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Family participation in after surgical nurse care: relations with the practice environment and nurses' attitudes - scoping protocol

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ADMINISTRATIVE INFORMATION

Support - None reported.

Review Stage at time of this submission - Preliminary searches.

Conflicts of interest - None declared.

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INTRODUCTION

Review question / Objective What is the evidence on the relationship between family participation in nursing care, the practice environment and nurses' attitudes in a hospital setting? Population (P) families; nurses. Concept (C) family participation; practice environment; nurses' attitudes. Context (C) hospital.

Background Technological advances, increasingly rapid surgical recovery processes and strategies to optimize care and costs, in which hospitalization periods are becoming shorter, so is very timely and necessary to increase knowledge about family participation in care, as well as the recognition of care provided by family members (Kokorelias et al., 2019).

Schreuder et al. (2019) states that family participation has the potential to improve patient outcomes in the postoperative period by preventing complications and facilitating the discharge process, reducing readmissions due to complications after discharge. This author concluded that the group of patients in whom families actively participated in care mobilized more, and showed greater adherence to breathing exercises , oral hygiene, and cognitive activities.

Mackie et al. (2018) states that nurses' attitudes, beliefs and care environment influence the quality of clinical practice and the provision of fundamental care such as promoting family participation in nursing care.

A european study carried out between 2017 and 2019, (n=8112 nurses) using the “Families' importance in Nursing Care - Nurses Atttudes” (FINC-NA), concluded that male nurses, younger nurses and nurses working in hospitals are associated with a less positive attitude towards family involvement in care (Shamali et al., 2023). In Portugal, 84.6% of nurses were under the age of 40, and individuals under the age of 30 represented 54.5% of the population of registered nurses in Portugal (OE, 2023). It should also be noted that 46% of nurses in Portugal work in hospital settings. In this study, the Portuguese

nurses surveyed (n=309) revealed a positive attitude towards the importance of family in nursing care with a total FINC-NA score = 102.3, out of an overall average of 90 (range 26-130). This fact is also confirmed in the studies by Sousa, (2011) and Fernandes et al. (2015) with a total FINC-NA score of 74.75 and 79.2 respectively. In both Portuguese studies, the value of the "Family as a burden" subscale exceeds the midpoint of the scale (8.15 and 12.2 respectively (in a range of 4-16)), which indicates that the nurses surveyed consider the "family as a burden", an alarming factor as this data hinders the establishment and development of a collaborative relationship between families and nurses.

In the study by Fernandes et al (2015), nurses providing care in the surgery department had the second lowest average (73.7), while the emergency department had the worst average (71.3) and the obstetrics department had the best average (81.1).

Although the relationships between nurses and family members are significant, we note that other broader factors such as organizational and contextual issues shape families' involvement in nursing care and these are under-researched (Olding et al., 2015).

Hetland et al., (2017) in their study concludes that the care environment in the ICU significantly influences nurses' attitudes towards family involvement, as well as their workflow. It also reveals that nurses who worked in units with higher nurse-patient ratios, as well as those who intended to leave the profession in the next six months, were less able to involve families.

In the study carried out in a surgical inpatient setting (Schreuder et al., 2019), there was no increase in workload.

The study by Smits et al. (2022) concluded that surgical inpatient nurses show "work-role conflicts" (conflicts about what their professional responsibilities are) and "work-role ambiguity".

An australian study, researchers explored the preferences of 30 family members of intensive care unit patients and found that around 60% of families preferred a passive role in the physical care of their loved one, 33% preferred shared participation with staff and 3% preferred active participation with little staff involvement (Wong et al., 2021).

Rationale The family has always played a key role in caring for their healthy or sick loved ones. It is a privileged place of care, where sharing and participating in the other person's journey becomes mandatory (Vieira, 2013). However, when adults are hospitalized, the family's involvement in caring for their relative is conditioned (Kirkham, 2022).

The presence of the family with their hospitalized relatives during periods of acute illness is recognized as a source of support for the patient (Mackie et al., 2018) and has been widely recommended for its positive emotional effects, such as reducing anxiety, as well as facilitating the discharge process, reducing readmissions due to complications after discharge (Schreuder et al., 2019) and improving the quality of life of patients and family members (Mackie et al., 2018). Involving families in nursing care also increases families' and patients' trust in healthcare professionals and improves nurse-patient/family relationships (Kiwanuka et al., 2023).

Family involvement in healthcare has been the focus of attention in many European healthcare systems (Shamali et al., 2023).

Even so, the involvement of the inpatient's family still generates contradictory opinions and behaviors (Al Mutair et al., 2014; Schwartz et al., 2022), and there are still a number of barriers that hinder this integration into daily nursing practice at a global and national level.

Authors who have studied this issue report that the involvement of families is often only passive (Olding et al., 2015), that nurses internationally and nationally perceive the family as an obstacle (Sousa, 2011; Fernandes et al. 2015), as a disturbing element that results in an increase in workload (Bishop et al., 2013; Kiwanka et al., 2015), 2013; Kiwanuka et al., 2023), as an enabler of safety failures (Correia et al., 2021), and as a factor in role conflicts (Smits et al., 2022; Kiwanuka et al., 2023). Nurses also fear that the family may enter their domain of professional competence (Kiwanuka et al., 2023), depriving the professional of their prominence as a specialist who has the solutions and resources that the family needs, and also that family members may observe poor performance in the provision of care (Fisher et al., 2008). Various studies have shown that nurses working in hospital settings have less positive attitudes towards family involvement in care, compared to nurses in other settings (Benzein et al., 2008;Cranley et al., 2022;Shamali et al., 2023).

