EFFECTS OF FAMILY-CENTERED CARE ON SELF-EFFICACY IN PARTICIPATORY INVOLVEMENT IN CHILD CARE AND SATISFACTION OF MOTHERS IN PICU

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIRMENTS FOR
THE DEGREE OF MASTER OF NURSING SCIENCE
(PEDIATRIC NURSING)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2005

ISBN 974-04-6786-5

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was submitted to the Faculty of Graduated Studies, Mahidol University
For the degree of Master of Nursing Science (Pediatric Nursing)
on
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ACKNOWLEDGEMENTS

I would like to express my deep appreciation to my distinguished committee members who have guided me through this learning process. Firstly, I deeply thank Assist. Prof. Dr. Tassanee Prasopkittikun, the committee chair, who patiently helped me conduct the study step by step from the beginning until the end of the study. Furthermore, she also supported, encouraged, and understood me throughout my study. Secondly, I would like to thank Assoc. Prof. Dr. Kaimook Wichiencharoen for her kindness, invaluable suggestions, constantly encouragement throughout master program. Thirdly, I would like to thank Lt. Col. Assist. Prof. Dusit Staworn for his constructive suggestions that have been very helpful to improve my thesis. My special appreciation was also given to Assoc. Prof. Dr. Fongcum Tilokskulchai and Dr. Tassanee Attharos for their valuable comments and recommendation for this study.

I would like to acknowledge all my experts for their useful comments and valuable suggestion to the instruments. I wish to express my deep appreciation to nursing team and medical team of the PICU at Phramongkutklao Hospital for their great assistance and cooperation during the collection of data as well as of the mothers and families who willing by participated in this study.

Special thank would extend to Nursing Department of Phramongkutklao Hospital for research grant. Also, I would like to thank my cohort of Master's students in academic year 2002 for their kind support, especially Miss Laksana Loycharoen, Miss Benya Julamutcha, and Mrs Dusadee Kaewdirak.

Finally, I am grateful to my mother and my sisters for their concerns, entirely care, and love.

The usefulness of this study, I dedicate to my father.

Supattra Kuntaros

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ABSTRACT

The philosophy and principles of family-centered care can provide a framework for nurses to help families cope with the stress of hospitalization and support them in their care-giving role. This philosophy of care positively influences psychological well-being resulting in satisfaction of families with nursing care. This study with a quasi-experimental design aimed to examine the effects of family-centered care on self-efficacy in participatory involvement in child care and mothers' satisfaction with nursing care. The study subjects included 32 eligible mothers (16 for each group of control and experimental) whose children were admitted to PICU at Phramongkutklao Hospital. The control group received usual nursing care, and the experimental group received the family-centered care approach. T-test was analyzed to compare the mothers' self-efficacy and satisfaction scores between the control and experimental groups.

The results revealed that, at Day 5 after the PICU admission, the mothers' self-efficacy in participatory involvement in child care and satisfaction with nursing care in the experimental group were statistically significantly higher than that in the control group. These two favorable outcomes, increased self-efficacy in care for the ill child and satisfaction, will lead to effective collaborative relationships in working with families. This study provides a guide for implementing a concept of family-centered care in pediatric intensive care units.

KEY WORDS : CHILD CARE / FAMILY-CENTERED CARE / PEDIATRIC INTENSIVE CARE UNIT / SATISFACTION / SELF-EFFICACY

82 P. ISBN 974-04-6786-5

ผลของการดูแลโดยให้ครอบครัวเป็นศูนย์กลางต่อการรับรู้สมรรถนะในการมีส่วนร่วมดูแลบุตรและความพึงพอใจของมารดาในหออภิบาลผู้ป่วยเด็กภาวะวิกฤต (EFFECTS OF FAMILY-CENTERED CARE ON SELF-EFFICACY IN PARTICIPATORY INVOLVEMENT IN CHILD CARE AND SATISFACTION OF MOTHERS IN PICU)

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บทคัดย่อ

ปรัชญาและหลักการของการดูแลโดยให้ครอบครัวเป็นศูนย์กลางเป็นกรอบปฏิบัติการพยาบาลที่ช่วยให้ครอบครัวสามารถจัดการกับความเครียด ตลอดจนสนับสนุนบทบาทของครอบครัวในการดูแลบุตรป่วยเมื่อต้องเข้ารับการรักษาในโรงพยาบาล ซึ่งจะส่งผลในเชิงบวกต่อสภาวะจิตใจของครอบครัวและนำไปสู่ความพึงพอใจต่อการบริการพยาบาลที่ได้รับตามมา การศึกษาครั้งนี้เป็นการวิจัยกึ่งทดลอง มีวัตถุประสงค์เพื่อศึกษาผลของการดูแลโดยให้ครอบครัวเป็นศูนย์กลางต่อการรับรู้สมรรถนะในการมีส่วนร่วมดูแลบุตรและความพึงพอใจต่อบริการพยาบาลของมารดาผู้ป่วยเด็กในหออภิบาลผู้ป่วยเด็กภาวะวิกฤต กลุ่มตัวอย่างเป็นมารดาผู้ป่วยเด็กในหอผู้ป่วย ไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า จำนวน 32 ราย แบ่งเป็นกลุ่มควบคุมและกลุ่มทดลองกลุ่มละ 16 ราย กลุ่มควบคุมได้รับการพยาบาลตามปกติ และกลุ่มทดลองได้รับการพยาบาลตามแนวคิดการดูแลผู้ป่วยเด็กโดยให้ครอบครัวเป็นศูนย์กลาง การวิเคราะห์ข้อมูลใช้สถิติที (t-test) เพื่อเปรียบเทียบคะแนนการรับรู้สมรรถนะของมารดาและคะแนนความพึงพอใจต่อบริการพยาบาลระหว่างกลุ่มทดลองและกลุ่มควบคุม

ผลการวิจัยพบว่า คะแนนการรับรู้สมรรถนะในการมีส่วนร่วมดูแลบุตรและความพึงพอใจต่อบริการพยาบาลของมารดาในกลุ่มทดลองสูงกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติ และผลลัพธ์ที่พึงปรารถนาสองประการคือ การรับรู้สมรรถนะในการดูแลบุตรป่วยและความพึงพอใจที่เพิ่มขึ้นนี้จะนำไปสู่สัมพันธภาพของความร่วมมือที่มีประสิทธิภาพในการทำงานร่วมกับครอบครัว การศึกษาครั้งนี้ได้ให้แนวทางการนำแนวคิดการดูแลโดยให้ครอบครัวเป็นศูนย์กลางมาใช้ในหออภิบาลผู้ป่วยเด็กภาวะวิกฤต

82 หน้า ISBN 974-04-6786-5

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

Family is a unit or system that family members are interconnected, and consequently, events that befall a single member have effects on all family members and family system. Illness of the children, the beloved ones of families unavoidably affects entire families and results in disruption of family structures, family functions, and roles of family members. These alterations can throw a highly organized family system into disequilibrium, especially when the children are admitted to the intensive care unit for a life-threatening illness. It is a crisis event for both the children and their families (Bowden & Greenberg, 2003; Hartshorn, Lamborn, & Noll, 1993; Ross & Cobb, 1990).

When the children are admitted to a pediatric intensive care unit (PICU), the event that mostly caused from sudden illness can be traumatic for the children. The critically ill children may confront with stressful events that impact on their minds, emotions, and feelings, such as being separated from parents or the primary caretakers, being subjected to multiple painful and invasive procedures (Ball & Bindler, 2003). At the same time, families especially parents, considered as the vital environment of the children, are panic-stricken, sad, afraid of loss, and angry as well as stressful and anxious. Sources of stress and anxiety of having a child admitted in a PICU are different; for example, uncertain outcomes from not knowing what to expect, altering in the parental role (being separated from the children), not being the primary decision-makers about the child’s care, feeling unable to protect their child and not knowing how to best help their child (Carter, Miles, Buford, & Hassanein, 1985; Heuer, 1993; Miles, 1989; Miles, Carter, Riddle, Hennessey, & Eberly, 1989). In addition, environmental factors, such as the sound of medical monitors and equipments, procedures relating to the use of needles, endotracheal-tube, and others for the child are some of the most critical stressors for parents (Board & Ryan-Wenger, 2003). Stress and anxiety, the consequences of above sources, make the parents feel loss of control, mistrust, confused, guilty, and denial. They may sometimes react by being on the defensive resulting in discord between them and health care providers. It also brings about strains among family members which of course yield possible loss of cohesiveness among them and a potentially negative impact on adjustment and recovery of the child (Schepp, 1991). That is, traumatic experiences of critical illness not only affect on the child, but also the family.

It is important that provision of care in PICU should focus both on the critically ill child, and on the whole family. Health care personnel play a pivotal role in care for both the children and families to meet their needs in terms of physical, emotional, psychological, and spiritual. A study of the needs of hospitalized children showed that those children want their mothers to stay with them or frequently visit them (Attharos, 2003), and vice versa. Furthermore, parents desire health care personnel to give information about their children, to provide times for them to ask questions and answer questions honestly during visiting period (Scott, 1998). They also wish that health care personnel would allow them to involve in care for their children and would listen to them regarding the observations made to their children and incorporate those observations into the care plan (Ahmann, 1994).

Family-centered care is a philosophy of care that recognizes and respects the vital role of the families in children’s lives concerning special health needs. It is a philosophy that strives to support families in their natural care-giving roles by building upon their unique strengths as individuals and as families. It is a philosophy that views parents and health care personnel as equals in a partnership (Bruce & Ritchie, 1997). When family-centered care is implemented into practice, it has elicited positive feeling from health care personnel and reports of the increase of parents’ and children’s satisfaction (DePompei, Whitford, & Beam, 1994; Gill, 1987; Heller & McKlindon, 1996) resulting in trusting relationship and collaboration between families and health care personnel, as well as the improvement of care. Since families are empowered to involve in the care for their ill children, they experience the feeling of increased confidence, more competence, less dependence on health care personnel, and more control (Ahmann, 1994).

Currently, treatment and nursing care in a PICU is mostly focused on the patients' conditions. There are less information exchange and less interrelation between health care personnel and families than it should be. Moreover, parents' needs are beyond the responsiveness they received from health care personnel, especially nurses (Yapvattanapan, 2000; Vaicheta, 1995). This indicates that nurses can respond to only partial needs of parents; it may be due to patterns of working in intensive care setting (in which quickened care for urgency is required) and regulations of hospital (such as the limits of member of visitors and visiting time). The PICU at Phramongkutklao Hospital has also confronted such situation as well. The PICU has attempted to promote parental participation by providing more time for information exchange, allowing parents to have more time visit and provide closed care to their terminated ill children. Even though, nursing care that families have been received is assured to reach the standard of care by obtaining accreditation from the Institute of Hospital Quality Improvement & Accreditation, such a standard of care have not yet applied concepts of family-centered care.

Therefore, the investigator is interested in applying a nursing intervention based on the concept of family-centered care in the PICU at Phramongkutklao Hospital. The investigator expects that philosophy of family-centered care will enhance the self-efficacy of parents in participatory involvement in child care and increase satisfaction of parents with nursing care, all of which lead to effective collaboration in participatory involvement with health care personnel.

Purpose of the Study

To compare maternal self-efficacy in participatory involvement in child care and satisfaction with nursing care between the control group that received usual nursing care and the experimental group that received family-centered care approach.

Conceptual Framework

Family-centered care is a philosophy of care that recognizes and respects the pivotal role of the family in the lives of children with special health needs. This philosophy strives to support families in their natural care-giving roles by building upon their unique strengths as individuals and as families. It is a philosophy that views parents and professionals as equals in a partnership (Shelton, Jeppson, & Johnson, 1987 cited in Bruce & Ritchie, 1997).

Note that the philosophy of family-centered care is consistent with the concept of empowerment which includes enabling people to recognize their strengths, abilities, and personal power and includes power-sharing, respect for self and others as part of the process (Mason, Backer, Georges, 1991).

Close examination of any number of definitions of family-centered care finds that they include features that are closely aligned with component of framework of effective helpgiving practices by Dunst & Trivette (1996). The foundation of this framework is the adaptation of empowerment perspective which considers helpgiving effective when it provides help receivers opportunities to strengthen and develop their abilities, leading to a sense of control. A content / comparison analysis of the elements of care found in the family-centered care and the individual helpgiving practices described by Dunst & Trivette (1996) as empowering finds considerable overlap in the intent / focus of both sets of feature. Several things can be noted from these two sets of characteristics. It is apparent that to a large degree, family-centered care is a special case of effective helpgiving and effective helpgiving is a special case of an empowerment approach. Thus, the framework of effective helpgiving practices was used as the conceptual framework of this study.

A synthesis of relevant research and clinical practice by Dunst and Trivette indicates that helpgiving consists of three components: technical quality, helpgiver traits / attributions, and help receiver participatory involvement.

Technical quality refers to knowledge, skills, and competence as the consequences of professional training and experience. This expertise can be expressed as part of practicing one's craft.

This study was performed in the PICU at Phramongkutklao Hospital which is accredited by the Institute of Hospital Quality Improvement & Accreditation. This unit is one of the famous settings caring for critically ill children in Thailand. The physicians and nurses who work in the PICU have already been trained to care for critically ill children. They have the knowledge, skills, competence in caring for critically ill children and using technological / modern equipments.

In this study, technical quality was considered as constant component. This component was not manipulated; in other words, both the control and experimental groups were obtained services from the same ward with same quality of care.

Helpgiver traits / attributions refer to characteristics and beliefs of helpgivers who should be responsive to family concerns / priorities, respectful to family individuality, and recognize family diversity, as well as strengths and limits.

