cannot be overlooked. Kutahyalioglu et al. (2022, USA) found that empowerment accounted for 35.1% of the variance in FCC practices, while Prasopkittikun et al. (2020, Thailand) revealed a significant gap between what nurses believed was necessary and what they actually practiced ($t = -19.20$, $p < 0.001$). These findings show how professional growth and training are vital for effective FCC. Respect for families and their involvement in care is another essential factor. Studies such as Al-Oran et al. (2023) emphasize the importance of valuing family involvement, with "Family as the constant" rated highest ($M = 3.56$, $SD = 0.78$). Okunola et al. (2017) found that more experienced nurses particularly recognized this aspect, with detailed explanations scoring 4.48. Furthermore, institutional support is critical. Restrictive policies, inadequate infrastructure, poor teamwork morale, and burnout can hinder FCC, while better infrastructure and strong support systems facilitate its success. Malepe et al. (2022) and Nematifard et al. (2023) observed these points, highlighting thus the need for a robust institutional backing of the implementation of FCC. These factors are interconnected and mutually reinforcing, highlighting the need for a holistic approach to implementing and improving FCC. The evidence from the cited studies underscores the importance of investing in these areas to enhance the quality and effectiveness of paediatric care.

4.8. Findings on cultural and regional differences in family-centered care

4.8.1 Asia: Thailand and Pakistan

A Thaistudy by Prasopkittikun et al. (2020) reported a significant gap between nurses' perceptions and practices of FCC. Nurses scored the necessity of FCC at a mean of 3.22, but their actual practice at 2.56 ($t = -19.20$, $p < 0.001$). This gap arose from cultural clashes. Nurses traditionally held authority in Thai healthcare, conflicting with FCC's collaborative approach. Pakistan presented a similar picture, as Pasha et al. (2020) revealed that nurses were scored highly in respect for family privacy (mean = 3.02), but cultural constraints implied that parents' roles were not fully embraced. There was a notable divide between how nurses and families perceived their roles in care. More quality studies are needed from that region for a clearer understanding of this issue.

4.8.2 Middle East: Jordan and Iran

In Jordan, Al-Oran et al. (2023) study showed that cultural influences on FCC. "Family as the constant" received the highest score ($M = 3.56$), but collaborative support among families was rated much lower ($M = 3.26$). Older nurses preferred offering emotional support ($\beta = 0.24$, $p = 0.02$), suggesting generational differences in how care is provided in region. In Iran, Vasli (2021) noted positive perceptions of FCC, especially in collaboration and support, but respect for family diversity lagged behind. Educational interventions reportedly improved attitudes of nurses towards FCC, with a 1.571-unit increase (improvement) in behaviour ($p < 0.05$). These findings suggest that culturally informed training makes a difference.

4.8.3 Africa: Ghana, Nigeria, and South Africa

In Ghana, Abukari and Schmollgruber (2024) reported that nurses struggled with high workloads and negative staff attitudes, thereby restricting FCC implementation. Nurses were viewed as authority figures, which hindered collaborative care. Similarly, Okunola et al. (2017) found that nurses rated themselves highly on collaboration (mean = 4.33), but there was a mismatch between nurses' perceptions and families' actual experiences in Nigeria. In South Africa, Malepe et al. (2022) pointed out that cultural mistrust and restrictive hospital policies were the major barriers to FCC. The physical environment of hospital settings waslacking in space and privacy was a concern, thereby limiting effective patient care. These findings collectively illustrate how structural, cultural, and environmental factors significantly restrict FCC across the region.

4.8.4 Western Regions: Poland and the USA

In Poland, Wojnar et al. (2023) observed that reluctance to fully involve families stemmed from deeply held cultural beliefs. While 95.2% of nurses that took part in their study supported parental presence during the day, only 46.4% allowed it at night. Nurses feared potential increase in workloads, with 50.5% reporting that parental involvement added strain on the job. In contrast, Kutahyalioglu et al. (2022) in the USA found that empowering nurses improved FCC practices, with empowerment explaining 35.1% of the variance in practices. Magnet hospitals with support systems for nurses had better FCC outcomes, suggesting cultural support for staff autonomy fosters FCC. This contrast suggests that while cultural hesitations can limit FCC in Poland, structural empowerment in the USA promotes its success, indicating the need for both cultural and systemic changes to foster effective FCC.

4.8.5 South Asia: Sri Lanka

In Sri Lanka, Done et al. (2020) revealed a gap between nurses' FCC perceptions and actual practice. Family participation was rated the highest in perception (mean = 4.09) but much lower in practice (mean = 3.38). Cultural constraints, such as the exclusion of fathers from care, hindered collaboration. Nurses recommended improving FCC education and hospital infrastructure to address these barriers. These findings clearly show that cultural and regional differences clearly shape FCC across the globe. In some regions, traditional hierarchies in healthcare impede full family participation. Nurses in these regions tend to see themselves as authority figures, which conflicts with FCC's emphasis on collaboration. In other places, like the USA, empowering

nurses through supportive policies and training resulted in better FCC practices. Across most studies, there is a consistent gap between perceptions and practices, with cultural and systemic barriers playing a pivotal role.

