Original Article

Concept Analysis of Family Participation in Hospitalized Patient Care: Using Hybrid Models

Abstract

Background: Family participation in patient care is critical for delivering quality care, and many interventions in the healthcare system have been dedicated to improving this complex process. There is no agreement about what this participation means and how it should be conducted. The current study aims to clarify the concept of family participation in hospitalized patient care. **Materials and Methods:** This study used a hybrid model and a three-step concept analysis. In the theoretical phase, credential databases were searched to retrieve studies published from 1990 to 2022. In the fieldwork phase, semistructured interviews were conducted with six patients, six family members, and five healthcare workers. In the last phase, data from these steps were analyzed using conventional content analysis based on the Graneheim and Lundman approach. **Results:** According to the final analysis, 'family participation in hospitalized patient care' is a centric-process multidimensional phenomenon that includes involvement in comprehensive patient care and healthcare decision-making. This partnership is based on "interactions", "information exchange", "collaboration between families and healthcare teams", and "support from the healthcare system". If it is implemented in a planned and coordinated manner, family participation can lead to positive consequences for the healthcare system and favorable outcomes for hospitalized patients. **Conclusions:** This study provides insights into the concept of family participation as well as its features and factors affecting its correct implementation. Healthcare providers need to boost their knowledge regarding this type of care and improve clinical practice in this area.

Keywords: *Concept analysis, concept formation, family, hospital, nursing, participation, patient care*

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Introduction

Family-Centered Care (FCC) is a model of care provision based on which the family plays an important role in determining a patient's psychological and physical well-being.[1] The FCC model's origin lies in child healthcare and was first discussed as a general concept in the 1950s, boosting awareness that separation of the child from the family could bring about emotional trauma in the hospital setting.[2] This concept introduced a seismic shift in healthcare from patriarchy and paternalism to partnership.[3] The five main components of FCC include collaboration, respect and dignity, participation, information sharing, and decision-making.[4] Family participation as a component of FCC is a complex and dynamic concept and means that family members are allowed to participate in plans, programs, and decisions concerning the physical and psychological care and support of their patients.[5] Family participation plays a critical role in improving the quality of care,[6,7] and enormous efforts have been dedicated to incorporating this concept into the healthcare system.[8] The positive consequences of family participation in patient care include enhancing patient adherence to treatment,[9] better care planning and performance of nurses,[10,11] and receiving useful information and learning new skills for families[12,13]; however, family participation in hospital care faces obstacles and challenges, some of which oppose ideologies about family participation, including the lack of agreement on definitions, methods, and levels of providing clinical care for different stakeholders.[7] Despite the demands of international institutions to increase family participation in patient care, there is no agreement on what this participation means and how it should be done.[6,7] There is little

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information in the literature about how nurses and family members should collaborate in this partnership.[14] Different terms have been suggested to illustrate family participation and the levels of involvement, participation, collaboration, FCC provision, partnership, and contribution of family members, revealing the lack of consensus on the meaning of the family participation concept.[6]

The conceptual ambiguity surrounding the meaning of participation creates problems in facilitating joint cooperation of patients, families, and healthcare providers and challenges in the planning, implementation, and evaluation of family care programs. Another issue is the different understandings of the way and degree of participation expected from patients and families.[7] Research has also highlighted that nurses lack a clear understanding of family-centered nursing interventions.[15] Besides, research on family participation in patient care has been less translated from texts to hospital environments.[16] Family participation in care depends on different factors (cultural, attitudinal, social, religious, and educational)[17] and can vary in various fields.[18] In addition, people's opinions, perceptions, desires, experiences, and different needs regarding collaborative activities may also affect their participation.[19] In Iran, although families commonly participate in patient care, there is scant research on the roles, experiences, and expectations of those involved in this process.[20] On the other hand, there is still no standard guideline in Iran for the participation of family members in the patient care process.[21]

The concept of family participation in hospitalized patient care can be operationalized only when a detailed analysis of this concept and clarification of its dimensions are available. Concept analysis is a valuable method to clarify nursing concepts with a vague meaning despite their extensive applications. The hybrid model, as a concept analysis approach, considers the real experiences of participants in the concept definition.[22] This model combines theoretical analysis with empirical observations,[22] making it possible to emphasize the basic dimensions of the concept, including "family participation in care". In such circumstances, the target concept can be more effectively applied in the health system to enhance the health of patients and their families. Finally, the results of hybrid model analysis can provide a standard measurement tool to measure the level of family participation in hospitalized patient care. Therefore, the present study aimed to clarify the concept of family participation in hospitalized patient care using the hybrid model.