In this study, the investigator reflected these characteristics and beliefs through concrete activities predetermined in the experimental intervention that included greeting / talking to families with warm and caring, actively listening to problems / needs / concerns of families, giving correct information, recognizing competencies of families, and supporting families to become capable of dealing effectively with their children and related problems. The communication in these activities was based on Curley's (1988) – Nursing Mutual Participation Model of Care (NMPMC). It was the communication model for pediatric intensive care unit which comprised of questions for the purposes of;

- Establish a caring relationship with the mothers and family
- Assess mother's / family's perception of the child illness
- Determine mother's / family's goal, objectives, and expectations
- Seek informed suggestions and preferences, and invite participation in care

Participatory involvement refers to practices that provide families opportunities to discuss intervention options and the benefits and limitations of different choices, provision of information for making such choices, collaboration, and shared decision making between families and health care personnel, active involvement of families in carrying out decided-upon options, and other efforts to involve help families actively and meaningfully in helping relationships.

In this study, according to the definition as seen above, the investigator would cover three main activities in the family-centered practice. These activities included information sharing, joint decision making, and participating in care activities. The investigator provided the opportunities by encouraging the families to actively involve in 3 activities for their critical ill children.

Expected outcomes of family-centered care approach through effective helpgiving practices framework include the followings:

1. Families are satisfied with nursing care. This satisfaction results from the help characterized by the presence of positive helpgiver traits / attributions. It may also result from technical quality of care as well; however, positive helpgiver traits / attributions are more likely to be associated with the best quality of care (Dunst & Trivette, 1996; Levinson, 1994).
2. Families develop self-efficacy in participatory involvement in care for their children. In the process of empowerment, power is shared (Hegar & Hunzeker, 1988), that is, power is both taken and given. Health personnel considered as the 'powerful' release power by allowing, encouraging, and inviting families considered as the 'powerless' to participatory involve in care for their children. Throughout such process families have opportunities to perform such particular activities as information sharing, joint decision making, and participatory in care activities. Through repeated successful enactment of these activities, self-efficacy is consequently developed (Bandura, 1997a; Gibson, 1995).

In this study, thus, the outcomes of family-centered care approach based on effective helpgiving practices framework include satisfaction with nursing care and self-efficacy in participatory involvement in child care. The components of the framework and its outcomes are shown below.

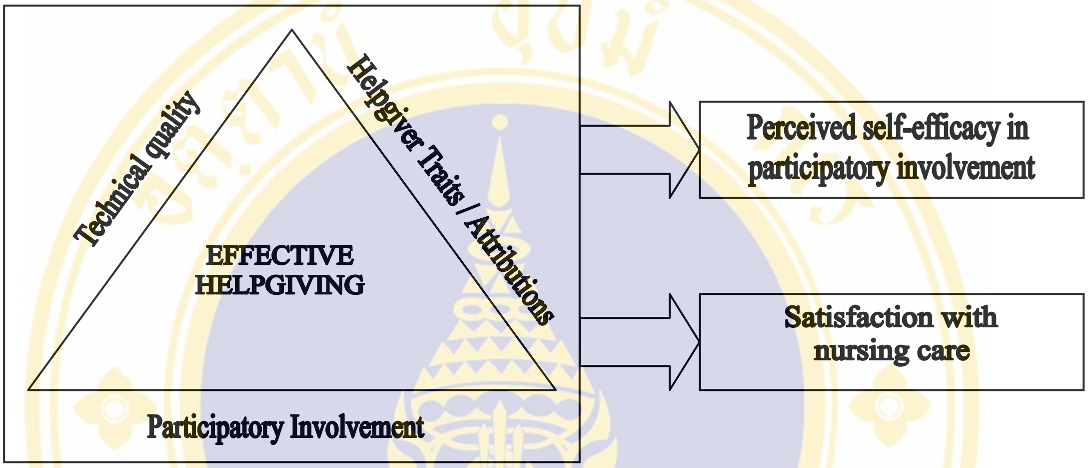

Figure 1 Conceptual framework of the study

Hypotheses

1. Self-efficacy in participatory involvement in child care in the experimental group was higher than that in the control group.
2. Satisfaction with nursing care in the experimental group was higher than that in the control group.

Scope of the Study

This study was a quasi-experimental research aimed to examine the effects of family-centered care on self-efficacy in participatory involvement in child care and mother’s satisfaction with nursing care.

The sample was composed of 50 mothers whose children were hospitalized to the PICU at Phramongkutklao Hospital. Only mothers were focused as the study subjects; however, in the experimental group family member could participated in care activities for the children. Data collection was conducted from May, 2004 to September, 2005.

Definition of Terms

Family-centered care was defined as nursing approach in which the pivotal role of the family was recognized and respected in the lives of ill children admitted to PICU, Phramongkutklao Hospital. In this approach, families and professionals were seen as equals in a partnership committed to the development of optimal quality of care. Families would be supported in information exchange, decision making roles, and participation in care. The nursing approach was guided by a “Handbook of family-centered care in PICU” developed by the investigator.

Self-efficacy in participatory involvement in child care was defined as mother’s judgment or confidence in their ability to participatorily involve in child care at the PICU which included information sharing, joint decision making, and participating in care activities. Self-efficacy in participatory involvement in child care questionnaire developed by the investigator was used for the assessment. In each of 22 statements, mothers were asked to indicate the degree of belief in their ability to perform a designated task on a range from 0 (not confident at all to do) to 100 (certainly confident to do).

Satisfaction with nursing care was defined as the pleasure that the mothers felt with the nursing care provided for their families and children when admitted at the PICU. Satisfaction with nursing care questionnaire developed by the investigator included 20 items with 4-point response scale ranging from 1 (hardly satisfied) to 4 (very satisfied). Total score would range between 20-80.

Expected Outcomes and Benefits

This study was a pilot study aimed to apply family-centered care to the nursing care at the PICU, Phramongkutklao Hospital. The expected outcomes and benefits after completing this study included the followings:

1. The family-centered approach used in this study intervention should serve as a guide for improving the current nursing practice in the PICU, Phramongkutklao Hospital.
2. Health care personnel would gain more knowledge and have positive attitude towards the application of family-centered care in their practice.
3. The practical aspects of the family-centered approach used in this study would initiate a "change" in the current nursing practice in term of the possibility of such positive change.
4. This study would provide a basis to future research focusing on family-centered care for ill children in other settings.

CHAPTER II
LITERATURE REVIEW

The literature review is organized to present and discuss the important and the related studies of the followings:

1. Impact of critical illness on children and their families
2. Needs of critically ill children and their families
3. Family-centered care
4. Research related to family-centered care

Impact of Critical Illness on Children and Their Families

Critical illness is a traumatic experience for both the critically ill children and their families. Unpredicted illness of children can alter family roles and family functions (Ross & Cobb, 1990), including disruption of family lifestyles; for example, parents may take a leave from work to visit or care for their children, or work harder to gain more income when their children were admitted in the hospital. This situation can throw a highly organized family system into disequilibrium. Family members must reorganize in order to successfully regain their equilibrium. If family members cannot well adjust to the alteration, it may lead a family to a crisis situation (Daley, 1984; Trungkasombut, 2001).

Admission to a pediatric intensive care unit (PICU) is one of the most frightening experiences for children. The critically ill children may appear extremely anxious and fearful. The four most significant sources of stress for hospitalized children of all ages are (1) separation from parents or the primary caretaker, (2) loss of self-control, autonomy, and privacy, (3) being subjected to multiple painful and invasive procedures, and (4) being fear of bodily injury and disfigurement (Ball & Bindler, 2003). Such anxiety and fear cause natural responses from the critically ill children by whom the parents are called out for help (Kutchaprugdee in Tungnararutchakit et.al., 2002).

As a family, parents suffered from critical illness of their children as well, because events and behaviors of their children affect their feeling, make them feel uncertainty, and generate many questions. Finally, the parents would have stress and anxiety. The clinical studies and researches revealed that sources of parental stress were diverse besides above sources of stress which were (1) *uncertainty over outcome* from the constant ambiguity of the situation, not knowing what to expect, how life-threatening their children' illness, how and why it happened (LaMontagne & Pawlak, 1990); (2) *environmental factors,* such as seeing the child being injected, having alarming or working sound of monitors and equipments, and seeing the child with inserted endo-tracheal tube (Board & Ryan-Wenger, 2003); (3) *alterations in the parental role* included being separated from the children, not being able to hold, feed, and bathe the children, not being the primary decision-makers about the children's care, feeling unable to protect their children and not knowing how to best help their children (Carter et al., 1985; Heuer, 1993; Miles, 1989; Miles et al., 1989). In addition, The study of Huckabay & Tilem-Kessler (2002) showed that parental anxiety was at 98th percentile-near panic-on the first day of their child's admission to the PICU, decreasing to the 84th percentile-still relatively high-on Day two, three, and four.

The ill children can absorb their parent's stress (Hazinski, 1992). Such stress can negatively affect the critically ill children both physical and socio-emotional. In terms of recovery and individual adjustment of the children (Schepp, 1991). Furthermore, siblings of the critically ill children may derive an impact from parental stress (Panchamedithee, 1993). For example, parents scold or punish the siblings of critically ill children even if the siblings do not do a serious wrong, this phenomenon can cause the worse relationship between parents and well-being children. Moreover, it was found that the well-being children who perceived more changes in their parents' behavior experienced more stress (Curley & Moloney-Harmon, 2001).

From examples above, it can be summarized that stressful experience of critical illness has a profound effect not only on the children, but also on their family member, and family system. It is consistent with family systems theory that describes family as a unified whole, which is created by the interrelations among subunits. The whole family unit is greater than its members, or the sum of its part. When a change occurs in any individual subunit, the whole unit will also be affected (Von Bertalanfy, 1968 cited in Trungkasombut, 2001). Therefore, it is important that care should be focused not only on the critically ill children, but also on the whole family. It is necessary to view critically ill children both as an individual and as a member of a family unit. A comprehensive assessment of the family is essential to develop an individualized care plan for the children and the parents, and to continue on the family's involvement in nursing care. Health care personnel must concern needs and expectations of the children and families so that their met needs will be properly responded in the care delivery.

Needs of Critically Ill Children and Their Families

When critically ill children are admitted to the a PICU – a place that they are not familiar with, then they would like to have their families to stay close to them, because a sense of psychological safety is best achieved by the presence of parents (Ball & Bindler, 2003). Staying with parents is basic necessity for all children because they will obtain essential responses. Supported by the study of Attharos (2003), it was found that the hospitalized children wanted to have their mothers to stay with them or frequently visit them. They also needed moral support from their mothers, especially when they were in pain or felt uncomfortable. When their mothers were not with them, the children would like a nurse to frequently visit them and played with them. Furthermore, the children need tender communication from nurses.

In regard to the families of critically ill children, the previous studies indicated that child-related information was identified as the first prioritized need of the parents. Parents wanted health care personnel to give information about their child at least once a day, allowing times for them to ask questions, and answering questions honestly. Needed information included the prognosis, how the child was being medically treated, what was exactly done for the child whether their child was being treated for pain relief and whether she/he felt comfortable, whether their unconscious child may still be able to hear them, and the regulation of the unit such as visiting time (Fisher, 1994; Scott, 1998).

In addition to taking and giving the needed information, parents want to be assured that the best care is provided for their child. Also, they wish to be able to visit their child at any time, and be informed at home about their child's condition changes, and have the feeling of hope (Scott, 1998). McNeil's (1992 cited in Ahmann, 1994) longitudinal exploratory study in a neonatal intensive care unit revealed that parents desired to be seen as the constant in child's life and needed more collaboration and communication. Themes raised by mothers in his study included the following: a desire to be asked by nurses about what the mothers would like to do for the child, a desire to be taught about the meaning of their child's behavior, and a wish that professional would listen to parental observation regarding their child and incorporate those observations into the care plan.

The study of Neill (1996a) found that parents wanted to be involved in giving the basic care to their child, and they believed that it was beneficial for their child. In addition, parents wanted to be able to negotiate with health care personnel, to establish their own roles, and thereby had some control over the extent of their involvement. Parents wanted to involve in all discussion concerning their child as a means of providing them with information about their child's illness and treatment. Negotiation and discussion would be considerably easier for parents if the nursing and medical staff initiate the process (Neill, 1996b).

In summary, while the critically ill children are admitted to a PICU, they want to have their parents stay with them or frequently visit them. They also need moral support from their parents, especially when they are in pain or felt unwell. At the same time, parents want to visit their child at any time, and desire to have their own expertise recognized and accepted by health care personnel. They wish health care personnel to accept and listen to their opinions or making decision, including asking for a favor from them. Moreover, families want health care personnel to adequately/suitably communicate with them, to give useful and understandable information about their child, and to allow them to participate in child's care. To meet above needs of critically ill children and their families, family-centered care is an imperative approach as it recognizes that the family is central in a child's life and should be central in the child's plan of care.

Family-Centered Care

The Association for the Care of Children's Health or ACCH (Shelton, Jeppson, & Johnson, 1987 cited in Bruce & Ritchie, 1997) defines family-centered care as a philosophy of care that recognizes and respects the pivotal role of the family in the lives of children with special health needs. It is a philosophy that strives to support families in their natural care-giving roles by building upon their unique strengths as individuals and as families. It is a philosophy that views parents and professionals as equals in a partnership. Newton (2000) emphasizes that professional becomes the consultant, and provider of education, support, and assistance to the empowered family. In addition, Ahmann (1994) states that parent-professional collaboration is vital factor for effectively occurring of delivery of family-centered care; thus, developing collaborative parent-professional relationship is important. Ahmann (1994) characterizes following features of collaborative relationships.

Communication: including complete and unbiased sharing of information with parents about their child's care.

Dialogue: an exchanging of information, and a sharing of reactions and ideas.

Active listening: a listening beyond the words to hear and understand concerns, including checking to be certain that interpretations are correct.