When the families' perspective is evaluated, they report that fear, emotional stress and a sense of helplessness are emotions that make it difficult to participate in care, especially in the physical care of their family member (Wong et al., 2020), with nurses playing a central role as advocates and facilitators of these practices (Mackie et al., 2018).

In the study by Goldfarb et al. (2022), which measured the involvement of the families of patients admitted to the ICU, the dimension in which the family felt least encouraged was participation in the care of their loved one (63.1%),

with the “being present” dimension obtaining the highest score (98.8%).
Studies on family participation in care have mostly been carried out in a community setting and little focus has been given to this issue in a hospital setting (Ambrosi et al., 2017). In addition, most of the research carried out looks at the family as vulnerable subjects who need to be brought into the care setting (Olding et al., 2015).
So far, through the literature review, we have not identified the relationship between the care practice environment and the nurses attitudes towards family involvement in hospital contexto in Portugal.

METHODS

Strategy of data synthesis Initially, an exploratory search was carried out in the CINAHL and MEDLINE databases with the central search terms in English - family participation; nursing practice environment; nursing attitudes; hospital - one by one in order to identify synonymous search terms used in the indexing of articles, in titles, abstracts and keywords and which will be used to develop a complete search strategy. The Boolean operators used were AND and OR. The keywords used initially in English were: (nurses OR nursing OR nurs *) AND (family OR families OR relatives) AND (participation OR active involvement OR collaboration) AND (nurs*practice environment OR Work Environment) AND (nurs*attitudes) AND (hospitals). After this, the same keywords and search terms were used in the remaining databases: Scopus; Cochrane Database of Systematic Reviews; LILACS; Scientific Electronic Library Online (SciELO); and the Open Access Scientific Repositories of Portugal (RCAAP). At last, we tried to find new studies, which were identified by searching the bibliographic references of all included articles, following a snowball manual search strategy . Table 1 shows the search strategies used in each database. Similar keywords were used for all the data in the databases.

Eligibility criteria For this study, all quantitative and qualitative studies, mixed studies and literature reviews, master's and doctoral theses and dissertations, opinion articles, books and book chapters were considered.
To carry out the search, the search terms in the title and abstract were considered.
The following inclusion criteria were defined: studies in Portuguese or English, excluding all other languages in order to limit translation errors and make the quality of the interpretation of the content unfeasible given the linguistic limitations of the reviewers; with abstracts or full texts available; no limitation was applied as to the date of publication, allowing this review to capture the accumulation of knowledge produced on the subject to date.
For this review, we adopted an inclusive approach, incorporating all relevant forms of available literature. This included primary research studies that provide original data and systematic reviews that synthesize existing evidence in a comprehensive way. The inclusion of all these sources of evidence was based on seeking a holistic understanding of the topic, allowing us to address the complexity and diversity of perspectives present in the available literature. All studies identified through the search strategy were considered and assessed for their relevance to the objectives of this review and correspond to the PCC mnemonic.

Source of evidence screening and selection Once the search strategy defined for each database has been applied, duplicates will be removed from other articles identified through other sources. Subsequently, the articles of interest in answering the review question will be selected according to the relevance of their title and abstract. Their references and abstracts will be imported into the especific software and grouped according to the database from which they were extracted. In the event of disagreement or uncertainty between the two reviewers about the relevance of a study based on its abstract, the full article will be obtained for further reading. If doubt persists as to whether or not to include the article in the review, a third reviewer should be involved. Once all the articles have been selected by title and abstract, their full versions will be obtained so that the reviewers can independently assess the eligibility of each article in terms of the pre-defined inclusion criteria. Those that do not meet the inclusion criteria will be excluded. The reasons for excluding articles will be described in the scoping review along with the bibliographic reference of the source.
After this process of inclusion and exclusion, the remaining articles will be those to be included in the scoping review. Their bibliographic reference lists will then be analyzed to identify possible additional studies of interest to the topic. The selection of articles from the list of references will be based on the relevance of their title, and they will also go through a process of evaluation as to their eligibility.
The entire process of selection, inclusion and exclusion of studies will be presented in the PRISMA flowchart according to , translated into European Portuguese by Abreu et al. In the event

of disagreement between the reviewers at any stage of the selection process, this will be resolved by discussion between the two or by a third reviewer if the previous discussion is inconclusive.

Data management May be adapted during the data extraction process. In this sense, it will be necessary to carry out a pilot test to assess the ability of this form to capture the appropriate information by reading and extracting at least two or three of the studies selected by two researchers independently, in order to ensure that all relevant results are extracted (Peters et al., 2020). The final data extraction tool will be reviewed by the reviewers in order to eliminate discrepancies, ensuring the consistency of the data included. Any adaptations that may occur in this instrument will be mentioned in the scoping review.
Any discrepancies that may arise at this stage of data extraction will be resolved through discussion between the reviewers or, as a last resort, with the participation of a third reviewer. The authors of the included studies will be contacted if there is a need to clarify data or request additional information.
Given that a scoping review study does not seek to address very specific research questions, nor does it seek to assess the quality of the evidence produced (Arksey & O'Malley, 2005), the methodological quality of the included studies will not be assessed.

Presentation of the results Extracted data will be reviewed, categorized, and synthesized in table and narrative formats in order to answer the review question. These data will be organized in three subsections: (1) Practice Environment Characteristics; (2) Nurses attitudes; (3) Family Participation in Nursing Care (Facilitators; Barriers; Level of involvement; and Care provided). In these three subsections, we will describe the generated analytical themes. This description will be accompanied by citations to illustrate whether they are from the studies' participants or their authors.

Language restriction Studies in Portuguese or English.

Country(ies) involved Portugal.

Keywords Family; Participation; Nursing Care; Surgery; Care Practice Environment; Nurses' attitudes; scoping review protocol.

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