Materials and Methods

The study was conducted in 2022. This study utilized the hybrid model concept analysis introduced by Schwartz-Barkot and Kim (2000) to analyze the concept of "family participation in hospitalized patient care" with a clinical aspect.[22] In comparison with other approaches in this field, the abovementioned model can draw general attitudes and insights into clinical practice.[23] This model includes three phases: theoretical, fieldwork, and analytical phases.[22] Studies are reviewed in the theoretical phase to examine the nature of existing knowledge in the desired field and present a practical definition of the concept for the fieldwork phase. In the fieldwork phase, the empirical data obtained from qualitative studies are used to more comprehensively analyze the concept. This stage overlaps with the first phase in terms of time and emphasizes the experimental component of the process. The literature review started in the first stage and continues at this stage as well. In the third phase, the analytic results obtained in the first phase are combined with the insights from experimental observations, and an analytical approach is applied to refine and provide a clear concept.[22,24] Considering the importance of family participation in hospitalized patient care and the lack of clear definitions, dimensions, and characteristics for this concept in the clinical setting, we selected this concept for analytic exploration.

In the first phase, the keywords and phrases "family, relatives, surrogates, carer, caregivers, family-centered care, involvement, participation, engagement, collaboration, partnership, encouragement, contribution, co-operation, cooperation, patient, and hospitalized patient" were used to review existing knowledge and identify related studies published from 1990 to 2022. A detailed search was conducted in the databases of PubMed, Web of Science, Scopus, CINAHL, EBSCO, Scopus, OVID, Cochrane Library, PsycINFO, Google Scholar, ProQuest, MagIran, IranDoc, SID, Med-lib, and Iran-Medex. Full-text articles published in Farsi or English with related keywords in the title, abstract, and keyword list were included, and studies conducted on neonates and pediatric patients and those admitted to the intensive care unit or emergency department were excluded due to the variable conditions of patients in these wards. The first author completed the selection process for all levels, and other authors assisted with participation in discussions. All authors read eligible papers, and defining attributes were discussed moving back and forth between antecedents, attributes, and consequences until an agreement was reached. The search resulted in 2024 articles, which were reduced to 26 after reviewing and selecting those related to research objectives [Figure 1]. At this stage, data were analyzed utilizing the conventional qualitative content analysis method as described by Graneheim and Lundman.[25]

The next phase was the fieldwork phase. This stage of study was carried out in one of the hospitals of Kermanshah City in the west of Iran in March–September 2022. The data were collected with the participation of hospitalized patients, their families, and caregivers, including nurses and doctors. The research sample population included nurses working in different wards of the hospital who had at least a bachelor's degree and a minimum of 6 months of work experience in providing care for patients. Eligibility criteria for family caregivers included being the main caregiver, being at least 18 years old, and providing care to the patient for at least