4.9 Findings on training and education intervention

Educational interventions significantly enhance FCC among nurses, as shown in various studies. For instance, Rostami et al. (2019) found that structured training boosted nurses' attitudes and behaviours by 1.571 and 0.619 units respectively ($p<0.05$). Lim and Bang (2023) also reported a strong positive correlation ($r = .594$, $p < .001$) between FCC perceptions and performance, emphasizing the importance of education and experience. However, Done et al. (2020) noted a gap between perception (mean = 4.02) and performance (mean = 3.38), largely due to inadequate training and cultural barriers. Additionally, Al-Oran et al. (2023), Okunola et al. (2017), Malepe et al. (2022), and Vasli (2021) highlight the importance of recognizing family involvement, institutional support, and addressing barriers like restrictive policies, limited space, poor teamwork, and burnout. For example, Al-Oran et al. (2023) found that "Family as the constant" was the highest-rated FCC component ($M = 3.56$, $SD = 0.78$), while Okunola et al. (2017) showed that experienced nurses valued family involvement highly, with detailed explanations scoring 4.48. The findingshighlight the importance of continuous professional development, carefully designed interventions, and robust support from institutions to assist nurse to practices in line with their perceptions.

4.10 Quantitative synthesis

The reviewed studies predominantly utilised cross-sectional designs, with only one study employing a quasi-experimental design (Rostami et al., 2019). Most cross-sectional studies performed descriptive analyses without engaging in comparative evaluations. Common reasons cited for these design choices included limited resources such as time, space, and finances, alongside ethical constraints. Diverse outcome measures were reported, thereby making direct comparisons between studies challenging (see Table 3). In several instances, new instruments were developed to assess outcomes, while some studies used validated measures to ensure consistency. In terms of outcome focus, nurse perceptions of FCC and their actual practices were commonly measured, with most studies relying on Likert-type survey items. For example, Al-Oran et al. (2023) in Jordan and Okunola et al. (2017) in Nigeria assessed nurses' FCC practices and found mean scores ranging from 3.26 to 4.48 across key FCC components, indicating moderate to high perceptions of FCC. Similarly, Vasli (2021) in Iran reported mean scores between 2.64 and 3.28, demonstrating some gaps in respecting family privacy and diversity. Two studies evaluated the impact of educational interventions, with Rostami et al. (2019) showing significant improvements in nurses' FCC attitudes and behaviours, while Lim and Bang (2023) identified positive correlations between perceptions and actual FCC performance ($r = .594$, $p < .001$). Across the studies, no outcome patterns emerged based on country or setting, and effect sizes were rarely reported, making it difficult to compare the impact of different FCC interventions quantitatively.

4.11 Synthesis of qualitative (and mixed-methods findings)

The qualitative and mixed-methods studies included nurses from South Africa, Sri Lanka, Nigeria, and Jordan (Al-Oran et al., 2023; Done et al., 2020; Malepe et al., 2022; Okunola et al., 2017). These studies focused on challenges nurses face in delivering Family-Centered Care (FCC). Communication emerged as a common theme in two studies, while other themes varied, due to different patient groups and care settings. In South Africa, for example, nurses struggled with restrictive hospital policies and mistrust, thereby making it difficult to fully respect families' needs (Malepe et al., 2022). Studies from Nigeria and Jordan found that nurses recognised the importance of keeping families informed, aligning with FCC's information-sharing principle (Al-Oran et al., 2023; Okunola et al., 2017). The Sri Lankan study highlighted cultural barriers, such as excluding fathers from caregiving, which is a limiter to parental involvement (Done et al., 2020). Across all studies, themes of collaboration were clear, with parents wanting to advocate for their children and be part of the care team (Al-Oran et al., 2023; Done et al., 2020). These findings confirm that while challenges remain, FCC principles are widely recognised and supported in practice.

