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Personal and Contextual Factors to the Successful Implementation of a Family Nursing Approach in Oncology Care

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Abstract

The aim of this study was to explore nurses' attitudes and beliefs about the importance of families in nursing care, as well as the barriers and facilitators within the clinical context that influence the implementation offamily nursing in an in-patient oncology service. A cross-sectional study design, incorporating quantitative and qualitative measurements, was used with a sample of nurses in Spain from an oncology service (N = 39). In general, oncology nurses reported positive attitudes and beliefs about the importance of family in nursing care. However, they did not effectively involve the family in their daily clinical practice. This was due to the nurses' lack of clinical skills and competence to work with families as well as contextual factors such as the lack of time and workload that acted as barriers to the implementation of family-oriented care. This study identified areas of improvement that are needed to promote the effective and sustainable implementation of family nursing knowledge in clinical practice settings.

Keywords

nurses' beliefs, illness beliefs, family nursing, family, nurses' attitudes-nursing care

The diagnosis of cancer is often an important psychological and emotional challenge, both for the person experiencing the disease and for family members (Möllerberg et al., 2019; Northouse et al., 2012). The adaptation of the family to the reality imposed by the disease and the demands of care can cause an imbalance in the dynamics and functioning of the family system (McLeod et al., 2010; West et al., 2015).

The literature indicates that oncological disease is often a "family affair" (Konradsen et al., 2021; Wright, 2017). Because of this and due to the interdependence that exists between family members, the effectiveness of cancer care is believed to increase when the focus of care includes the family unit (Çol & Kılıç, 2019; Faarup et al., 2019; Holst-Hansson et al., 2017; Lewis et al., 2019, Wright, 2017; Wright & Bell, 2009, 2021). In fact, a systematic review of family interventions, carried out by Chesla (2010), concluded that interventions aimed at the family members living with a complex disease, such as cancer, positively influened the physical and psychological health of both the patient and his or her family.

Based on the increasing evidence in the literature about the positive outcomes of involving families in health care services, several Family Nursing (FN) knowledge translation projects have been globally initiated with promising results (Kläusler-Troxler et al., 2019; Naef, Kaeppeli et al., 2020; Svavarsdottir et al., 2015; Zimansky et al., 2018). Family nursing was implemented in Iceland at institutional level, as a part of the Landspitali University Hospital Family Nursing Implementation Project (Svavarsdottir et al., 2015). However, the complex process of implementing and sustaining family nursing in health care setting continues to be a challenge (Duhamel, 2010; Duhamel et al., 2015). In health services, an individual approach centered on the patient and his or her

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pathology still prevails (Duhamel, 2010). This may be due, among other reasons, to the lack of nursing education in family-oriented care models as well as the attitudes and beliefs of professionals about including the family in nursing care (Duhamel, 2017; Svavarsdottir et al., 2015).

According to clinicians and leaders (Wright & Bell, 2009, 2021; Wright & Leahey, 2013) who conceptualized the influence of beliefs in their theoretical models, positive beliefs or attitudes held by nurses about including the family in nursing care are prerequisite for creating a nurse–family therapeutic relationship that leads to healing and to a reduction in suffering caused by the disease. In fact, if family members experience a meaningful and quality relationship with health care professionals, they are less likely to develop feelings of abandonment, loneliness, vulnerability, and uncertainty in their roles as caregivers, favoring the functioning and well-being of the family and, ultimately, the health of the patient (Wright & Bell, 2009, 2021). In addition, the attitudes and beliefs of nurses are key factors in involving families in nursing care. Nurses who see the family as the unit of care and have positive attitudes toward family members are more likely to include family members in care. In contrast, nurses who perceive the family as a threat to their knowledge and professionalism and do not recognize the importance of family in the recovery of the patient often show little interest in involving families in nursing care (Benzein et al., 2008; Sveinbjarnardottir et al., 2011).