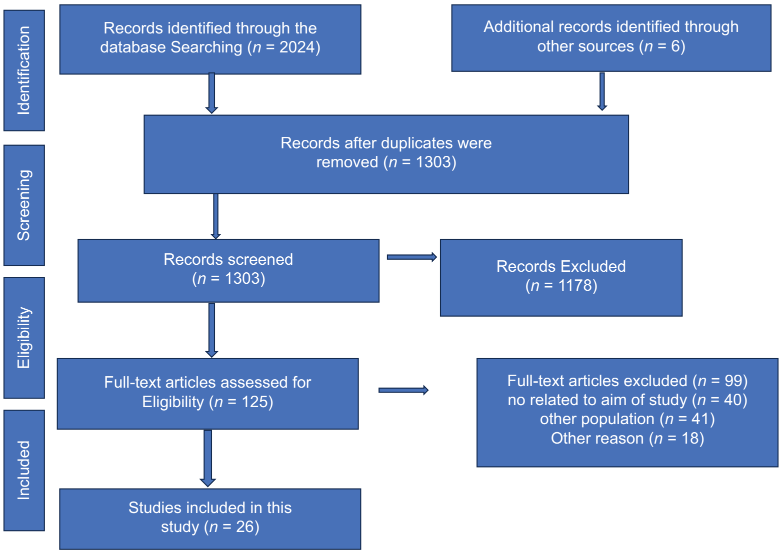

Figure 1: Flow diagram of the present study

2 days (increasing the probability of being involved in care provision). Besides, patients who were at least 18 years old, those hospitalized for a minimum of 2 days, and those who could communicate with others met the criteria for entering the study. Purposeful sampling was conducted in different hospital wards except for the neonatal and pediatric ward, intensive care unit, and emergency department due to the variable conditions of patients admitted to these places. When selecting participants, we tried to recruit a sample population with maximum diversity in terms of gender, marital status, and so on. Semistructured and in-depth face-to-face interviews were conducted, and field notes were taken by one of the researchers until reaching data saturation. Before conducting interviews, the participants and the researcher agreed upon the time and place of the interview. The interviews lasted 45–60 minutes, and all the participants were interviewed only once. In total, five healthcare workers (three nurses and two doctors), six patients (three women and three men), and six family members (one housewife, one husband, one son, one daughter, one sister, and one brother) were interviewed. An interview guide was used to collect information. As an example, the questionnaire included the following questions for family members: What do you do for your patient in the hospital? How do you do this? Is your presence in the hospital necessary?, and if yes, Why?, and What conditions make you unable to take care of your patient in the hospital? The following queries were asked from health care teams (HCTs): Do you allow families to be involved in patient care? How do you achieve this?, and What is the outcome? Follow-up questions and phrases like "Can you explain more?" or "Please express what you mean more clearly" were also used. Before starting the study, participants received necessary explanations regarding research objectives and were ensured about the confidentiality of their information and the fact that the information would only be used for research purposes. After obtaining informed consent and permission for recording, all interviews were recorded, then transcribed, and finally analyzed. Key codes were extracted to form categories and main themes to clarify and specify the concept under the study (saturation). Data analysis was conducted simultaneously with data collection (by FM and MA). Conventional qualitative content analysis was used to analyze the data following Granheim and Lundman criteria.[25] MAXQDA software was used for information management. A total of 1320 initial codes were extracted from the interviews. In order to meet trustworthiness, Lincoln and Guba (1985)[26] proposed four criteria (i.e., credibility, confirmability, dependability, and transferability).

For credibility, maximum diversity in sampling, prolonged engagement with data, triangulation (various data collection methods), and member check (validation of concepts by participants) were considered. For confirmability, we ensured that other experts could review and evaluate our data by accurately recording all stages of the research. Recording and transcribing the interviews and analyzing the data immediately afterward were conducted to achieve data dependability. For transferability, the experiences reported by participants and their characteristics were accurately described. During the final analysis phase, results from the theoretical and fieldwork phases were comparatively analyzed to define an integrated concept.[22]

Ethical considerations

Permission to carry out this study was granted by the head of our department and the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences (IR.USWR.REC.1401.197). Informed consent was taken from all participants for taking part in the research and recording their voices. They were also ensured of information confidentiality, the possibility of withdrawing from the research at any time, and the right to receive the results upon their request.

Results

Theoretical phase

During the theoretical phase, the attributes, antecedents, and consequences of the concept of “family participation in hospitalized patient care” were collected from related studies available in different databases and sources [Table 1].

Attributes

The review of the literature led to the extraction of eight categories and eight subcategories from the attributes of “family participation in hospitalized patient care” as follows:

Involvement in care with two subcategories: Involvement in physical care and Involvement in nonphysical care.

According to various related studies, family participation can be implemented in two dimensions, including “physical care and nonphysical care”. The former includes meeting basic needs, such as bathing, changing clothes, and feeding. The latter can be in the form of presence at the bedside and psychological, emotional, and cognitive support of the patient.[16,23-27] Psychological and emotional support includes reducing stress, encouraging, reducing loneliness, talking to the patient, and providing reassurance. Cognitive support includes communication between the patient and the medical team, keeping the patient informed of his/her situation, and communication between the patient and the outside environment.[20,27]

Involvement in healthcare decision-making

Various studies have shown that the family’s involvement in decision-making is an important dimension of family participation in patient care. Participation has been defined as “being involved in the decision-making process on health-related issues”.[28,29] In the hospital environment, family members demonstrate their willingness to make bigger contributions to care decisions. The family’s involvement in decisions has been a critical concept in the patient–family-centered care approach, which has a positive effect on self-management, disease outcomes, the quality of life of patients and family members, and the rate of rehospitalization.[9,28,29] This is especially important for elderly patients with significant weaknesses and vulnerabilities, making them reluctant to take part in self-care decisions and more inclined to have their families involved in the process,[13,30] requiring family members to become involved in patient care and related decisions.[16,24,25,31,32]

Based on interaction and information exchange with two subcategories: Based on mutual communication and Based on information sharing.