5. Discussion

5.1 Summary of key findings

This review examined 15 studies involving 2,102 nurses from various countries, with focus on FCC. The findings showed that while nurses generally held positive perceptions about FCC, there were still significant gaps between what they believed and what they actually practised. In Jordan, for instance, Al-Oran et al. (2023) found that "Family is the constant" received the highest rating ($M = 3.56$), while "Parent-to-parent support" was rated the lowest ($M = 3.26$). Similarly, in Nigeria, Okunola et al. (2017) reported that nurses rated their FCC practices highly, especially in offering detailed explanations (mean = 4.48) and treating parents as part of the healthcare team (mean = 4.33). It was also found that more experienced nurses were better at putting FCC into practice. However, there were notable challenges, particularly in South Africa, where Malepe et al. (2022) identified issues like mistrust from caregivers and hospital policies that limited family involvement. In Iran, Vasli (2021) showed that nurses had positive views on FCC, especially in terms of collaboration (mean = 3.28) and support (mean = 3.10). however, there were clear gaps in respecting family diversity, with the lowest mean score in the respect domain (mean = 2.64). Educational interventions made a big difference too. Rostami et al. (2019) demonstrated that structured training in Iran significantly improved nurses' attitudes by 1.571 units and their behaviours by 0.619 units ($p<0.05$). Despite these improvements, the gap between perception and practice remained. Done et al. (2020) found that although nurses' perceptions of FCC were high (mean = 4.02), their actual performance was lower (mean = 3.38). These studies show that while nurses value FCC, challenges like mistrust, lack of resources, and insufficient training make it

hard to implement the intervention fully. Nevertheless, training programmes have been effective in aligning what nurses believe with how they practise, suggesting the need for improvement when these issues are addressed.

5.2 Implications of the study and practice

The studies show a clear gap between what nurses know about FCC and what they practise. Nurses see the value of family involvement, but challenges like staff shortages, heavy workloads, and restrictive policies limit their actions. In some areas, cultural differences and a lack of resources added to these difficulties confronting implementation of FCC. These barriers suggest the need for healthcare systems to rethink their structures. Compassion fatigue also hinders nurses, accentuating the importance of emotional support. The studies revealed that training programmes have improved nurses' FCC skills, but real progress will come from better resources provision, policy changes, and sustainable emotional and professional supportdirected at empowering nurses to practice FCC intervention.

5.3 Limitations of the Study

The study has several limitations that may affect the results. Many studies used small samples, like one with only five nurses, which makes it hard to generalise the findings. Cross-sectional designs only capture a moment in time and cannot show changes over time. Self-reported data also pose issues, as nurses may give answers they think are expected, which can skew results. Additionally, cultural differences in some studies limit the relevance to other settings. Resource constraints, such as inadequate staffing, further complicate the implementation of family-centred care (FCC). Finally, these studies mainly focus on nurses' perceptions, which may not reflect actual practice. More robust research with larger samples, longitudinal designs, and diverse settings is needed to validate these findings and improve FCC practices.

5.4 Conclusion

The global recognition of FCCby nurses is clear, but a substantial gap persists between their perceptions and actual implementation in practice. Systemic barriers, including insufficient staffing, inadequate resources, and structural challenges within healthcare environments are hindering the full adoption of FCC principles. To bridge this gap, healthcare systems must focus on enhancing nurse education, implementing strategic reforms, and improving resource allocation to create an environment where FCC can be consistently and effectively practised.

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Appendix 1

Table 4: JBI Critical Appraisal Checklist for Randomized Controlled Trials

Author	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	%Yes	Interpretation
(Rostami, 2019)	Unclear	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	73%	Low bias risk

Questions 1 to 10 refer to the JBI risk assessment tool. The risk of bias was classified as high if the study achieved up to 49% of "yes" responses, moderate if it achieved between 50% and 69% of "yes" responses, and low if it achieved more than 70% of "yes" responses.

In the JBI Critical Appraisal Checklist for Randomized Controlled Trials, (Rostami, 2019) scored "Yes" for Q2, Q4, Q5, Q6, Q7, Q8, and Q9, while Q1 and Q3 were marked "Unclear," leading to an overall 73% "Yes" score, which indicates a low risk of bias as it exceeds the 70% threshold.

Appendix 2

Appendix 1: Critical Appraisal Skills Programme (CASP)

No	Critical Appraisal Skills Programme (CASP) Assessment	(Abukari & Schmollgruber, 2024)	(Malepe et at., 2022)	(Nematifard et al., 2023)
1.	Was there a clear statement of the aims of the research?	Yes	Yes	Yes
2.	Is a qualitative methodology appropriate?	Yes	Yes	Yes
3.	Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes
4.	Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes
5.	Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes
6.	Has the relationship between researcher and participants been adequately considered?	Can't tell	Can't tell	Can't tell
7.	Have ethical issues been taken into consideration?	Yes	Yes	Yes
8.	Was the data analysis sufficiently rigorous?	Yes	Yes	Yes
9.	Is there a clear statement of the findings?	Yes	Yes	Yes
10.	How valuable is the research?	Yes	Yes	Yes

Critical Appraisal Skills Programme (CASP) assessment for the three studies (Abukari & Schmollgruber, 2024; Malepe et al., 2022; and Nematifard et al., 2023) showed consistency across the criteria.