Awareness and acceptance of differences: a willingness to exam one's own cultural biases and to accept that others may think and act out of different value systems.

Negotiation: the process of examining different options, priorities, and preferences to best meet the needs of the child and family.

According to the above features, nursing strategy that supports family-centered care is to create the relationship in order to obtain opportunity and collaboration in information sharing, joint decision making, and participating in care activities.

In addition, ACCH identifies eight following elements of family-centered care (Shelton, Jeppson, & Johnson, 1987 cited in Bruce & Ritchie, 1997):

1. Recognizing that the family is the constant in a child's life, whereas service systems and personnel within those systems are fluctuated.
2. Facilitating parent-professional collaboration at all levels of health care.
3. Recognizing family strengths and individuality; and respecting different methods of coping.
4. Sharing unbiased and complete information about their child's care with parents on an ongoing basis in an appropriate and supportive manner.
5. Encouraging and facilitating parent-to-parent support.
6. Understanding and incorporating the developmental needs of infants, children, adolescents, and their families into health care system.
7. Implementing appropriate policies and programs that are comprehensive and providing emotional and financial support to meet the needs of families.
8. Assuring that the design of the health care delivery system is flexible, accessible, and responsive to family needs.

Based on the eight elements above, it can be concluded that family-centered care has the following core concepts (Cincinnati children's hospital medical center, 2003; Johnson, 2003).

1. *Family strengths*: encouraging and facilitating families to participate in their child's care that builds on each family strengths and resources which are different.
2. *Respect*: respect for each family's values, beliefs, religious and cultural background, knowledge concerning their child and acknowledge their authority as decision-makers.
3. *Choice*: providing necessary and sufficient information regarding the treatment so that family can have make-sense choices and then supporting the choice they choose.
4. *Information sharing*: providing medical information to family and valuing personal information regarding their child given by family.

5. *Support*: supporting family's decision, offering comfort as they cope with the child's illness, recognizing the social development and emotional needs of the child, and encouraging family members' confidence in their ability to care for their child.

6. *Flexibility*: being flexible so that the needs and preferences of all families can be met.

7. *Collaboration*: working together with family as collaborators for the best benefit of the child.

8. *Empowerment*: helping family become more competent in care for the child by building on family's strengths rather than correcting weaknesses.

Parents and health care professional as equal in a partnership in child's care lead to the following benefits for all patients, families, and health care personnel (Johnson, 2003):

1. create the positive results for the ill children both clinical and developmental outcomes.
2. guide for indicating policy which realized the response to children's and family's desires as the first priority.
3. make the best use of limited resources wisely.
4. enhance a patient's and family's satisfaction and staff's satisfaction.
5. create a more supportive work atmosphere that encourages more recruitment and retention of staff.
6. create more effective learning environments for health care professional.

Research Related to Family-Centered Care

Family-centered care holds promise for improving the quality of nursing care. Although family-centered care has received substantial recognition as a satisfying and useful experience for children and their families as well as health personnel, this approach has not found its rightful place in health care personnel and settings. That is why the literature is barren of reports that identify the influencing factors, practice models, and the consequences in shifting the orientation of nursing practice toward a family-centered model. Only some core concepts of family-centered care were focused in the previous studies. Moreover, most of those studies were not built on the framework of family-centered care but on the other of which some components overlap with the first framework.

However, the previous nursing studies closely related to the family-centered care are reviewed and discussed as follows:

Curley (1988) studied the effects of parent-professional collaboration based on the nursing mutual participation model of care (NMPMC) on parental stress in the pediatric intensive care unit. Thirty-three parents, having a child admitted to a PICU for the first time, participated in the study, and were divided into two groups, control and experimental. The experimental group was approached using the communication model of the NMPMC, which included four steps as follows: (1) establishing a caring relationship, (2) ascertaining parental goal, objective, and expectations, recognizing their importance in their ill child's recovery, (3) assessing family's perception of the child's illness and beliefs and attitudes toward health. The nurse builds trust by clarifying any misconceptions and providing primary information concerning independent nursing activities, (4) eliciting the parent's informed suggestions and preferences, negotiating any disagreements concerning interventions, and inviting parental participation in nurturing care. The dependent measure was the Parental Stress Scale: Pediatric Intensive Care Unit administered within 24 to 48 hours of PICU admission, every 48 hours thereafter, and 24 hours after PICU discharge. The results indicated that the NMPMC was helpful in alleviating parental stress, specifically the stress related to the interruption in the parent-child relation, in the PICU setting. In the present study, the investigator used the NMPMC as well. Even though the dependent measures of the present study was not parental stress but mother's self-efficacy in care for the child and satisfaction, Curley's study supports the logic that the less-stress the more self-efficacy and satisfaction.

Prasert (1997) studied the effects of application of theory of goal attainment on parents' anxiety in pediatric intensive care unit (PICU). King's theory of goal attainment and model of parental stress in PICU of Miles & Carter were used together to guide the study. Eighty-six subjects were fathers and/or mothers whose child was admitted to PICU. Subjects were purposively assigned into control and experimental group. Each group consisted of at least 20 fathers and 20 mothers. The intervention which provided for experimental group was an application of theory of goal attainment that included establishment of relationship by talking, information sharing, goal setting, finding method or problem solving, implementation according to selection, and evaluation, in addition to the routine care that control group received. The result of the study indicated that both the mothers and the fathers in the experimental group had a significantly lower anxiety than that in the control group.

Lojanawongsagorn (1998) studied the effects of information provided to mothers of premature infants on levels of maternal stress and mother-infant attachment. Model of parental stress in NICU developed by Miles (1983) was used to guide the study. The sample consisted of 40 mothers of premature infants who were admitted in a neonatal intensive care unit (NICU). They were selected by purposive sample technique and were randomly assigned into control and experimental group. Each group consisted of 20 subjects. The experimental group received the structured information about premature infants in the NICU from the researcher before visiting their infants structured, while the control group received the routine care. The results of the study were that mothers in the experimental group had significantly lower score of stress and higher score of mother-infant attachment than that in the control group.

Silprasert (1999) studied the effects of supportive educative nursing system on parents' coping and anxiety in neonatal intensive care unit (NICU). Orem's general nursing theory and Lazarus and Folkman's stress theory were used to guide the study. The purposive sample was composed of 60 parents whose children were admitted to NICU. Subjects were purposively assigned into control and experimental groups with 30 subjects in each group. Both groups received usual nursing care, but the experimental group also received the supportive educative nursing system program that included teaching, guidance, support, and established environment for promoting effective coping of parents according to provided nursing intervention. The findings showed that the mean scores of the total coping and the emotive coping were significantly higher in the experimental group than that in the control group. In addition, the mean score of anxiety in the experimental group was significantly lower than that in the control group.

Thammachart, Romyasirithai, Detkasem, Aswinnanonh (1999) studied the effects of parent participation on mother's anxiety, coping and satisfaction on nursing service. The purposive sample was composed of 47 mothers whose children were admitted to pediatric surgical ward. Subjects were purposively assigned into control and experimental group, 24 and 23 subjects respectively. The experimental group received supportive-education nursing that consisted of giving information about disease, treatment, and child care during hospitalization, and allowing mother to provide care for the child, while the control group received routine nursing care. The results showed that the experimental group had significantly lower anxiety compared to the control group. Total coping and confrontive coping in the experimental group were also significantly lower than that in the control group. However, mother's satisfaction on nursing service of both groups was not different.

Thechaverakarn (2001) studied the effects of family-centered care based on King's theory on nursing service provided for newborns. Subjects consisted of primary caregivers and professional nurses were purposively assigned into two groups: (1) professional nurses divided into control and experimental groups with 8 subjects in each group, (2) caregivers of newborns in NICU divided into control and experimental group with 30 subjects in each group. The control groups of both types of subjects followed their routine approach and care received. Before the start of the experiment, professional nurses in the experimental group were educated about philosophy of family-centered care. Then professional nurses applied family-centered approach with caregivers in the experimental group. Approach of family-centered care included giving information, staying with ill child, participating in child care, giving morale and expressing one's feelings. Then, the researcher assessed perceptions of caregivers towards family-centered care they received. The finding revealed that family-centered care did occur in the existing reality as perceived by the caregivers in the experimental group and such perceptions were more predominant compared to that in the control group. In Thechaverakarn's study, it seems that she rather tested the effectiveness of the nurses' education program relevant to family-centered care, that is, whether nursing approach based on family-centered care existed after nurse were educated and encouraged to implement.

Puntanit (2002) studied the effects of psychosocial care on anxiety of mothers whose children being hospitalized in a pediatric intensive care unit (PICU). The stress, appraisal and coping theory of Lazalus & Folkman was used as a framework for this study. Forty mothers were selected by purposive sampling, and divided into two groups. The experimental group received the psychosocial care focused on relationship establishment between nurses and mothers, encouragement, touch, and provision of information, while the control group received the usual nursing care. The finding of this study showed that the mothers who received the psychosocial care had significantly lower anxiety than their counterparts.

Through action research design, Attharos (2003) developed a model of family-centered care for children with cancer in pediatric cancer unit. The participants included 26 staff nurses, 41 children admitted in a pediatric cancer unit, and 45 family members. Data were collected and analyzed by interviewing the participants, conducting focus group, and directly observing the participants. Family-centered care model was developed through three cycles, each of which included planning, action and observation, refection, and re-planning. The first cycle was to promote mutual understanding of the model. The second cycle was to establish an individual practice by apply the model. In the third cycle, the ward would be committed to practice this model together as a team. The core components to initiate family-centered care included a caring and empathetic relationship, mutual learning, partnership, and enhancing strength. The process of care involves three phases: initiation of family-centered care, mutual care, and care directed by family. Nurse's roles, family roles, as well as children's roles in each phase were described. Related factors consisted of hospital policy, setting, knowledge and attitude of the nurse, the child's stage of development, the stage of the illness, severity of the child's illness, and the family's coping. Output of care included a provision of nursing care that became family-centered, increased self-esteem and professional autonomy, the child's happiness, unbiased and sincere communication, increased confidence in care and satisfaction. Attharos's study is the first study in Thai literature attempting to develop the family-centered care model that fits Thai context. However, the model has not been confirmed for its applicability.

As has been previous stated, most of the above related studies were not fully based on the framework of family-centered care. Only some concepts or components in those studies partially agreed with the core concepts of family-centered care. Moreover, the outcomes of interest in those studies were emphasized on decreased stress and anxiety. In fact, the outcomes of family-centered care extend beyond the decrease stress and anxiety to self-efficacy and satisfaction (Attharos, 2003; Budreau & Chase, 1994; Coyne, 1994, 1995; Hutchifield, 1999; Moynihan, 1995).

Even though there is no previous research explicitly indicating that self-efficacy and satisfaction are the outcomes of family-centered care, concept analysis papers regarding family-centered care (Hutchifield, 1999), parent participation (Coyne, 1994, 1995), and empowerment (Gibson, 1991, 1995; Rodwell, 1996) have logically demonstrated that these two outcomes are the consequences of such approach. The scant research in this area confirms that an empirical study is needed. This present study would pilot the promise of the implementation of family-centered care.

In summary, literature review of family-centered care indicated that a few studies regarding family-centered practice that covered significant core concepts of philosophy of family-centered care, have been found. Therefore, the researcher was interested in applying philosophy of family-centered care based on Effective Helpgiving Practice (Dunst & Trivette, 1996) in nursing practice at PICU, Phramongkutklao Hospital. This pilot study was the attempt to bring an empirical evidence that family-centered care can be realistic in nursing practice and yields favorable outcomes.

CHAPTER III

METHODOLOGY

Research Design

A quasi–experimental design was used in this study to examine the effects of family-centered care on self-efficacy in participatory involvement in child care and mother's satisfaction in PICU.

Population and Sampling

This study was conducted in the pediatric intensive care unit (PICU) at Phramongkutklao Hospital. The sample included mothers whose children were admitted to the PICU.

Inclusion criteria

Eligible mothers included mother who met the following criteria:

1. Having a child admitted in the PICU within 24 hours.
2. Able to read and write Thai.
3. Willing to participate in this study.

Exclusion criteria

The mothers who faced the following situations would be excluded from the study:

1. The mothers in the experimental group were not able to participate in the experimental activities continuously for 4 days.
2. The children in both study groups passed away or were discharged from the PICU before the completion of the experiment.

In accordance with the “Central Limit Theorem”, sample mean has normal distribution when the sample size is closed to 25 cases (Mendenhall & Beaver, 1994). Initially, thus, 25 mothers were required for each of the control and experimental group. However, during the period of data collection many patients in the PICU were under sedation. As a result, some activities in the experimental intervention could not be performed. Finally, within a limited time frame for data collection, only 16 mother-child dyads were involved in each of the study group.

Due to previous studies indicating that maternal education was associated with perceived self-efficacy in child care (Sumranchaithum, 1998; Danchai, 1997; Koafai, 1998; Chotivithayatharakorn, 2000), thus, eligible mothers in both control and experimental groups were matched with their years of education. To ease the matching the years of education were classified as 1-6, 7-9, 10-12, 13-15, 16 and more years.

Setting

The study was conducted in the pediatric intensive care unit (PICU) at Phramongkutklao Hospital. There were 5 beds in the PICU, all of which were occupied by patients from birth to fifteen years.

Upon the admission, nurses usually provided necessary information about patient's condition, visiting time, and some hospital regulations. At least once during the admission of patients in the PICU, a physician discussed with their parents and family regarding patients' conditions and medical treatment.

Visiting time was between 12.00 - 13.00 and 18.00 - 19.00. With few exceptions, parents of severely ill children could take more time for their visit. During a visit, parents were allowed to take part in some easy care like changing clothes and feeding, for example.