Based on different studies, family participation demands mutual relations and dialog.[31] Communication is the basis of information exchange, cooperation in patient care, and information sharing.[28] In this type of partnership, communication between families and nurses is a principle for sharing knowledge.[32] In the hospital environment, the family and healthcare team share information with each other in a mutual manner with regard to the patient’s health status.[23,24,33,34]

Based on a partnership between the patient, family, and healthcare providers

Given the perceived advantages of family participation in patient care, there has been international emphasis on planning, delivering, and evaluating care by health service providers as “an approach based on mutually beneficial partnership”.[31,35,36] According to healthcare standards, nurses are required to engage with patients and their families to improve healthcare quality[37] and gain valuable knowledge from families who consider themselves as “collaborating partners”.[35] Families can help enhance the patient’s trust and cooperation with the healthcare team, which ultimately nurtures partnerships between formal and informal care providers in acute care settings.[27]

Based on the health care system support with two subcategories: The existence of organizational policies aligned with family participation in care and The support of the health care team for family participation in care.

Family participation in providing care requires the existence of hospital policies concerning the way and level of the family’s involvement in patient care along with providing comprehensive support for healthcare providers regarding the family’s involvement in care. Family participation in patient care requires the support and education of caregivers by health professionals.[16,24,33]

Based on collaboration with the healthcare team

It has been mentioned in various studies that patient comprehensive care requires collaboration between the family and the HCT.[16,23,24,27] Li *et al*.[27] referred to collaboration with healthcare workers as one of the main activities of the patient’s family in the hospital. Nurses’ attitudes toward family participation in care are a strong predictor of this collaboration.[28]

Centric and multidimensional process with two subcategories: Complex process and Multidimensional approach

Various studies have repeatedly pointed out that family participation is a phenomenon that does not happen instantaneously but in the context of a complex and fluctuating process affected by social interactions, including communicating and information sharing, as well as participation in decision-making and patient care.[23,33] This participation, as a multidimensional approach, refers to both visible interactions and the thoughts, desires, and perceptions of the people involved in these activities and interactions.[34]

Table 1: Results of the theoretical, fieldwork, and analytical phases

	Theoretical phase		Fieldwork phase		Analytical phase	
	Category	**Subcategories**	**Category**	**Subcategories**	**Category**	**Subcategories**
Attributes	Involvement in care	- Involvement in physical care - Involvement in nonphysical care	Involvement in comprehensive patient care	- Taking part in Physical care -Taking part in non-physical care	Involvement in comprehensive patient care	- Taking part part in physical care - Taking part part in nonphysical care
	Involvement in Healthcare decision makings		Difficulty accepting family involvement in treatment decisions	-Limited authorities of the family in decision-making	Involvement in Healthcare decision makings	- Authorities of the family in decision-making concerning the care
			-	-Difficult access to healthcare workers to consult about patient treatment		- Family accessibility to the healthcare team for a consultation about patient's care
	Based on interaction and information exchange	-Based on mutual communication -Based on information sharing	Information exchange between the family and HCT	-Giving information from the family to the treatment staff - Giving information from the treatment staff to the family	Based on interaction and Information exchange	- Based on mutual communication - Based on information sharing
	Based on a partnership between the patient, family, and healthcare providers		-		Based on partnership Between patient, family, and healthcare	-
	Based on the health care system support	-The existence of organizational Policies aligned with family participation in care - The support of the health care team for family participation in care	Unsupported participation	-Failure to pay attention to the preparation and awareness of the family about how to care for patients -Not receiving support and care guidance by healthcare professionals during their presence in hospitals - Lack of space and facilities for family Participation -Lack of hospital policies for the presence or participation of the family	Based on healthcare system support	-The existence of organizational policies aligned with family participation in care - The support of the health care team for familyparticipation in care
	Based on collaboration with the health care team		Based on collaboration with nurses		Based on Collaborating with HCTs to provide care	-
	Centric process and multidimensional	- Complex process - Multidimentional Approach	-		Centric process and multidimensional	-
			- Nonagreed and uncoordinated participation in care	-Unclear family roles in hospital care - Unclear boundaries of the family and nurses role in care		-

Contd...