Similarly, the evidence indicates that there are several factors in the context of clinical practice that can increase or limit family nursing care such as the lack of professional autonomy and organizational support as well as the lack of time (Hoplock et al., 2019; Naef, Kaeppeli, et al., 2020). These factors influence the quality of clinical practice and can lead nursing professionals to focus exclusively on the patient, despite recognizing the benefits of using a family approach in their care (Weimand et al., 2013; Wong, 2014).

These findings suggest that the attitudes and beliefs of health care professionals, as well as factors within the context of the process of implementing knowledge of family nursing in clinical practice. In addition, evidence indicates that these variables are related to each other; that is, having a delilberate and clearly defined approach to the care of families in the workplace predicts more positive attitudes of nurses towards including the family in daily care (Alfaro-Díaz et al., 2020; Hagedoorn et al., 2021; Østergaard et al., 2020).

Experts in the field of family nursing (Duhamel, 2010; Leahey & Svavarsdottir, 2009) note that as part of the strategy of implementing family nursing knowledge, it is important to first define the context of clinical practice that allows for the identification of barriers and facilitators in each care environment that affect the implementation of knowledge. To our knowledge, no studies have investigated these aspects in the context of oncology care. Furthermore, research exploring the relationship between nurses' attitudes and beliefs and contextual factors is limited. Therefore, as part of the strategy of implementing family nursing in the field of oncology at a university hospital in Spain, in this study, we proposed the following objectives:

1. to understand the attitudes and beliefs of nursing professionals toward the importance of including the family in nursing care in oncology;
2. to identify the barriers and facilitators present in the context of clinical practice for the implementation of family nursing in the context of oncology; and
3. to explore the relationship between beliefs of nurses and the barriers that contrain or facilitate the practice of nursing in oncology care.

Method

Design and Setting

A cross-sectional survey approach was used adhering to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines addressing articles reporting cross-sectional studies (von Elm et al., 2014; see Supplementary File 1). Also, a qualitative analysis of responses provided to the open-ended questions of the Iceland Health Care Practitioner Illness Beliefs Questionnaire (ICE-HCP-IBQ) was used to complement the analysis of the quantitative data.

The study was conducted in the oncology department (including hospitalization ward, day hospital, consultation, and palliative care service) of a hospital in northern Spain: Clinica Universidad de Navarra.

Sample

The selection of participants was performed through convenience sampling, i.e., all nursing professionals who were part of the oncology staff of the hospital ($n = 46$) and who met the following inclusion criteria: (a) working at the time of the study, (b) fluent in the Spanish language, (c) in contact with families in their daily clinical practice, and (iv) working in the unit for a minimum of 1 year.

Measures

Families' Importance in Nursing Care–Nurses' Attitudes scale (FINC-NA). The FINC-NA measures the attitudes of nurses regarding the importance of including the family in nursing care (Saveman et al., 2011). It has been validated in different health care settings, and it is the only measure based on Family Systems Nursing theory that measures nurses' attitudes toward families in nursing care from a generic nursing perspective (Alfaro-Díaz et al., 2019). This scale includes a total of 26 items grouped into four subscales: "Family as a Resource in Nursing Care (Fam-RNC)" (10 items), "Family

as a Conversational Partner (Fam-CP)" (eight items), "Family as a Burden (Fam-B)" (four items), and "Family as Its Own Resource (Fam-OR)" (four items). All items were assessed using a Likert-type scale, with 5 response options, ranging from 1 = *strongly disagree* to 5 = *strongly agree*. The Fam-B subscale scores are scored inversely. A higher score on the questionnaire indicates a more positive attitude of the nurse toward the importance of including the family in nursing care (Saveman et al., 2011).

For this study, a version of the FINC-NA questionnaire translated into the Spanish context was used (Pascual Fernández et al., 2015), after validation by the authors of this study in a sample of 263 nursing professionals. Cronbach's alpha for the total scale was .90, and for the subscales, Cronbach's alpha was .84 (Fam-RNC), .77 (Fam-CP), .64 (Fam-B), and .74 (Fam-OR).