In the PICU, medical team consisted of a pediatric intensivist, 3 pediatric house staff and 1-2 externs (6th year medical students). In each 8-hour shift, there were 2 registered nurses, a nurse assistant, and a nurse aid. The nurse and patient ratio was 1: 2-3.

Instruments

1. Instruments used in data collection (See Appendix A)

1.1 *A data record form* included 2 parts:

1.1.1 Mother's information: age, education level, occupation, average family income, marital status, number of living children, and an experience of having a child admitted in the PICU.

1.1.2 Patient's information: age, diagnosis, birth order, date of admission in the PICU, and use of respirator.

1.2 *Self - efficacy in participatory involvement in child care* questionnaire was developed by the investigator. The scale development was based on Bandura's (1997b) guide for constructing self-efficacy scale. The questionnaire consisted of 22 items, divided into 3 dimensions:

1.2.1 Information sharing – developed by reviewing the related literature and composed of 8 items (item 1 - 8).

1.2.2 Joint decision making – developed by reviewing the related literature and composed of 3 items (item 9-11).

1.2.3 Participating in care activities – developed by brain-storming of the investigator and the registered nurses who work in the PICU at Pramongkutklao Hospital. The conclusion came up with seven aspects of care activity for mother's participatory involvement in child care including;

- Feeding: milk, food, and medicine (oral or tube feeding)
- Cleaning (included clothing, diaper changes, and other personal hygiene) and recording urine output and bowel movement
- Positioning
- Giving comfort and encouragement
- Showing love and tender care (e.g. holding, embracing, kissing, touching)
- Promoting development (talking, singing, reading, telling stories, and playing)
- Helping nurse as requested

Then the investigator developed question items based on these aspects of care. There were 12 items (item12-22). The responding scale ranged from *not confident at all to do* (0) to *certainly confident to do* (100). Total scores would be divided by total items giving average scores to be used in the analysis. The higher percentages of confidence, the higher perceived self-efficacy in participatory involvement in child care.

1.3 *Satisfaction with nursing care* questionnaire was developed by the investigator. Reviewing the related literature was performed to develop the item questions. The items covered the satisfaction of mothers about nurses' personality and performance in providing nursing care. There were 20 items with 4-point rating scale ranging from *hardly satisfied* (1) to *very satisfied* (4). The higher scores, the higher level of satisfaction.

Validity and reliability

Self-efficacy in participatory involvement in child care questionnaire and *Satisfaction with nursing care questionnaire* were content validated by 3 pediatric nurse instructors and a head nurse from the PICU (See Appendix C). The investigator revised the questionnaire based on the comments and suggestions from the validators.

Reliability of the questionnaires was tested with 15 mothers whose children were admitted in the PICU. Using Cronbach's alpha coefficient, the reliability of each questionnaire was as follows:

1. *Self - efficacy in participatory involvement in child care questionnaire,* $\propto = .75$
2. *Satisfaction with nursing care questionnaire,* $\propto = .97$

2. Instruments used in the intervention

Handbook of family-centered in PICU (See Appendix B) was developed by the investigator that used as a guideline for the investigator to provide nursing activities for the mothers in the experimental group.

This hand book guided the investigator how to

Implement nursing activities which covered three main aspects of information sharing, joint decision making, and participating in care activities. The communication in these activities was based on Curley's (1988) – Nursing Mutual Participation Model of Care (NMPMC). It was the communication model for pediatric intensive care unit which comprised of questions for the purposes of;

- Establish a caring relationship with the mothers and family
- Assess mother's / family's perception of the child illness
- Determine mother's / family's goal, objectives, and expectations
- Seek informed suggestions and preferences, and invite participation in care

Also, inside the handbook, family assessment tools were included. All data obtained were used for helping the investigator to understand more about patient's family and used as references during conversation and discussion with the mothers and families. These information would help the investigator be able to seek their needs and problems and be more responsive.

Validity of the instruments used in the intervention

The content validity of *handbook of family-centered care in PICU* was performed by 3 pediatric nurse instructors and a head nurse from PICU (See Appendix C).

Then, the refinement of the instruments was performed based on the validators' suggestions.

Data Collection

Upon the approval the committee on the Human Right Relating to Human Experimentation at Phramongkutklao Hospital (See appendix D), the investigator met the head nurse and the chief pediatrician of the PICU to explain the study procedures and ask for cooperation from medical and nurse staff in the PICU. Then the data collection procedures were initiated as follows (See Figure 2):

The control group

1. On the first day of the admission, the patients' mothers who met the study criteria were approached by the investigator regarding participation in the study. Each mother was informed about the study, confidentiality of their responses and the right to refuse to participate in or to withdraw from the study. Mothers who agree to participate in the study signed a consent form (See Appendix E).

Then the investigator interviewed the mothers using a data record form. Then, the mothers were asked to complete a questionnaire, "the self-efficacy in participatory involvement in child care" by themselves.

2. During Day 1-4, the mothers and families received routine nursing care.

3. On the fifth day of the admission, the mothers were asked to complete the previous self-efficacy in participatory involvement in child care questionnaire again and also the other one, "the satisfaction with nursing care"

Each time all of the questionnaires were put into a prepared box by the mothers themselves after the completion to assure the confidentiality of the responses.

The experimental group

The experimental intervention required that the mother and family would be allowed to visit their children at anytime and as long as they wanted. Moreover, the mother would also be allowed to involve in child care much more than the control group did. All of these activities were different from the routine practice and, thus, much cooperation from the staff nurses was needed. Then, before the start of data collection, the investigator and the thesis major advisor arranged a meeting with all staff nurses. The philosophy of family-centered care and the study objective and procedures were explained to the staff nurses. Any concerns, questions, limitations, and ideas were discussed to find out the practical way to implement the experimental intervention. After clarification and discussion, the staff nurses agreed to change some routinely practice/ regulations in order to facilitate the study.

1. On the first day of the admission, the patients' mothers who met the study criteria were approached by the investigator regarding participation in the study. Each mother was informed about the study, confidentiality of their responses and the right to refuse to participate in or to withdraw from the study. Mothers who agree to participate in the study signed a consent form (See Appendix E).

Then the investigator interviewed the mothers using a data record form. Then, the mothers were asked to complete a questionnaire, "the self-efficacy in participatory involvement in child care" by themselves.

The experimental intervention using family-centered care approach was provided for 4 days as follows:

Day 1

1. Provided information to the mother and family about the child's condition, PICU environment, and health care personnel.

2. Accompanied the mother and family to bed-side visit, informed about medical equipments used with the child, and answered questions.

3. Encouraged the mother and family to provide mental and emotional support by touching, talking to, and hugging the child.

4. Encouraged the mother and family to share information and ideas that might be useful for health care team in care provision to the child.

5. After the visit, requested some information from the mothers by using the forms FCC 1 – General information, FCC 2 – Family structure, FCC 3 – Family network (Family ecomap), and FCC 4 – Family function (Family APGAR).

6. Made an appointment for the next day visit.

Total time spent for Day 1 activities was about 1 hour and 30 minutes.

Day 2-4

1. Assessed the mother's (and family's) perception of the child's illness and expectation towards nursing services, in the meantime clarified or corrected any misperception.

2. Provided and updated information about the child's condition, medical treatment, nursing care, and provided a chance for the mother and family to ask questions.

3. Encouraged the mother and family to share their concerns, needs, and ideas; and provided a chance to discuss, negotiate, and make joint decision with nurses and physicians.

4. Encouraged the mother and family to participate in child care activities by teaching, demonstrating, coaching, and allowing them to provide care to the child by themselves. The child care activities included the following:

- Feeding: milk, food, and medicine (oral or tube feeding)
- Cleaning (included clothing, diaper changes, and other personal hygiene) and recording urine output and bowel movement
- Positioning
- Giving comfort and encouragement
- Showing love and tender care (e.g. holding, embracing or kissing, touching)
- Promoting development (talking, singing, reading, telling stories, and playing)
- Helping nurse as requested

Day 5

On the fifth day of the admission, the mothers were asked to complete the previous self-efficacy in participatory involvement in child care questionnaire again and also the other one, "the satisfaction with nursing care"

Each time all of the questionnaires were put into a prepared box by the mothers themselves after the completion to assure the confidentiality of the responses.

In case that the child was transfer to another unit on day 5, the investigator would follow to collect data from the mothers and asked the mother to return the questionnaire at the PICU by putting in the prepared box.

Upon the completion of the intervention implement (Day 1-4), if the child were still admitted in the PICU, the mother and family continued receiving chances to participatory involvement in care. However, the mother and family would be informed that the investigator would not closely approach the mother and family as usual.

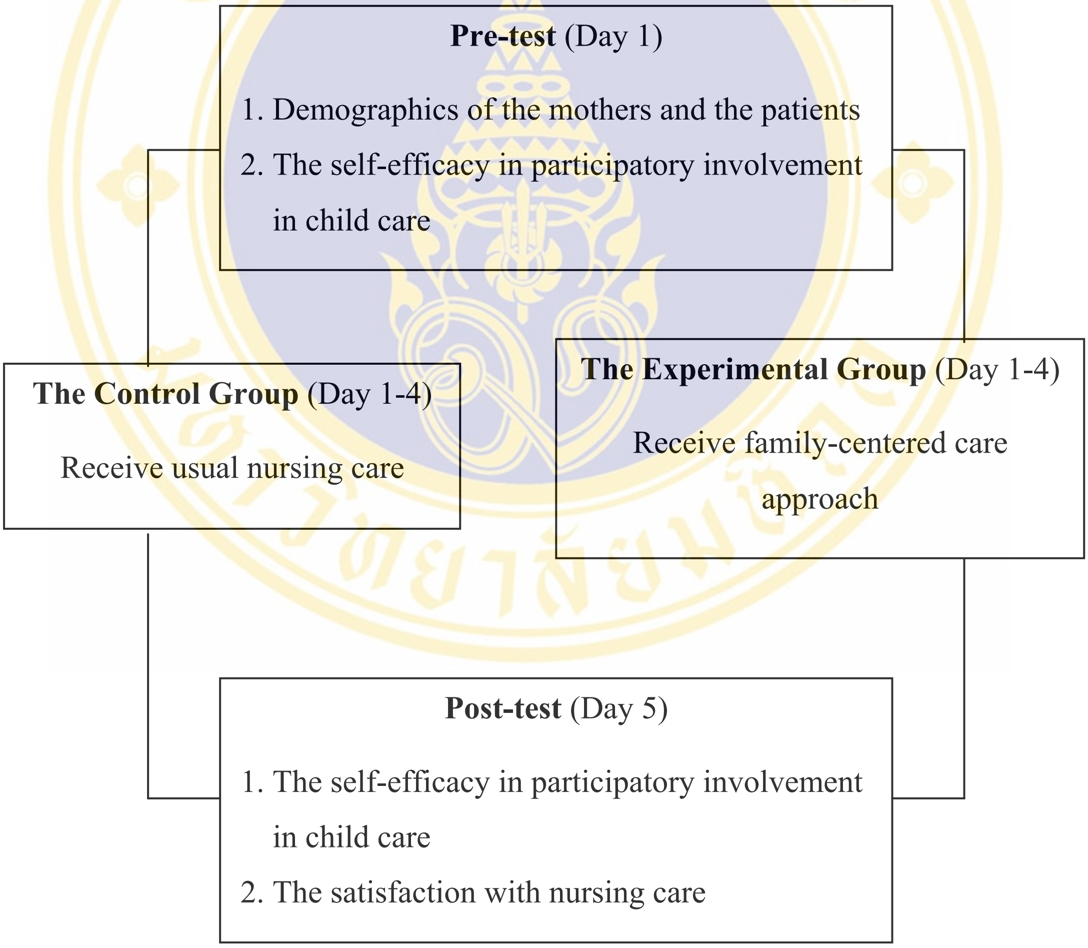

Figure 2 Milestones of data collection and intervention implementation

Protection of Human Subjects

Approval for involvement of human subjects was obtained from the Committee on Human Right Relating to Human Experimentation at Phramongkutklao Hospital. The researcher completely explained the purposes, process of the study, and the protection of their human rights on participating in this study to all participants. The informed consent was signed to ensure that the mothers participated in the study on a voluntary basis. The mothers were also assured that all of the responses would be strictly confidential, that their identity would not be revealed, and that their answer, particularly the satisfaction with nursing care questionnaire couldn't be linked to any respondents. In addition, they were confirmed that they had the right to participate in and the right to withdraw from this study at any time, and their decisions would not affect the medical treatment or the care given for their children.

Data Analysis

1. Descriptive statistics were used to present general characteristics of the mothers, the ill children in both control and experimental groups.

2. ANCOVA was applied to analyze the differences of post-test scores on self-efficacy in participatory involvement in child care between the control and experimental groups by using the pre-test scores as the covariate. If the assumption of using ANCOVA was not met, *t*-test was computed instead.

3. T-test was applied to compare the satisfaction scores of the mothers after receiving nursing care in both control and experimental groups.

CHAPTER IV
RESULTS

The current study aimed to determine the effects of family-centered care on self-efficacy in participatory involvement in child care and satisfaction of mothers whose children were admitted in pediatric intensive care unit (PICU) at Phramongkutklao Hospital. The research results were presented in the following manner:

1. Characteristics of the study subjects
2. Self-efficacy in participatory involvement in child care
3. The mother' satisfaction towards nursing care

1. Characteristics of the Study Subjects

The study subjects included 32 mothers (16 for each group of control and experimental) whose children were admitted in PICU at Phramongkutklao Hospital.