Table 1: Contd...

Theoretical phase		Fieldwork phase		Analytical phase	
Category	Subcategories	Category	Subcategories	Category	Subcategories
				Based on coordination and agreement between family and health care workers	- Clarity of the family role in hospital care - Clarity boundaries of the family and nurses role in care
		Dependence on the attitudes of HCTs regarding family participation in care	- Positive attitude of HCTs toward family Participation - Negative attitudes of HCTs toward family participation	Dependence on the attitudes of HCTs regarding family participation in care	-The positive attitude of HCT -The Negative attitude of HTC

Antecedents

Antecedents of family participation in care included two subcategories: facilitators and barriers.

Facilitators were categorized into six subcategories:

Preferences and attitudes of healthcare workers: Positive attitudes of nurses and HCTs toward family participation in care.[25,35,38,39]

The family's preferences and attitudes: Positive attitudes and willingness of the family to participate in patient care.[36,38]

Establishing communication between family members involved in patient care: the three-way relationship between patients, family members, and nurses;[40] effective interactions between nurses and families;[20,41] good communication among relatives, patients, and nurses;[39] and a friendly and reliable atmosphere for establishing effective interactions between relatives and nurses.[42]

Support, training, and supervision of healthcare staff for family participation: This subcategory covered continuous supervision of family caregivers by nurses,[40] the guidance of staff for family participation,[43] training of family caregivers by nurses,[40,41] emotional and cognitive support, and encouraging the family to participate in care.[36,42]

Characteristics of family members and healthcare staff: Personal characteristics of nurses (especially being human and skilled and having empathy and intimacy), the health status of family members and staff,[36] the willingness of family caregivers to participate in patient care,[43] and the feeling of family power.[44]

Environmental and organizational factors: Shorter home-to-hospital distance, low administrative workload,[36] more flexible visiting hours for participation in care,[31,36] planned and structured care programs,[20] organizational support for family caregivers,[45] adequate health resources such as sufficient staff, and environmental factors such as lack of bureaucracy.[42]

The category of barriers was classified into four subcategories, including factors related to the patient, family, staff, and organization:

Patient-related Factors: Poor health status, lack of interest and unwillingness of the patient to cooperate with the family,[42] poor health literacy of the patient,[44] privacy issues, severity of the disease, and disease-related anxiety.[43]

Family-related Factors: Factors related to the poor health status of the family, reluctance of relatives to participate in patient care, ignorance, lack of recognition of relatives, fear of making mistakes,[42] difficulty in communicating with doctors and obtaining information from them,[44] the family's poor health literacy,[44] family conflicts and problems understanding the care plan,[31] lack of family capacity for care provision, emotional imbalance, and old age or comorbidities of family members.[39]

Health staff-related Factors: Nurses' negative attitudes toward partnership,[39] nurses' negative attitudes toward participation, the need to maintain patient autonomy,[44,46] and using traditional methods for interacting with informal caregivers.[39]

Environmental and Organizational Factors: Fear of contracting an infection, bureaucracy, lack of privacy in the hospital, lack of time, multiple tasks, ineffective communication,[42] and inconsistent care.[41]

Consequences

The consequences of family participation can be directed toward the patient, the family, or the system.

Patient-related consequences: Shorter hospital stay,[24,26,31,38] improvement of adherence to the therapeutic regimen,[28,46] better patient care,[42,44] and lower rate of rehospitalization.[31,46]

Family-related consequences: A reduction in the quality of life of family members,[46] assisting in home care and meeting family expectations,[24] information sharing between family members and HTC,[47] promotion of the family's satisfaction,[27] and receiving the latest medical information regarding the patient's condition.[36]

System-related consequences: Supporting quality nursing care, acquiring valuable knowledge from families, better nursing care planning,[48] assisting HTCs to provide care,[46] saving nurses' time for more essential care,[20] enhancing nursing care quality, accelerating the workflow, boosting nurses' satisfaction, and facilitating closer communication between nurses and families.[35,45,46]

The working definition of the concept

Family participation in patient care is an important and critical element of healthcare provision, in which family members should be provided with the chance to be involved in physical and nonphysical care and decision-making concerning the care. This complex and multidimensional process demands interactions and exchange of information as well as active partnerships between HTCs, patients, and families. Simultaneously, there should be an emphasis on healthcare system support, attitudes, preferences, and individual characteristics of families and HTCs as well as organizational and environmental factors that can lead to positive outcomes for families, patients, and the healthcare system.