Iceland Health Care Practitioner Illness Beliefs Questionnaire (ICE-HCP-IBQ). The ICE-HCP-IBQ, originally developed by Svavarsdottir, Looman, et al. (2018) and later modified by Alfaro-Díaz et al. (2020), evaluates the beliefs of health professionals about their understanding of the meaning that a disease has on a family. This questionnaire consists of one dimension (illness beliefs) and includes seven items and four open-ended questions: (a) What beliefs do you have about the health situation that your patients and their families are dealing with that may influence your practice? (b) Do you have any beliefs about the health situation that may hinder your work with your patients and their families? (c) What core belief have you found helpful to rely on when dealing with your patients and their families? and (d) What do you believe the future holds for your patients and their families? All items were assessed using a Likert-type scale, with 5 response options, ranging from 1 = *never* to 5 = *always*. A higher score reflects greater confidence of the professional in his or her beliefs about understanding the meaning of the illness to the family (Alfaro-Díaz et al., 2020).

The ICE-HCP-IBQ has been validated in the Spanish context, showing good psychometric properties. Cronbach's alpha for the total questionnaire was .83 (Alfaro-Díaz et al., 2020).

The Demand–Control–Support Questionnaire (DCSQ). The DCSQ consists of 17 items, grouped into four subscales: "Psychological Demands" (five items), "Control" (six items), "Social Support" (six items), and "Satisfaction at Work" (five items) (Alfaro-Díaz et al., 2021). The items are assessed using a Likert-type scale, with 4 response options, ranging from 1 = *strongly disagree* to 4 = *strongly agree*. The responses are scored inversely for Items 4, 9, and 22. Higher scores on the subscales indicate greater psychological demands (range = 5–20), greater decision latitude (range = 6–24), greater social support at work (range = 6–24), and greater satisfaction at work (range = 5–20).

The Spanish version of the DCSQ used in this study showed adequate internal consistency for the following subscales: Psychological Demands (Cronbach's $\alpha = .76$), Control (Cronbach's $\alpha = .62$), Social Support (Cronbach's $\alpha = .87$), and Satisfaction at Work (Cronbach's $\alpha = .76$) (Alfaro-Díaz et al., 2021).

Data Collection

Data were collected between January and February 2020. For access to the sample, a meeting was held with the supervisor and the advanced clinical nurse of the oncology department to explain the objective of the study and request their collaboration for the recruitment of the sample. Next, a brief introduction to the study was presented at the various oncology services, where potential nurse participants were invited.

The nurses who voluntarily agreed to participate in the study signed an informed consent form, and the principal investigator personally distributed the Spanish versions of the FINC-NA, ICE-HCP-IBQ, and DCSQ in paper format, along with a sociodemographic questionnaire. Nurses individually filled out the survey forms in the presence of the principal researcher, who collected them immediately as they were completed.

Ethical Considerations

The study was approved by the Clinical Research Ethics Committee (CREC) of the University of Navarra (Reference 2018.086). Data were dissociated by numerical coding, preventing people outside the study from identifying the participants. The objective and design of the study were explained to the participants orally and in writing, and all provided signed informed consent for their participation in the study.

Data Analysis

Quantitative data analysis. A descriptive analysis of all variables was performed, calculating measures of frequency for categorical variables and measures of dispersion and central tendency for continuous variables. Likewise, bivariate analysis was carried out, calculating the Spearman correlation coefficients for continuous variables. All analyses were conducted using IBM SPSS Version 25.0 (IBM Inc., Armonk, NY, USA). Listwise deletion was used to address missing values.