In the control group, average age of the mothers was 33 years (*SD* = 6.4), and half of them (50%) were between 31-40 years. Most of the mothers (87%) were married. Average years of maternal education were 8.9 years (*SD* = 4.7), and over half of the mothers (56%) complete their primary school level. Fifty six percent of the mothers were housewives or earned the living by working at their own home, while the rest (44%) were employed or working outside. An average household income was 12,937.5 baht (*SD* = 11,491.8). More than half (63%) of the mothers had at least two children. Half of the mothers had no previous experience of having a child admitted in PICU. Average age of the patients was 53 months (*SD* = 41.8), and most of them were in pre-school ages. Half of the patients were first-born child. Majority of the patients (75 %) used respirator. (See Table 1)

In the experimental group, average age of the mothers was 36.2 years (*SD* = 7.0). Most of mothers (75%) were married. Average years of maternal education were 8.8 years (*SD* = 5.0), and over half of the mothers (56%) completed their primary school level. Fifty six percent of the mothers were employed or working outside, while the rest (44%) were housewives or earned the living by working at their own home. An average household income was 34,395.6 baht (*SD* = 85,544.7). More than half (81%) of the mothers had at least two children. Sixty three of the mothers had no previous experience of having a child admitted in PICU. Average age of the patients was 77.9 months (*SD* = 41.8), and most of them were in pre-school ages. More than half of the patients were after first-born child. Almost all of the patients (93%) used respirator. (See Table 1)

Table 1. Demographic Characteristics of the Mothers and the Patients

Characteristics	Control group (N=16)		Experimental group (N=16)	
	n *(%)*	*M* *(SD)*	*n* *(%)*	*M* *(SD)*
Mother's age (years)		33 (6.4)		36.2 (7.0)
20-30	6 (37)		5 (31)	
31-40	8 (50)		6 (38)	
41-50	2 (13)		5 (31)	
Marital Status				
Married	14 (87)		12 (75)	
Divorced/separated	2 (13)		4 (25)	
Mother's education (years)		8.9 (4.7)		8.8 (5.0)
Primary school level	9 (56)		9 (56)	
Secondary school level	3 (19)		3 (19)	
Bachelor degree and upper	4 (25)		4 (25)	

Table 1. (continued)

Characteristics	Control group (N=16)		Experimental group (N=16)	
	n *(%)*	*M* *(SD)*	*n* *(%)*	*M* *(SD)*
Mother's occupation				
Working at home/ housewife	9 (56)		7 (44)	
Working outside	7 (44)		9 (56)	
Household income (Baht/ month)		12,937.5 (11,491.8)		34,395.6 (85,544.7)
(median / mode)		10,000 / 10,000		6,000 / 6,000
Number of children				
1	6 (37)		3 (19)	
>1	10 (63)		13 (81)	
Previous experience of having a child admitted in PICU				
Yes	8 (50)		6 (37)	
No	8 (50)		10 (63)	

Table 1. (continued)

Characteristics	Control group (N=16)		Experimental group (N=16)	
	n *(%)*	*M* *(SD)*	*n* *(%)*	*M* *(SD)*
Patient's age (months)		53 (41.8)		77.9 (41.8)
1 - 12	3 (19)		-	
13 – 60	6 (37)		7 (44)	
61 – 120	6 (37)		6 (37)	
≥ 121	1 (7)		3 (19)	
Birth order				
First	8 (50)		6 (37)	
After	8 (50)		10 (63)	
use of respirator				
No	4 (25)		1 (6)	
Yes	12 (75)		15 (94)	

2. Self-Efficacy of Mothers in Participatory Involvement in Child Care

Even though the maternal education was paired match in both control and experimental groups, another differences in the demographic make-up the group conditions could have introduced some confounding variables. Thus, prior to testing the study hypotheses, determining whether there were significant differences between two group conditions on measured demographic variables was performed (See Appendix F). The result did not show any significant differences.

Before using ANCOVA in the data analysis, the assumption was checked; that is, there is no interaction between the covariate and the treatment. In the current analysis, an interaction between the pre-test scores of maternal self-efficacy in participatory involvement (the covariate) and the group conditions (the treatment) was found (See Appendix G). Thus, ANCOVA could not be applied.

Since sample size was small, normal distribution of the post-test scores of maternal self-efficacy in participatory involvement (the dependent variable) using Fisher’s measures of skewness and kurtosis (Munro, 2001) was checked. The result showed that the post-test scores were normally distributed. Thus, *t*-test was computed to answer the hypothesis I.

Self-efficacy in participatory involvement in child care in both control and experimental groups at pre-test were examined. As seen in Table 2, the average self-efficacy scores in both groups did not show any differences (t = -.567, $p > .05$). However, the average self-efficacy scores at post-test in the experimental group was statistically significant higher than its counterpart (t = -4.22, $p < .001$). To assure the influence of experimental intervention, comparison between pre-test and post-test scores of each group was also performed. The result revealed that the significant difference of such comparison was seen only in the experimental group (See Appendix H).

Table 2. Comparison of Mean Scores, and Standard Deviation of Self-Efficacy in Participatory Involvement in Child Care at Pre-test and Post-test in the Control and the Experimental Groups

Source	**Pre-test**			**Post-test**		
	M	***SD***	***t***	***M***	***SD***	***t***
Control group	69.7	18.3	$-.567^{ns}$	70.4	16.5	-4.22^{***}
Experimental group	72.9	12.8		89.7	8.0	

^{ns} = The difference was not statistically significant.

*** $p < .001$

In sum, the hypothesis I (self-efficacy in participatory involvement in child care in the experimental group was higher than that in the control group) was statistically supported.

3. The Mother' Satisfaction with Nursing Care

Upon the intervention completed, the mother's satisfaction with nursing care in both control and experimental groups was examined. An average satisfaction scores in the experimental group were higher than that in the control group (63.9 ± 11.44 vs 73.5 ± 6.8), as seen in Table 3. Since sample size was small, normal distribution of the satisfaction scores using Fisher's measures of skewness and kurtosis (Munro, 2001) was checked. The result showed that the scores were normally distributed. Thus, *t*-test was computed to answer the hypothesis II. The comparison using *t*-test revealed that the higher scores on satisfaction with nursing care in the experimental group was statistically significant (t = -2.875, p <.01).

Table 3. Comparison of Actual Range, Mean Scores, and Standard Deviation of the Mother' Satisfaction with Nursing Care in the Control and the Experimental Groups

Source	**Actual range**[a]	***M***	***SD***	***t***
Control group	32 - 80	63.9	11.4	-2.875**
Experimental group	56 - 80	73.5	6.8	

[a] possible range was 20 - 80

** p < .01

In sum, the hypothesis II (the mother's satisfaction with nursing care in the experimental group was higher than that in the control group) was statistically supported.

CHAPTER V

DISCUSSION

This research was aimed to study the effects of family-centered care on mothers' self-efficacy in participatory involvement in child care and satisfaction with nursing care in PICU. The results are discussed based on the hypotheses as follows:

Hypothesis 1. Self-efficacy in participatory involvement in child care in the experimental group was higher than that in the control group.

The result supports the first hypothesis, and can be explained as the following:

The investigator supported mothers' participatory involvement in child care by inviting and stimulating the mothers to take part in child care. These activities enhanced those mothers to understand their own roles so they were more willing to involve in child care at the PICU. Besides, the investigator provided education, advice, and demonstration of many activities for child care which helped them clarify of their roles and knew how to perform the care activities. Most mothers felt more able to perform such activities, and then they were allowed to practice child care activities under the advice and assistance of the investigator. This would ensure the self-efficacy of the mothers in practicing those activities. The study result supports the self-efficacy theory which mentions that directly succeeded experience was the most powerful source of self-efficacy (Bandura, 1997a). It was consistent with many intervention studies showing that maternal self-efficacy in care for their ill children was succeeded through enactive mastery experience (e.g. Samranchaithum, 1998; Danchai, 1997; Koafai, 1998; and Chotivithayatharakorn; 2000). In contrast to the control group receiving the routing nursing practice, participation in child care at the PICU is limited. Only during the visiting time mothers were allowed to take part in the child care activities such as feeding and comforting. Moreover, most of the time, the mothers obtained no advice or assistance (except they had asked for). With the less chances to participatorily involve in care, their self-efficacy was not provoked. Thus, it was not surprising when this study revealed that mother in the control group had less perceived self-efficacy in child care compared to the experimental group.

In addition to enactive mastery experience, physiological and emotional states of an individual are also an important source of self-efficacy (Bandura, 1997a). Other intervention studies of self-efficacy enhancement always concerned the physical and emotional readiness of the study subjects before implementing the intervention. For example, to enhance maternal self-efficacy in care for premature newborns, Koafai (1998) had implemented intervention on the day that the study subjects felt less exhausted from the delivery. The physical and mental readiness of the subjects made them gain positive perception towards their own ability. Likewise, in the present study the investigator has believed that the nursing intervention set for mothers in the experimental group affected the reduction of stress and anxiety. The cause of high stress and anxiety of parents whose children admitted in PICU maybe from the uncertainty of treatment results which leads to unpredictable situation (LaMontagne & Pawlak, 1990). More over stress has increased when those parents hear alarming or working sound of medical equipments, observe the heart beat on the ECG screen, and see the child with inserted endo-tracheal tube, or being on invasive procedures (Board & Ryan-Wenger, 2003). In addition, the parents seem to face the change and loss of their parents' role because they are unable to stay with their children all the time or respond their children as they used to. Being unable to protect and assist their children, those parents can not perform decision making in child care (Carter, Miles, Buford, & Hassanein, 1985; Heuer, 1993; Miles, 1989; Miles, Carter, Riddle, Hennessey, & Eberly, 1989). As a result, reducing causes of stress is the important process to prepare physiological and emotional states to be ready for learning new skills and roles. The nursing approach used in this study included starting friendly greeting and warm conversation to help the mothers fell relaxed, and continuously giving correct information about disease, general condition of the patient, medical instrument used with patients, environment of ward and other topic as per mother's request. These activities as reported elsewhere did relieve stress and anxiety caused from uncertainty toward the children's illness (Curley, 1988; Heuer, 1993; Prasert, 1997; Vrolan, 1992). In addition, the investigator allowed the mothers to express feelings in a private and quiet place, and visit the child at their convenience. By all of these nursing approaches in the present study, the mothers' stress and anxiety are believed to be lessened regardless of whether the stress and anxiety were measured. As mothers in the experimental group had more positive emotional states than those in the control group, they then had better readiness to be able to learn new skills and roles in care for the ill children. Thus, there is no doubt why self-efficacy in participatory involvement in care was significantly increased.

Ahman (1994) states that family-centered care is, in fact, about the relationship established to enhance collaboration between family and health care personnel. Such relationship can be achieved through empowerment process, the process of helpgiving that focuses people's strengths, rights, and abilities rather than deficits and needs (Kieffer, 1984). According to the meaning of empowerment process, there is no doubt why self-efficacy, one's judgment in her ability to execute the designated task, increases upon receiving such helpgiving. The result of the present study indicating the increased self-efficacy of the mothers did confirm the concept of empowerment analyzed elsewhere (Gibson, 1991; Rodwell, 1996). The finding was also consistent with the study by McCarthy and colleagues (McCarthy, Herbert, Brimacombe, Hansen, Wong, & Zelman, 2002). In their study the families receiving asthma education based on empowering approach perceived more control, ability to make decision, efficacy in care for the child than did the families receiving routine approach.

Hypothesis 2. Satisfaction with nursing care in the experimental group was higher than that in the control group.

The study result supports the second hypothesis and it can be explained as follows:

According to Dunst & Trivette (1996), clients' satisfaction with the help results from the presence of positive characteristics of the helpgiver. That is, helpgiving is likely to positively influence psychological well being, when helpgiving relationships are characterized as caring and respectful and helpgivers treat help receivers as capable and acknowledge their role in achieving desired outcomes. In this study, the investigator reflected such positive characteristics of the helpgiver through the nursing approach. That included actively listening to problem or needs, giving unbiased information, recognizing the family's competency, and so on. The investigator believes that these activities provided for the mothers in the experimental group did elicit their satisfaction. It was consistent with the qualitative study of Attharos (2003) on nursing model development of family-centered care. In her study, it was found that a caring and empathetic relationship, mutual learning, partnership, and enhancing strength led to the satisfaction with nursing care.

From previous studies, it was found that ill children needed security by being closed to their parents while the family of those children needed information the most, at least one time a day. Furthermore, the parents would like health care personnel to answer their questions about their ill children and allow them to have more time for visit, make decision, share information, and care for their children (Ahmann, 1994; Attharos, 2003; Farrel & Frost, 1992; Fisher, 1994; Neill, 1996a, 1996b). In this study, the investigator had provided many activities for the mothers and family such as giving information and answering the family's questions, allowing mothers to visit their children as often as they needed, encouraging mothers' participation in child care during their visit, allowing them to do what they needed if it was not against the treatment plan (e.g. allowing them to bring toys that children like so that those children could play during their stay in PICU or even letting children's siblings to visit them), allowing mothers to provide special food for their children. These nursing care activities were responsive to the mothers', families', and children's needs resulted in the mothers' satisfaction with nursing care. It could be said that, according to Long & Greeneich (1994) the mothers' satisfaction emerged from the balance among the mothers' expectations, needs, and experiences of care involvement that they received.

CHAPTER VI

CONCLUSION

Summary of the Study

A quasi experimental design was used in this study to examine the effects of family-centered care on self-efficacy in participatory involvement in child care and satisfaction of mothers in PICU.

A total of 32 PICU patients' mothers in Phramongkutklao Hospital who were purposively selected according to the study criteria were the samples. Sixteen mothers were required for each of the control and experimental group. The control group received normal care while the experimental group received family-centered care. Data collection was conducted from June, 2004 to September, 2005. T-test was used to determine the differences of the mothers' self-efficacy in participatory involvement in child care and satisfaction with nursing care between the control and experimental groups.

Research results showed that

1. Self-efficacy in participatory involvement in child care score in the experimental group was significantly higher than that in the control group ($p<.001$).
2. Satisfaction with nursing care in the experimental group was significantly higher than that in the control group ($p<.01$).