Model case: Mr. Sharifi was a 67-year-old man hospitalized in the cardiac care unit with a diagnosis of heart failure. His wife was present at his bedside during hospitalization, performed his basic care, and supported him mentally. During this time, the patient's wife and HTCs interacted, collaborated, and established a partnership in the care process. The wife provided HTCs with patient information and received the information that she needed to know regarding her husband's status. In the hospital, there were policies and procedures regarding the presence and involvement of family members in patient care, and HTCs were obliged to support family participation in patient care and related decisions. Patients and caregivers were both satisfied with the atmosphere of participation in care.

Fieldwork phase results

At this stage, seven categories and 14 subcategories were extracted from the rich and deep explanations provided by the participants [Table 1].

Involvement in comprehensive patient care with two subcategories: Taking part in physical care and Taking part in nonphysical care. In this regard, family member No. 1 said, *"We do a lot of things for patients that nurses don't have time to do. For example, we help them get out of bed, change their clothes, or take their medicines. We are the ones who stay with our patients all the time and talk to them. We would do this and give them the spirit to reduce their stress"*.

Information exchange between the family and HCTs with two subcategories: Giving information from the family to health staff and giving information from health staff to the family: Physician No. 2: *"Many times, families give us very good information about some aspects of their patient's condition, which even patients themselves may fail to provide. That is why we prefer to ask some questions about the patient's medical records from the family. In return, we try to give them the information they want about their patient's illness or health"*.

Based on collaboration with nurses: Family member No. 2: *"In this ward, we collaborate a lot with nurses regarding the condition and care needs of our patients. For example, they asked me to pour betadine when they wanted to change the wound dressing of my mother's leg, or they wanted me to give her medicine"*.

Difficulties in accepting family participation in health-related decision-making with two subcategories: Limited authority of the family in decision-making and difficult access to healthcare workers to consult about decisions: Family member No. 3: *"We would very much like to consult with the doctor about the treatment of our patient, but unfortunately, the doctors do not give us this right, and nurses kick us out of the ward when the doctor comes to visit. In fact, they behave as if we have no right to interfere in decision-making. They give us the right to make decisions only when there is an emergency, for example, our patient needs an operation"*.

Unsupported participation included four subcategories: Failure to pay attention to boost the preparation and awareness of the family about how to care for patients, not receiving support and care guidance by healthcare professionals during hospitalization, lack of space and facilities for family participation, and lack of hospital policies assisting family participation. Family member No. 1: "*During the entire time, I was in the hospital with my patient, no one guided me on how to do my husband's care, and none of the staff monitored me to see if I was doing things right. No one here has the time to guide us. They don't pay attention to us at all"*.

Patient No. 3: *"Unfortunately, there is no place here where families can comfortably spend time with their patients. The space in rooms is very small. No law specifies whether families should be with their patients or not, right?"*

Nonagreed and uncoordinated participation in care enclosed two subcategories: unclear family roles in hospital care, and unclear boundaries for the roles of the family and nurses. Nurse No. 2: *"We don't have any regulations or laws that tell exactly what families should do, but we entrust them with some simple tasks that cause no problems for the patient. Of course, we also ask families to do some activities that they think are not their jobs but ours, such as emptying the patient's urine bag, which families always do for their patients, but sometimes they don't accept doing it"*.

Dependence on the attitudes of HCTs regarding family participation in care included two subcategories: Positive and negative attitudes of HCTs toward family participation. Family member No. 4*: "What we do for our patient depends on the work shift of nurses. For example, in some shifts, nurses don't even allow us to be near our patients. In other shifts, they pay more attention to us, and we can not only easily do the care related to our patients, but they also ask us to do a series of other tasks, such as checking and informing them when our patient's IV solution is emptied".*

Antecedents in the fieldwork phase revealed two categories: facilitators and barriers to family participation. Facilitators were classified under six subcategories.

Preferences and attitudes of HCTs: Nurses' positive attitudes toward family participation in care and doctors' preferences to provide medical information to the family.

Families' preferences and attitudes: Positive attitudes and willingness of family members to participate in the care process and perform their patients' personal tasks.

Establishing a positive relationship: A good relationship between patients and family members and a conversation space between relatives and nurses.