Qualitative data analysis. The data collected through the four open-ended questions of the ICE-HCP-IBQ questionnaire were analyzed using thematic analysis by Burnard (1991), a method for systematic classification of data into categories. The aim of this thematic analysis was to produce a detailed and systematic recording of the themes and issues addressed in the open-ended questions and to link them together under a reasonable category system. Briefly, first, the responses

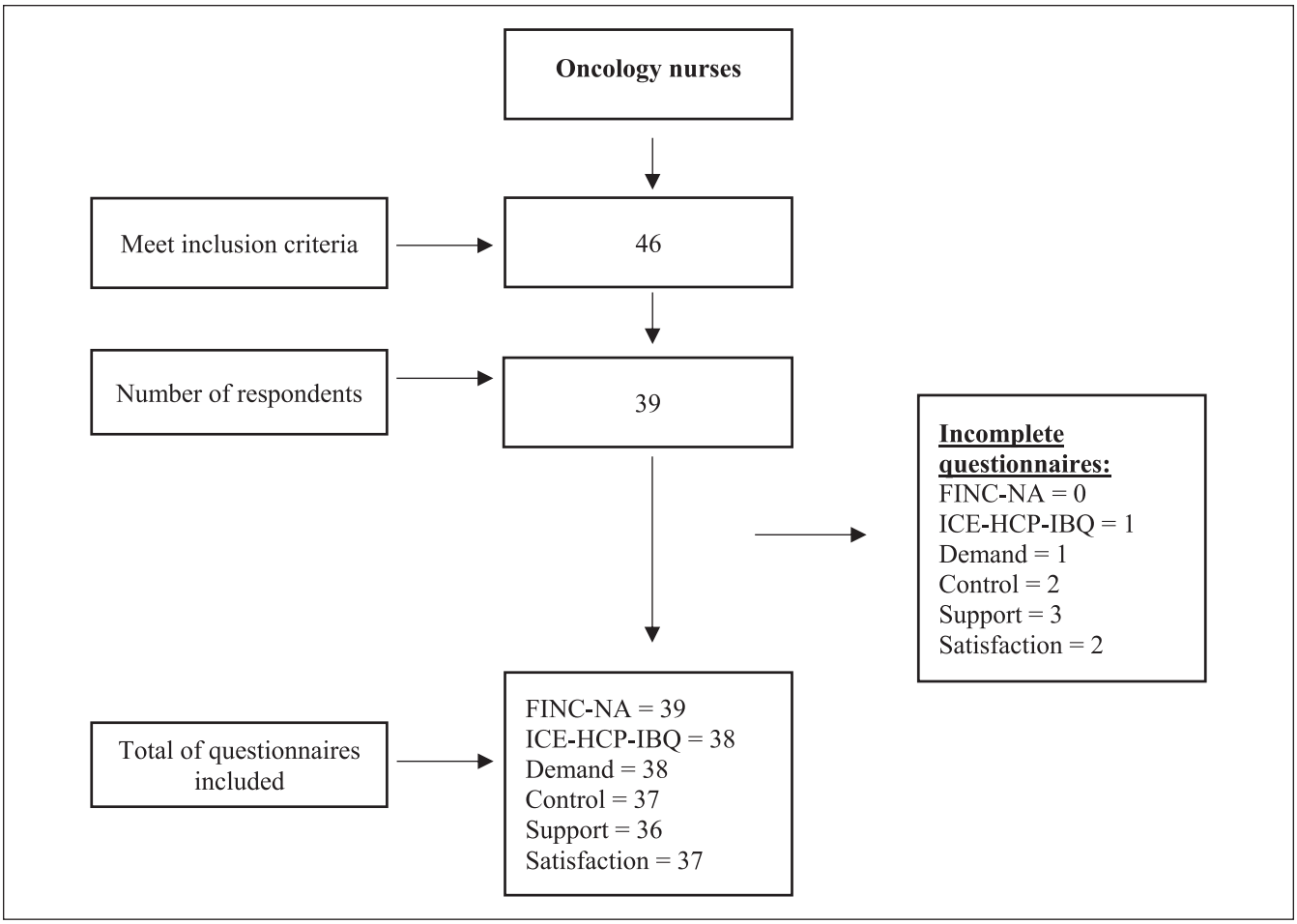

Figure 1. Flowchart of elegible respondents.
Note. FINC-NC = Families' Importance in Nursing Care–Nurses' Attitudes scale; ICE-HCP-IBQ = Iceland Health Care Practitioner Illness Beliefs Questionnaire.