Implications and Recommendations

Implications for nursing practice

After the investigator had introduced the family-centered care to the PICU at Phramongkutklao Hospital, the evaluation on opinions obtained from 8 nurses by using the questionnaires (See Appendix I) showed that all nurses thought that family-centered-care approach through information sharing, joint decision making on treatment, and participating in care activities is practicable although some activities were under limitations like time, quantity of work, and condition of ill children. One of them also recommended that some families whose ill children have to receive continuing care after discharged should be trained for some care skills such as care in patients with tracheostomy-tube, physical therapy, wound care in paralyzed patients, and ostomy care. Most of their opinions were positive towards family-centered care; it indicated the possibility of implementing this philosophy of care into practice at the PICU. The investigator would suggest the application of family-centered care in the PICU as follows:

1. Because family-centered care is a philosophy that drives broad organizational change rather than an isolated program of specific services, it is most effective when the hospital's leaders are fully committed and active involved. The investigator believes that this process is most successful when the hospital's and the unit's leaders articulate a clear vision and incorporate family-centered values into the mission, goals, policies, and procedures. Such explicit and supportive policy would empower all health care personnel and employees to be family-centered.

2. At the PICU of Phramongkutklao Hospital, there is a cardiovascular nurse case manager who is responsible for patients with cardiac surgery. Integration of family-centered care approach into the case manager's routine practice is probably a good start to initiate the desired change. This case manager should be trained as a role model to implement full approach of family-centered care. In the meanwhile, the staff nurses can gradually implement family-centered care in their practice by acting as the case manager's supporters and facilitators. This strategy would help the nurses feel more comfortable and do not feel that a change is threatened.

3. Some nurse's opinions indicated that such activities as sharing information, building relationship, demonstrating certain care skills are time-consuming work and under the limitation of manpower. As change could be threaten to some individuals. Thus, it is essential to correct the misunderstandings. In fact, family-centered care is an approach that most benefits both family and health care personnel. Provision of information and education about family-centered care, as well as training programs in enhancing communication skills and establishing relationship as partnership is imperative.

4. Using the family assessment tools (to assess family structure, network and function: See Appendix B), the investigator found that data received from such tools strengthened the relationships between the investigator and PICU patients' families. Such data was useful for the investigator to seek problems and develop nursing care plan for the patients and their families. Thus, the use of family assessment tools is suggested in the nursing practice at the PICU. However, which of family aspects should be assessed and the format of assessment tools may be subject to change.

Implications for further studies

First, the outcomes of family-centered care other than self-efficacy and satisfaction, for example, treatment compliance, length of hospital stay, nurses' work satisfaction, the patient (child)'s satisfaction, should be examined.

Next, a replication of the present study is also encouraged so that the applicability of the present study intervention and outcomes would be confirmed.

Last but not least, shifting the routine nursing care to family-centered care approach cannot be achieved without difficulties. Factors that may explain the lack of success in operationalizing the concept of family-centered care should be explored. The investigator would suggest a further study answer the following questions:

- What is the relationship between nurses' employee role conception and their orientation to family-centered care?
- What is the relationship between nurses' professional role conception and their orientation to family-centered care?

- What influences have such demographic factors as age, educational background, work experience, and clinical setting on nurse' family-centered care orientation?

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APPENDIX

APPENDIX A

Instruments used in data collection

ส่วนที่ 1. แบบบันทึกข้อมูลทั่วไป (A data record form)

ข้อมูลของมารดา

1. อายุ..............ปี
2. สถานภาพสมรส ( ) คู่
   ( ) ม่าย / หย่า หรือแยกกันอยู่
3. ระดับการศึกษาสูงสุดคือ......................................
4. อาชีพ...
5. รายได้ของครอบครัวเฉลี่ยต่อเดือน........................บาท
6. จำนวนบุตรมีชีวิต..................คน
7. เคยมีประสบการณ์มีบุตรหรือดูแลบุตรในไอ.ซี.ยู. มาก่อนหรือไม่..............

ข้อมูลของผู้ป่วย

1. อายุ...............ปี.............เดือน
2. ลำดับที่ของการเกิด...
3. การวินิจฉัยโรคของผู้ป่วย...
4. ย้ายเข้าไอ.ซี.ยู.กุมารวันที่.........................เวลา.............น.
5. แบบแผนการหายใจ ( ) ผู้ป่วยหายใจได้เอง
   ( ) ใช้เครื่องช่วยหายใจ

ส่วนที่ 2. แบบประเมินการรับรู้สมรรถนะของตนเองในการมีส่วนร่วมดูแลบุตร (Self-efficacy in participatory involvement in child care questionnaire)

คำชี้แจง ข้อความต่อไปนี้เป็นเรื่องเกี่ยวกับการรับรู้ความมั่นใจในความสามารถของท่านใน**การมีส่วนร่วมดูแลบุตรเจ็บป่วยขณะเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า** ขอให้ท่านอ่านข้อความดังกล่าวแล้วพิจารณาว่าท่านมีความมั่นใจกี่เปอร์เซนต์ในความสามารถของท่านที่จะเข้ามามีส่วนร่วมในการดูแลบุตรตามข้อความนั้น

ถึงแม้ว่าท่านยังไม่มีประสบการณ์ตามข้อความนั้น ๆ เลย ก็ขอให้ท่านพิจารณาว่าถ้ามีเหตุการณ์นั้นเกิดขึ้น ท่านมั่นใจกี่เปอร์เซนต์ว่าท่านจะสามารถเข้ามามีส่วนร่วมในการดูแลบุตรได้ตามข้อความนั้น

วิธีการตอบ จากมาตรวัดข้างล่างให้ท่านพิจารณาระดับความมั่นใจของท่านโดยให้ท่านเขียนตัวเลขที่แสดงถึงระดับความมั่นใจของท่านลงในช่อง ☐ ท้ายข้อความ

ตัวอย่าง

ฆ. ฉันมั่นใจว่า ฉันสามารถเล่าอาการที่เปลี่ยนแปลงของลูก ให้พยาบาลฟังได้ 65

จากคำตอบในตัวอย่าง แสดงว่าคุณแม่ท่านนี้มีความมั่นใจ 65 เปอร์เซนต์ที่จะเล่าอาการที่เปลี่ยนแปลงของลูก ให้พยาบาลฟังได้

เมื่อท่านเข้าใจวิธีการตอบและพร้อมที่จะตอบคำถามแล้วโปรดตอบข้อความต่อไปนี้

ขณะที่ลูกเจ็บป่วยอยู่ไอ.ซี.ยู.กุมาร	เปอร์เซนต์ความมั่นใจ
1. ฉันมั่นใจว่า ฉันสามารถซักถาม**อาการ**ของลูกจากแพทย์ และ / หรือ พยาบาลได้ทุกครั้งที่ต้องการ	☐
2. ฉันมั่นใจว่า ฉันสามารถซักถามใน**เรื่องที่สงสัย**เกี่ยวกับลูกจากแพทย์ และ / หรือ พยาบาลได้ทุกครั้งที่ต้องการ	☐
3. ฉันมั่นใจว่า ฉันสามารถให้ข้อมูลต่าง ๆ เกี่ยวกับลูกแก่แพทย์ และ / หรือ พยาบาลได้ครบถ้วนชัดเจน เพื่อประโยชน์ในการรักษาและการดูแลลูกขณะเจ็บป่วย	☐
4. เมื่อฉันมีปัญหาที่เกี่ยวกับการเจ็บป่วยของลูกในครั้งนี้ เช่น ปัญหาเรื่องค่าใช้จ่าย ปัญหาเรื่องการบริการ เป็นต้น ฉันมั่นใจว่า ฉันสามารถเข้าไปปรึกษาหรือพูดคุยกับแพทย์ และ / หรือ พยาบาลได้อย่างไม่ลำบากใจ	☐
5. เมื่อฉันมีเรื่องกังวลใจเกี่ยวกับการเจ็บป่วยของลูกในครั้งนี้ ฉันมั่นใจว่า ฉันสามารถเล่าหรือระบายความรู้สึกกังวลใจให้แพทย์ และ / หรือ พยาบาลฟังได้	☐
....	
....	
....	
22. ฉันมั่นใจว่า ฉันสามารถให้การดูแลทั่วไปกับลูกได้โดยที่ลูกไม่เกิดอันตราย	☐

ส่วนที่ 3. แบบประเมินความพึงพอใจต่อบริการพยาบาล (Satisfaction with nursing care questionnaire)

คำชี้แจง ข้อความต่อไปนี้เป็นความรู้สึกเกี่ยวกับการบริการพยาบาลที่ท่านได้รับในขณะที่บุตรของท่านเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า

โปรดใส่เครื่องหมาย ✓ ลงในช่องที่ตรงกับความรู้สึกของท่านมากที่สุดเพียงคำตอบเดียวในแต่ละข้อ

การบริการพยาบาล	ระดับความพึงพอใจ			
	มาก	ค่อนข้างมาก	ค่อนข้างน้อย	น้อย
1. พยาบาลสนใจเอาใจใส่และมีความห่วงใย				
2. พยาบาลสุภาพอ่อนโยนต่อผู้ป่วย				
3. พยาบาลสุภาพอ่อนโยนต่อท่าน				
4. พยาบาลรับฟังสิ่งที่ท่านพูด				
....				
....				
....				
....				
20. พยาบาลเปิดโอกาสให้ท่านได้กระทำตามความต้องการในสิ่งที่ร้องขอซึ่งไม่ขัดต่อการรักษาของแพทย์				

APPENDIX B

Instruments used in the intervention

แนวปฏิบัติการพยาบาลโดยให้ครอบครัวเป็นศูนย์กลางในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า (Handbook of family-centered care in PICU)

Day	Goal	Intervention
2-4	1. เพื่อประเมินการรับรู้และความคาดหวังของมารดาและครอบครัว	1.1 สร้างบรรยากาศความห่วงใยด้วยการใช้คำถามปลายเปิดและเปิดโอกาสให้มารดาและครอบครัวได้ระบายความรู้สึก *" วันนี้คุณเป็นอย่างไรบ้างคะ ? "* *" ตอนนี้คุณมีอะไรที่ยังกังวลใจอยู่ไหมคะ ? "* 1.2 หยั่งดูการรับรู้ของมารดาและครอบครัวที่มีต่อสภาพของบุตร *" วันนี้คุณว่าลูกเป็นอย่างไรบ้างคะ ?"* (จากคำตอบที่ได้จะทำให้ผู้วิจัยสามารถให้ข้อมูลที่ถูกต้องได้ทันที เมื่อพบว่ามีการรับรู้ที่ผิดหรือไม่ถูกต้องเกิดขึ้นกับมารดาและครอบครัว)... ....

FCC 1 – General information

1. รหัสของครอบครัว……………………………………………………………………...
2. ที่อยู่ปัจจุบัน (หรือเบอร์โทรศัพท์) ที่สามารถติดต่อได้……………………………………...
3. ที่พักอาศัย : ชนิดของบ้านพัก

    ( ) เช่า ( ) เจ้าของ ( ) อาศัยอยู่กับ……………

4. สภาพเศรษฐกิจของครอบครัว

    4.1 รายได้ของครอบครัว………………………………………………………………
    4.2 แหล่งของรายได้……………………………………………………………………...
    4.3 ค่าใช้จ่ายเมื่อเทียบกับรายได้เพียงพอหรือไม่……………………………………………
    4.4 มีปัญหาด้านการเงินหรือไม่ ถ้ามีได้รับการแก้ไขหรือช่วยเหลืออย่างไร……………...

……………………………………………………………………………………………...

5. สุขภาพและการใช้บริการสุขภาพ

    5.1 สถานบริการสุขภาพที่ครอบครัวใช้บริการเป็นประจำ……………………………...
    5.2 สาเหตุที่พาบุตรมารักษาที่ ร.พ พระมงกุฎเกล้าในครั้งนี้……………………………
    5.3 ผู้ตัดสินใจหลักในเรื่องเกี่ยวกับการเจ็บป่วยของบุตรครั้งนี้ (เช่น ด้านค่าใช้จ่าย การรักษาพยาบาล การดูแลอื่น ๆ ฯลฯ.)……………………………………………
    5.4 การจ่ายค่ารักษาพยาบาล

        ( ) จ่ายเอง ( ) เบิกได้จาก………………
        ( ) บัตรทอง 30 บาท ของ ร.พ …………… ( ) อื่น ๆ ระบุ………………

    5.5 ประวัติสุขภาพและความเจ็บป่วยของครอบครัว…………………………………...

……………………………………………………………………………………………...
……………………………………………………………………………………………...
……………………………………………………………………………………………...

FCC 2 – Family structure

1. ลักษณะครอบครัว

( ) เดี่ยว ( ) ขยาย

หัวหน้าครอบครัว…………………………………………………………………………..

อำนาจการตัดสินใจ……………………………………………………………………………

สมาชิกในครอบครัว / บุคคลที่อาศัยภายในบ้านเดียวกัน

ชื่อ	ความสัมพันธ์กับผู้ป่วย	อายุ	เพศ	เชื้อชาติ	การศึกษา	อาชีพ

FCC 3 – Family network (Family Ecomap)

FCC 4 – Family function (Family APGAR)

แนวคำถาม	ผลการสัมภาษณ์
Adaptation - ท่านและสมาชิกในครอบครัวมีการช่วยเหลือซึ่งกันและกันในเวลาที่มีปัญหาอย่างไร.................................	....
Partnership - ท่านและสมาชิกในครอบครัวมีการพูดคุยหรือตัดสินใจกันอย่างไรเวลาที่มีเรื่องต่าง ๆ.........................	....
Growth - สมาชิกในครอบครัวมีอิสระมากน้อยเพียงใดในการเลือกวิถีชีวิตของตน.................................	....
Affection - เวลาที่ท่านมีความรู้สึกเศร้า โกรธ และรัก สมาชิกในครอบครัวตอบสนองต่ออารมณ์ของท่านอย่างไร........	....
Resolve - สมาชิกในครอบครัวมีเวลาให้กันและกันมากน้อยเพียงใด..	....