Support and training of staff for family participation: Guidance and staff training for family participation and comprehensive support for family participation in care.

Individual characteristics of family members: Personal characteristics of family members (empathy and intimacy) and the health status of family caregivers.

Environmental and organizational factors: The existence of a hospital policy for supporting family participation and clear task assignments for family caregivers.

The category of barriers was classified into three subcategories, including factors related to the family, healthcare workers, and organizations.

Family-related barriers: Unwillingness to participate in patient care, difficulty in communicating with HCTs and obtaining information from them, and the old age of the family member.

Factors related to HCTs: Negative attitudes of nurses toward family participation and lack of communication between family members and healthcare staff.

Environmental and organizational barriers: Fear of making mistakes when providing care, care inconsistencies and challenges, and lack of clear policies, laws, and hospital guidelines for family participation in care.

Consequences: The consequences of family participation in care were categorized into three subcategories: consequences for patients, families, and the system.

Consequences for the patient: Improvement of patient adherence to therapeutic regimens and a reduction in the patient's stress and anxiety.

Consequences for the family: A reduction in the family's stress, ensuring that the patient will receive appropriate care, and receiving additional information from the doctor concerning the patient's condition.

Consequences for the system: Helping HCTs to provide care, strengthening the nurse–family relationship, and freeing up nurses' time for more essential care activities.

Final analysis

The final analytical phase included comparing the codes and categories extracted during the fieldwork phase with the data provided by the review of literature in the theoretical phase. Finally, the antecedents, consequences, and common attributes of the concept of family participation in hospitalized patient care were identified. At this stage, 10 categories and 12 subcategories were detected [Table 1]. The concept under study was finally defined as follows:

Family participation is a centric, multidimensional, and key element in providing health care, including involvement in patient comprehensive care and the decision-making process. This partnership is based on interactions, information exchange, collaboration, the attitudes and preferences of families, patients, and HTCs, and the support of the healthcare system. If this process is implemented in a planned and coordinated manner, family participation can lead to positive outcomes for patients, families, and the health system.

The framework of "family participation in hospitalized patient care" was created based on the results obtained in the final analytic step [Figure 2].

Discussion

The present research aimed to define the concept of "family participation in hospitalized patient care". The analysis of this concept led to its clarification and showed that this concept included several attributes, antecedents, and consequences. Most findings from the theoretical phase of the current study were in line with those from the fieldwork phase.

Data analysis emerged 10 attributes for the concept of family participation. The first theme mentioned by the participants when defining family participation in care was "involvement in comprehensive patient care" as an important category both in the literature and according to most of our participants. The participants believed that family participation in care should encompass a wide range of physical and emotional care. Meanwhile, various studies have also shown that family participation in care can be viewed from two dimensions, including "physical care and nonphysical care".[20,27,49] In another study, family involvement in care was divided into tangible and intangible types. Tangible activities refer to engaging in direct care, such as hygiene, oral and eye care, and preventive care of pressure ulcers. On the other hand, intangible collaborative activities are related to communication, psychoemotional support, and decision-making.[47]

Involvement in health care decision-making was another important attribute requiring discussion with the family. It has been shown that the effective participation of families in this process helps reduce anxiety in families.[30] It is worth mentioning that some dimensions of family participation in care, including the family's involvement in care-related decision-making, were not completely agreed upon by our participants likely because the involvement of families in making clinical decisions is not common in Iran, highlighting the needs for introducing more clear definitions and guidelines.[20] This finding agrees with those of other studies, declaring a low perception and probability of family participation in decision-making for patients. On one hand, this may be because healthcare professionals have been traditionally responsible for decision-making, and the engagement of families in the decision-making process may be perceived as a strange or scary event in some circumstances.[38]

In the present study, another attribute of family participation in care was Based on collaborating with healthcare teams to provide care, which was also emphasized by the participants. When the patient in the hospital cannot fully participate in the self-care process, family–nurse collaboration seems essential for the valid evaluation of patient care requirements and an effective care plan.[37] According to the study by Pretorius (2019), the family can collaborate with HCTs in a wide range of activities. For example, families and healthcare professionals and leaders collaborate in policy and program development, implementation and evaluation, research, facility design, and professional education, as well as in care delivery.[50]

Another attribute of family participation in providing care was Based on partnership between the patient, family, and healthcare providers. Various studies have emphasized that the development of partnership between the family and the nurse plays an essential role in providing high-quality patient care by families.[51,52] Khalaila (2014) stated that families must be included in all institutional policies and program development and implementation in order to promote this partnership and boost the satisfaction of patients and families.[53]