were read in full to become familiar with the data set. Subsequently, the responses were again read in full, and open coding was performed; that is, suggestions of categories were generated to identify units of meaning that responded to the objective of the analysis. The first and the last author coded independently all the free-text responses to assure trustworthiness and rigor (Lincoln & Guba, 1985). Subsequently, the categories were revised and reduced, grouping related categories and those with similar content under the same heading. Once the categories were obtained and combined with the text extract that supported them, they were reviewed and discussed with two other researchers involved in the study. They verified that the categories worked in relation to the coded extract and the complete data set and discussed any differences until reaching a consensus on the coding. Finally, a thematic map was generated with the main topics formulated, and a formal and clear definition of each topic was provided, supported by text excerpts. In attempting to achieve credibility for this analysis conducted, verbatim transcripts of the responses were used to support the meanings and interpretations presented in the final results. Anonymous files were entered into NVivo Version 12, a qualitative data analysis software, to support data management and analysis processes.

Results

Characteristics of the Sample

Of the 46 nursing professionals who met the inclusion criteria, 39 participated in the study (Figure 1).

All participants were women, with a mean age of 40.2 years (SD = 10.46). Regarding the workplace, 25 nurses worked in the hospital inpatient ward, six in the day hospital, four in consultation, and one on the palliative care team. Of the total number of participants, 25 nurses (64.1%) reported maintaining a family-oriented approach to care in their clinical practice, although only five of them (2.1%) indicated having received education or mentoring in family nursing (Table 1).

Table 1. Participants' Demographic Characteristics.

Characteristics	Respondents
Age, *M* (*SD*)	40.2 (10.5)
Highest level of education in nursing	
Diplomate, *n* (%)	23 (59.0)
Graduate, *n* (%)	12 (30.8)
Master degree, *n* (%)	4 (10.3)
Job training	
Specialization, *n* (%)	31 (79.5)
Expert, *n* (%)	8 (20.5)
Specialization and expert, *n* (%)	5 (2.1)
Workplace	
Hospitalization plant, *n* (%)	28 (71.8)
Consultation room, *n* (%)	4 (10.3)
Day hospital, *n* (%)	6 (15)
Palliative, *n* (%)	1 (2.6)
Time since graduation as RN, *M* (*SD*)	18.03 (10.7)
Years working in the current service, *M* (*SD*)	10.95 (8.1)
Employment status	
Temporary staff, *n* (%)	8 (20.5)
Permanent staff, *n* (%)	30 (76.9)
Other, *n* (%)	1 (2.6)
Training in family nursing	
Yes, *n* (%)	5 (2.1)
Family-approach[a]	
Yes, *n* (%)	25 (64.1)
Had a seriously ill family member[b]	
Yes, *n* (%)	24 (61.5)

Note. RN = registered nurse.
[a]Is there a general approach to the care of families at your place of work?
[b]Has a member of your family ever been seriously ill?

Quantitative Results

Attitudes of nurses toward including the family in nursing care, the FINC-NA scale. In this study, the mean score was 103.67 (*SD* = 10.61; theoretical range [TR] = 26–130), which indicates a general attitude toward including the family in nursing care (Table 2).

Family as a Resource in Nursing Care (Fam-RNC.). The Fam-RNC subscale, which considers the family as a resource in nursing care, refers to maintaining a positive attitude toward families and valuing their presence in nursing care. The mean Fam-RNC subscale score was 41.77 (*SD* = 4.69; TR = 10–50). The majority of nurses (97%) (strongly) agreed that it is important to spend time with the family. Likewise, the majority of nurses (95%) indicated that the presence of family members is important for the family members themselves; however, only 51% indicated that the presence of family members eases their workload.