FCC 5 – Key activities checklist

Day	Receiving information	Sharing information / opinion	Making decision	Participating in care activities							Note
				1	2	3	4	5	6	7	
1	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………								……………… ……………… ……………… ……………… ……………… ………………
2	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………								……………… ……………… ……………… ……………… ……………… ………………
3	…………… …………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… …………… ……………								……………… ……………… ……………… ……………… ……………… ……………… ………………
4	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………	…………… …………… …………… …………… …………… ……………								……………… ……………… ……………… ……………… ……………… ………………

หมายเหตุ กิจกรรมที่ให้มารดามีส่วนร่วมคือ 1. การป้อนอาหาร นม หรือยา 2. การดูแลความสะอาดภายหลังการขับถ่าย (รวมทั้งการเปลี่ยนผ้าอ้อม เสื้อผ้า การจดบันทึกจำนวนปัสสาวะหรืออุจจาระ) 3. การจัดท่านอนและพลิกตะแคงตัว 4. การให้กำลังใจและการปลอบโยน 5. การแสดงความรัก เช่น การอุ้ม การกอดจูบ การสัมผัส 6. การส่งเสริมพัฒนาการ (การพูดคุย การอ่านหนังสือ / เล่านิทาน การร้องเพลงกล่อม การเล่น) 7. การช่วยพยาบาลอาบน้ำหรือเช็ดตัว

APPENDIX C

List of validators

1. Assoc. Prof. Fongcum Tilokskulchai, Ph.D.
   Department of Pediatric Nursing
   Faculty of Nursing, Mahidol University

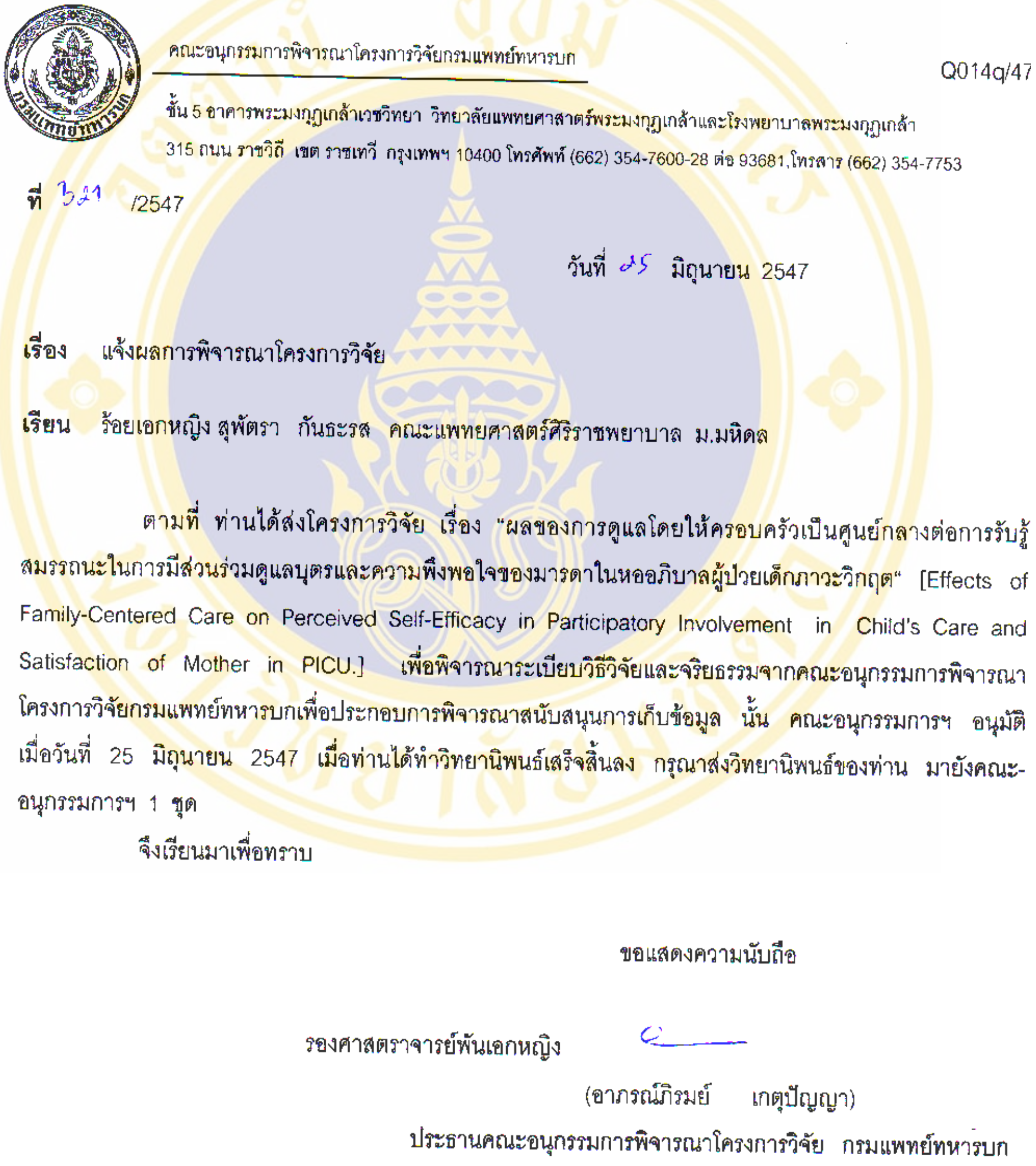
2. Assoc. Prof. Siriporn Khampalikit, Ph.D.
   Faculty of Nursing, Thammasart University

3. Assoc. Prof. Jariya Wittayasooporn, Ph.D.
   Nursing Department
   Faculty of Medicine Ramathibodi Hospital, Mahidol University

4. Lt. Col. Urai Mepoung
   Head Nurse from Pediatric Intensive Care Unit, Phramongkutklao Hospital

APPENDIX D

Permission letters for protection of human rights



คณะอนุกรรมการพิจารณาโครงการวิจัยกรมแพทย์ทหารบก

ชั้น 5 อาคารพระมงกุฎเกล้าเวชวิทยา วิทยาลัยแพทยศาสตร์พระมงกุฎเกล้าและโรงพยาบาลพระมงกุฎเกล้า
315 ถนน ราชวิถี เขต ราชเทวี กรุงเทพฯ 10400 โทรศัพท์ (662) 354-7600-28 ต่อ 93681,โทรสาร (662) 354-7753

Q014q/47

ที่ 321 /2547

วันที่ 25 มิถุนายน 2547

เรื่อง แจ้งผลการพิจารณาโครงการวิจัย

เรียน ร้อยเอกหญิง สุพัตรา กันธะรส คณะแพทยศาสตร์ศิริราชพยาบาล ม.มหิดล

ตามที่ ท่านได้ส่งโครงการวิจัย เรื่อง "ผลของการดูแลโดยให้ครอบครัวเป็นศูนย์กลางต่อการรับรู้สมรรถนะในการมีส่วนร่วมดูแลบุตรและความพึงพอใจของมารดาในหออภิบาลผู้ป่วยเด็กภาวะวิกฤต" [Effects of Family-Centered Care on Perceived Self-Efficacy in Participatory Involvement in Child's Care and Satisfaction of Mother in PICU.] เพื่อพิจารณาระเบียบวิธีวิจัยและจริยธรรมจากคณะอนุกรรมการพิจารณาโครงการวิจัยกรมแพทย์ทหารบกเพื่อประกอบการพิจารณาสนับสนุนการเก็บข้อมูล นั้น คณะอนุกรรมการฯ อนุมัติ เมื่อวันที่ 25 มิถุนายน 2547 เมื่อท่านได้ทำวิทยานิพนธ์เสร็จสิ้นลง กรุณาส่งวิทยานิพนธ์ของท่าน มายังคณะอนุกรรมการฯ 1 ชุด

จึงเรียนมาเพื่อทราบ

ขอแสดงความนับถือ

รองศาสตราจารย์พันเอกหญิง

(อาภรณ์ภิรมย์ เกตุปัญญา)
ประธานคณะอนุกรรมการพิจารณาโครงการวิจัย กรมแพทย์ทหารบก

APPENDIX E

Consent forms

(Control group)

วันที่..........เดือน.................พ.ศ............

ดิฉันชื่อ สุพัตรา กันธะรส เป็นนักศึกษาปริญญาโท คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล กำลังศึกษาวิจัยเกี่ยวกับการรับรู้ความมั่นใจของมารดาในการมีส่วนร่วมดูแลบุตรเจ็บป่วยในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า และความพึงพอใจต่อบริการพยาบาลที่ได้รับ ดิฉันจึงใคร่ขอความร่วมมือจากท่านซึ่งเป็นมารดาของ............................ ในการตอบแบบสอบ 2 ครั้ง ดังนี้

ครั้งที่ 1 วันแรกที่บุตรเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร ตอบแบบสอบถามเกี่ยวกับข้อมูลส่วนตัว การรับรู้ความมั่นใจของตนเองในการมีส่วนร่วมดูแลบุตร ซึ่งใช้เวลาตอบแบบสอบถามประมาณ 15 นาที

ครั้งที่ 2 วันที่ 5 ของการเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร ตอบแบบสอบถามเกี่ยวกับการรับรู้ความมั่นใจของตนเองในการมีส่วนร่วมดูแลบุตรและความพึงพอใจต่อบริการพยาบาล ซึ่งใช้เวลาตอบแบบสอบถามประมาณ 25 นาที

การวิจัยครั้งนี้อาจจะไม่ให้ประโยชน์แก่ท่านโดยตรง แต่ข้อมูลที่ได้มาจะเป็นประโยชน์ต่อการปรับปรุงบริการทางการพยาบาลในการช่วยเหลือครอบครัวผู้ป่วยเด็กที่เข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมารต่อไป ไม่ว่าท่านจะเข้าร่วมวิจัยหรือไม่ก็ตาม จะไม่มีผลกระทบต่อท่านหรือการดูแลที่บุตรของท่านจะได้รับแต่อย่างใด และหากท่านสมัครเข้าร่วมวิจัยไปแล้วเกิดเปลี่ยนใจภายหลัง ท่านมีสิทธิที่จะถอนตัวออกจากการวิจัยได้โดยไม่มีข้อแม้ใด ๆ ทั้งสิ้น ข้อมูลที่ได้จากท่านถือเป็นความลับ การเก็บแบบสอบถามจะกระทำเมื่อสิ้นสุดการวิจัย ผลการวิจัยจะถูกนำเสนอในลักษณะภาพรวม และหากท่านมีข้อสงสัยในภายหลังกรุณาติดต่อดิฉันตามที่อยู่ข้างล่างนี้

ร้อยเอกหญิง สุพัตรา กันธะรส
315 ไอ.ซี.ยู. กุมาร โรงพยาบาลพระมงกุฎเกล้า
ถ. ราชวิถี แขวง ทุ่งพญาไท เขต ราชเทวี กรุงเทพ 10400
โทรศัพท์ 0-2354-7661 (ที่ทำงาน)

สุพัตรา กันธะรส
นักศึกษาพยาบาลศาสตรมหาบัณฑิต
มหาวิทยาลัยมหิดล

สำหรับผู้เข้าร่วมวิจัย

ข้าพเจ้าได้ทราบรายละเอียดของการวิจัยดังที่ได้อธิบายข้างต้นแล้ว มีความเข้าใจและยินดีเข้าร่วมการวิจัย

ลงชื่อ.. ผู้ยินยอม
ลงชื่อ.. พยาน
ลงชื่อ.. พยาน

Consent forms

(Experimental group)

วันที่.........เดือน...............พ.ศ............