Dependence on the attitudes of healthcare teams regarding family participation in care was another feature raised by the participants. Families believed that the amount and level of their participation were in close relationship with the attitudes of HTCs regarding family participation in care. The findings of other studies also showed that therapeutic relationships were strengthened and families had an opportunity to participate in patient care if nurses had a positive attitude toward family participation in care[54]; however, nurses with a less positive attitude toward the value of family participation were inclined to demonstrate behaviors interfering with or delaying family participation in the patient care process.[46]

"Based on healthcare system support" was another attribute extracted from the literature review. The participants stated that they did not receive any information and guidance from HTCs about how to care for patients during their hospitalization. Various studies have shown that relatives need to be informed, guided, supported, and encouraged by HTCs to display a real

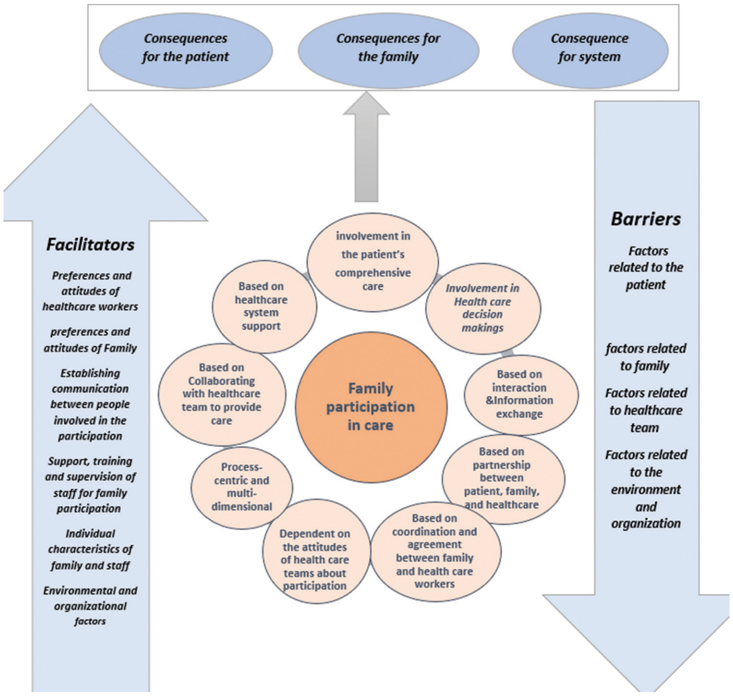

Figure 2: The Proposed conceptual model for family participation in care

inclination to participate in patient care.[48] Adequate material resources, positive attitudes from all stakeholders, and support from nurses are other substantial prerequisites for the success of family participation in patient care.[49]

Another attribute of family participation in care was Based on interaction and Information exchange. Relevant literature has shown that the family plays an essential role in providing HTCs with the required information about patients. Besides, families could be provided with beneficial information about the patient's condition during hospital stay and opportunities to learn new skills to employ at home after patient discharge.[20] In the study of Wong *et al*. (2021),[55] information sharing was observed when nurses updated family members about their patient's treatment process, and family members shared the information they received from the healthcare team with the patient or provided information about the patient to nurses based on their assessment of the situation. In Iran, Yousefi *et al*.[56] found that the most commonly reported family needs were information sharing, reassurance, and proximity. The lack of access to the full text of some articles was a limitation of this study partly because we have limited access to some databases in Iran, so only available data sources were used.

Conclusion

The analysis of the concept of family participation in hospitalized patient care resulted in the clarification of this concept and highlighted a range of relevant attributes, antecedents, and consequences. This study provided insights into the concept of family participation in hospitals and influential factors on its correct implementation. It is also expected to enhance the awareness of HCTs regarding this type of care while also improving clinical practice and motivating service providers and policymakers to focus on the incorporation of this concept into the health system to promote the health of patients and families. Also, an effective tool can be developed for the evaluation of family participation in hospitalized patient care using the dimensions that emerged for this concept in this study. It is necessary to discern the context-based concept of family participation from different cultural and contextual perspectives and propose a general definition. Therefore, more studies are needed to clarify more details of the concept of family participation in the social and cultural settings of Iran's hospitals.

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Conflicts of interest

Nothing to declare.

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