ดิฉันชื่อ สุพัตรา กันธะรส เป็นนักศึกษาปริญญาโท คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล และเป็นพยาบาลประจำหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า จะทำการศึกษาวิจัยเกี่ยวกับผลของการดูแลโดยให้ครอบครัวเป็นศูนย์กลาง เพื่อนำผลวิจัยไปใช้เป็นแนวทางในการปรับปรุงรูปแบบการพยาบาลในหออภิบาลผู้ป่วยเด็กภาวะวิกฤต ดิฉันจึงใคร่ขอความร่วมมือจากท่านซึ่งเป็นมารดาของ..............................ในการเข้าร่วมวิจัยครั้งนี้ กิจกรรมที่ท่านจะได้รับและต้องกระทำในการเข้าร่วมวิจัยมีดังนี้

1. ตอบแบบสอบถามเกี่ยวกับข้อมูลส่วนตัว การรับรู้ความมั่นใจของตนเองในการมีส่วนร่วมดูแลบุตรและความพึงพอใจต่อบริการ ในวันที่ 1 และวันที่ 5 ของการเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า ซึ่งใช้เวลาตอบแบบสอบถามประมาณ 25 นาที

2. ระหว่างวันที่ 1 ถึงวันที่ 4 ของการเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า ต้องขอความร่วมมือจากท่านมาเยี่ยมบุตรติดต่อกันทั้ง 4 วัน และพบกับผู้วิจัยทุกวันเพื่อแลกเปลี่ยนข้อมูล ความคิดเห็น ความรู้สึกเกี่ยวกับผู้ป่วยและการเจ็บป่วยครั้งนี้ ร่วมตัดสินใจในการดูแลรักษา และรับการฝึกทักษะการดูแลผู้ป่วยที่จำเป็น เช่น การป้อนนม อาหาร หรือยา การดูแลความสะอาดของร่างกาย การจัดท่านอนหรือพลิกตะแคงตัว เป็นต้น ในการพบกันแต่ละครั้งใช้เวลาประมาณ 1 - 1 ½ ชั่วโมง ทั้งนี้ท่านสามารถเลือกเวลาเข้าเยี่ยมบุตรและเวลาที่เข้าร่วมกิจกรรมกับผู้วิจัยได้ตามความสะดวกของท่าน นอกจากนี้สมาชิกในครอบครัวของท่าน (เช่น สามี ปู่ ย่า ตา ยาย ฯลฯ) สามารถเข้าร่วมกิจกรรมกับผู้วิจัยได้

การเข้าร่วมการวิจัยครั้งนี้จะเป็นไปตามความสมัครใจของท่าน ไม่ว่าท่านจะเข้าร่วมวิจัยหรือไม่ก็ตาม จะไม่มีผลกระทบต่อท่านหรือการดูแลที่บุตรของท่านจะได้รับแต่อย่างใด และหากท่านเข้าร่วมวิจัยไปแล้วเกิดเปลี่ยนใจภายหลัง ท่านมีสิทธิที่จะถอนตัวออกจากการวิจัยได้โดยไม่มีข้อแม้ใด ๆ ทั้งสิ้น ข้อมูลที่ได้จากท่านและครอบครัวถือเป็นความลับ การเก็บแบบสอบถามจะกระทำเมื่อสิ้นสุดการวิจัย ผลการวิจัยจะถูกนำเสนอในลักษณะภาพรวม และหากท่านมีข้อสงสัยในภายหลังกรุณาติดต่อดิฉันตามที่อยู่ข้างล่างนี้

ร้อยเอกหญิง สุพัตรา กันธะรส
315 ไอ.ซี.ยู. กุมาร โรงพยาบาลพระมงกุฎเกล้า
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มหาวิทยาลัยมหิดล

สำหรับผู้เข้าร่วมวิจัย

ข้าพเจ้าได้ทราบรายละเอียดของการวิจัยดังที่ได้อธิบายข้างต้นแล้ว มีความเข้าใจและยินดีเข้าร่วมการวิจัย

ลงชื่อ...ผู้ยินยอม
ลงชื่อ.......................................พยาน
ลงชื่อ.......................................พยาน

APPENDIX F

Comparison of demographic data between the study groups

Table 4. Comparison of Demographic Data between Control and Experimental Groups by T-test, Chi-square Test, and Fisher's Exact Probability Test

Characteristics	Control group (N=16)		Experimental group (N=16)		χ^2	*t*
	n (%)	*M* (*SD*)	*n* (%)	*M* (*SD*)		
Mother's age (years)		33 (6.4)		36.2 (7.0)		-1.350^{ns}
Marital status						
Married	14 (87)		12 (75)		$.654^{a,\ ns}$	
Divorced/ separated	2 (13)		4 (25)			
Mother's education (years)		8.9 (4.7)		8.8 (5.0)		$.073^{ns}$
Mother's occupation						
Working at home/housewife	9 (56)		7 (44)		$.724^{a,\ ns}$	
Working outside	7 (44)		9 (56)			
Household income (Baht/month) (median)		12,937.5 (11,491.8) 10,000		34,395.6 (85,544.7) 6,000		$.994^{ns}$
Number of children						
1	6 (37)		3 (19)		$.433^{a,\ ns}$	
>1	10 (63)		13 (81)			
Previous experience having a child admitted in PICU						
Yes	8 (50)		6 (37)		$.125^{ns}$	
No	8 (50)		10 (63)			

Table 4. (continued)

Characteristics	Control group (N=16)		Experimental group (N=16)		χ^2	*t*
	n *M*	*(%)* *(SD)*	*n* *M*	*(%)* *(SD)*		
Patient's age (months)		53 (41.8)		77.9 (41.8)		-1.688^{ns}
Birth order						
First	8 (50)		6 (37)			
After	8 (50)		10 (63)		.508 ^{ns}	
Use of respirator						
No	4 (25)			1 (6)		
Yes	12 (75)			15 (94)	.333$^{a, ns}$	.

^{ns} = The difference was not statistically significant.

^{a} = Probability from fisher's exact probability test.

APPENDIX G

Statistical assumption test for ANCOVA

Before using ANCOVA in the data analysis, the assumption was checked; that is, there is no interaction between the covariate and the treatment. In the current analysis, an interaction between the pre-test scores of maternal self-efficacy in participatory involvement (the covariate) and the group conditions (the treatment variable) was found (*F* = 14.14, p = .001). Thus, ANCOVA could not be applied.

Table 5. Analysis of Covariance of the Post-test Scores of Maternal Self-efficacy in Participatory Involvement with the Interaction between the Pre-test Scores and the Group Conditions

Source	***df***	***SS***	***MS***	***F***	***p-value***
Group	1	1150.08	1150.08	26.36	.000
Pre-test scores	1	1978.20	1978.20	45.34	.000
Group* Pre-test scores	1	616.87	616.87	14.14	.001
Error	28	1221.70	43.63		
Corrected Total	31	8023.23			

APPENDIX H

Comparison of self-efficacy in participatory involvement in child care between the pre-test and the post-test scores of the study groups

Comparison between the pre-test and the post-test scores self-efficacy in participatory involvement in child care of each group was also performed. The result revealed that the significant difference of such scores was seen only in the experimental group.

Table 6. Comparison of Mean Scores, and Standard Deviation of Self-efficacy in Participatory Involvement in Child Care between the Pre-test and the Post-test Scores of the Study Groups

	Control group			**Experimental group**		
	M	***SD***	***t***	***M***	***SD***	***t***
Pre-test	69.7	18.3	-.452^{ns}	72.9	12.8	-5.535***
Post-test	70.4	16.5		89.7	8.0	

^{ns} = The difference was not statistically significant.

*** $p < .001$

APPENDIX I

Nurses’ opinions about family-centered care

Table 7. แบบประเมินความคิดเห็นของเจ้าหน้าที่พยาบาลไอ.ซี.ยู.กุมาร โรงพยาบาลพระมงกุฎเกล้า (Opinions about Family-centered Care Expressed by PICU Nurses at Phramongkutklao Hospital)

กิจกรรม	จำนวนเจ้าหน้าที่ที่ระบุความเป็นไปได้ที่จะกระทำ (N=8)			เหตุผลที่ทำให้กระทำได้หรือไม่ได้
	ทำได้แน่นอน	น่าจะทำได้	มีโอกาสทำได้ยาก	
1. ให้คำแนะนำเกี่ยวกับกฎระเบียบการเยี่ยมและข้อมูลเกี่ยวกับหอผู้ป่วย ภายใน 24 ชั่วโมงแรกที่ผู้ป่วยเข้ารับการรักษาในหอผู้ป่วยไอ.ซี.ยู กุมาร	6	2		บางครั้งครอบครัวอยู่ในสภาวะที่ไม่พร้อมจะรับฟังการให้ข้อมูลโดยเฉพาะใน 24 ชั่วโมงแรก
2. ให้ข้อมูลแก่ครอบครัวอย่างน้อยวันละ 1 ครั้ง (โดยไม่ต้องให้ครอบครัวถามก่อน) เกี่ยวกับข้อมูลเรื่องโรคและสภาพทั่วไปของผู้ป่วย รวมทั้งข้อมูลอื่น ๆ ตามความเหมาะสม	5	3		บางครอบครัวไม่ได้มาเยี่ยมผู้ป่วยทุกวัน ทำให้ไม่สามารถให้ข้อมูลแก่ครอบครัวได้ทุกวัน
3. เปิดโอกาสให้ครอบครัวได้ซักถามข้อสงสัยทุกครั้งที่เข้าเยี่ยมผู้ป่วย	4	4		ในกรณีที่มีภาระงานมาก อาจไม่มีเวลาในการตอบคำถาม

กิจกรรม	จำนวนเจ้าหน้าที่ที่ระบุความเป็นไปได้ที่จะกระทำ (N=8)			เหตุผลที่ทำให้กระทำได้หรือไม่ได้
	ทำได้แน่นอน	น่าจะทำได้	มีโอกาสทำได้ยาก	
4. ให้คำแนะนำ สอน และสาธิตกิจกรรมการดูแลผู้ป่วยให้กับครอบครัวในเรื่องต่อไปนี้				บางครั้งทำไม่ได้เพราะกิจกรรมพยาบาลมีมาก แต่บุคลากรมีน้อย
4.1 การป้อนนม อาหาร และยา (ทางปากหรือทางสายยาง)	4	4		
4.2 การดูแลความสะอาดภายหลังการขับถ่าย (รวมทั้งการเปลี่ยนผ้าอ้อม เสื้อผ้า และการจดบันทึกจำนวนอุจจาระและปัสสาวะ	5	3		
4.3 การจัดท่านอนและพลิกตะแคงตัว	4	4		
4.4 การให้กำลังใจและปลอบโยนผู้ป่วย	6	2		
4.5 การมีปฏิสัมพันธ์กับผู้ป่วย เช่น การพูดคุย การร้องเพลงกล่อม การอ่านหนังสือ / เล่านิทาน และการเล่น	3	5		
4.6 การดูแลอื่น ๆ ได้แก่ การช่วยพยาบาลเช็ดตัว	3	3	2	เวลาที่ครอบครัวมาเยี่ยมไม่สัมพันธ์กับการทำกิจกรรม (เวลาเช็ดตัวคือ 05.00-06.00น.)

กิจกรรม	จำนวนเจ้าหน้าที่ที่ระบุความเป็นไปได้ที่จะกระทำ (N=8)			เหตุผลที่ทำให้กระทำได้หรือไม่ได้
	ทำได้แน่นอน	น่าจะทำได้	มีโอกาสทำได้ยาก	
5. ให้ครอบครัวได้มีส่วนร่วมในกิจกรรมการดูแลผู้ป่วยในเรื่องต่อไปนี้				
5.1 การป้อนนม อาหาร และยา (ทางปากหรือทางสายยาง)	4	4		ผู้ป่วยบางรายต้องระวังเรื่องการสำลัก เช่น ผู้ป่วยที่มีปัญหาทางปอด
5.2 การดูแลความสะอาดภายหลังการขับถ่าย (รวมทั้งการเปลี่ยนผ้าอ้อม เสื้อผ้า และการจดบันทึกจำนวนอุจจาระและปัสสาวะ	5	3		การดูแลความสะอาดภายหลังการขับถ่ายทำได้ แต่การจดบันทึกพยาบาลทำมากกว่า
5.3 การจัดท่านอนและพลิกตะแคงตัว	4	4		ในกรณีที่ผู้ป่วยได้รับการ sedate ไม่สามารถทำกิจกรรมนี้ได้
5.4 การให้กำลังใจและปลอบโยนผู้ป่วย	6	2		
5.5 การมีปฏิสัมพันธ์กับผู้ป่วย เช่น การพูดคุย การร้องเพลงกล่อม การอ่านหนังสือ / เล่านิทาน และการเล่น	3	5		ในกรณีที่ผู้ป่วยได้รับการ sedate ไม่สามารถทำกิจกรรมนี้ได้
5.6 การดูแลอื่น ๆ ได้แก่ การช่วยพยาบาลเช็ดตัว	3	3	2	ครอบครัวผู้ป่วยบางรายไม่พร้อมหรือไม่กล้าทำเพราะผู้ป่วยมีอุปกรณ์ทางการแพทย์ติดตัวมากมาย

กิจกรรม	จำนวนเจ้าหน้าที่ที่ระบุความเป็นไปได้ที่จะกระทำ (N=8)			เหตุผลที่ทำให้กระทำได้หรือไม่ได้
	ทำได้แน่นอน	น่าจะทำได้	มีโอกาสทำได้ยาก	
6. ให้ครอบครัวได้มีบทบาทเป็นผู้ตัดสินใจเกี่ยวกับแผนการดูแลผู้ป่วย	5	3		บางครั้งครอบครัวไม่มีความรู้ความเข้าใจ ถึงแม้อธิบายให้ฟังแล้วก็ตามแต่ก็ให้แพทย์หรือพยาบาลตัดสินใจให้
7. ให้ครอบครัวได้มีส่วนร่วมแสดงความคิดเห็นเกี่ยวกับการรักษาพยาบาล	4	4		
8. ให้ครอบครัวได้กระทำตามต้องการในสิ่งที่ร้องขอซึ่งไม่ขัดต่อการรักษาของแพทย์	5	3		
9. อนุญาตให้ครอบครัวได้เข้าเยี่ยมผู้ป่วยตามต้องการ	2	4	2	ในบางกรณีซึ่งมีภาระงานมาก ทาง ward ไม่สามารถเปิดโอกาสให้ครอบครัวเข้าเยี่ยมผู้ป่วยเด็กได้
10.ให้เวลาในการพูดคุยกับครอบครัวในเรื่องต่าง ๆ ได้ทุกครั้งที่ครอบครัวต้องการ	3	5		

* กิจกรรมการดูแลผู้ป่วยที่ท่านคิดว่าครอบครัวน่าจะสามารถเข้ามามีส่วนร่วมในการดูแลได้นอกเหนือจากที่ระบุไว้ในข้อคำถาม 10 ข้อข้างต้นมีอะไรบ้าง ?

คำตอบ

- การ suction ในผู้ป่วยเด็กที่ได้รับการเจาะคอ
- การทำกายภาพบำบัดในผู้ป่วยเด็กที่ไม่รู้สึกตัวหรือกล้ามเนื้ออ่อนแรง
- การดูแลแผลกดทับในผู้ป่วยเด็กที่ไม่สามารถเคลื่อนไหวได้เองและมีแผลกดทับ
- การดูแลแผล ostomy ในผู้ป่วยที่มี ileostomy หรือ colostomy

BIOGRAPHY

NAME	Capt. Supattra Kuntaros
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