Family as a Conversational Partner (Fam-CP). The subscale Fam-CP measures recognition of the importance of relating to members of a patient's family and maintaining continuous communication with them. The mean Fam-CP subscale score was 31.46 (*SD* = 4.27; TR = 8–40). The majority of nurses (97%) (strongly) agreed that it is important to find out what family members a patient has, and 85% indicated that they invite family members to speak about changes in the patient's situation. However, only half (51%) indicated that they ask the family to take part in discussions from the first moment in which the patient is under their care.

Family as a Burden (Fam-B). The Fam-B subscale measures the negative impact the presence of the family exerts on nurses and on their work. The mean score was 14.31 (*SD* = 2.96; TR = 4–20). Sixty-seven percent of the nurses (totally) disagreed that the presence of family members causes them to hold themselves back in their work. Likewise, 64% disagreed with the statements that the presence of family members makes them feel that the family is checking up on them and that the presence of family members causes nurses stress.

Family as its Own Resource (Fam-OR). The Fam-OR subscale measures the recognition by nurses that the family has its own resources to cope with the illness. The average subscale score was 16.13 (*SD* = 1.76; TR = 4–20). The majority of the respondents (90%) indicated that they consider themselves a resource for the family to cope with the illness, and 79% indicated that they encourage the family to use their own resources so that they have greater possibilities for coping on their own. However, only 69% of nurses ask how they can provide support to the family.

Beliefs of Nursing Professionals (ICE-HCP-IBQ). The mean score for the total sample was 25.00 (*SD* = 2.85; TR = 7–35), which indicates average confidence of the nursing professionals in their belief that they understand the meaning that the health situation, i.e., illness has for the family (Table 3). The majority of the nurses (84%) reported they believed they knew, (almost) always, the cause of the illness experienced by their patients and families. However, only half (55%) believed they knew who was suffering the most in the family due to the changes in family life caused by the illness. Likewise, 45% of the participants indicated that they believed they knew, (almost) always, the degree of control that their patients and families had over the illness, as well as the degree of control that the illness exerted on them.

Factors within the context of clinical practice, the DCSQ [Demand-Control-Support Questionnaire]

Psychological Demands. The Psychological Demands subscale focuses on the psychological demands that the job imparts on a professional. The average subscale score was 15.71 (*SD* = 2.41; TR = 5–20; Table 4). All nurses (strongly) agreed that they had to work very intensively. Likewise, the

Table 2. Results for the Families' Importance in Nursing Care–Nurses' Attitudes Questionnaire ($n = 39$).

Subscales and items	(Strongly) disagree[a] *n* (%)	(Strongly) agree[b] *n* (%)
Family as a Resource in Nursing Care (Fam-RNC)		
3. A good relationship with family members gives me job satisfaction	0 (0.0)	35 (89.7)
4. Family members should be invited to take an active part in the patient's nursing care	0 (0.0)	37 (94.9)
5. The presence of family members is important to me as a nurse	1 (2.6)	32 (82.1)
7. The presence of family members gives me a feeling of security	3 (7.7)	24 (61.5)
10. The presence of family members eases my workload	5 (12.8)	20 (51.3)
11. Family members should take an active part in planning patient care	3 (5.1)	28 (71.8)
13. The presence of family members is important for the family members themselves	0 (0.0)	37 (94.9)
20. Getting involved with families gives me a feeling of being useful	(0)	29 (74.4)
21. I gain a lot of worthwhile knowledge from families which I can use in my work	(0)	31 (79.5)
22. It is important to spend time with families	(0)	38 (97.4)
Family as a Conversational Partner (Fam-CP)		
1. It is important to find out what family members a patient has	1 (2.6)	38 (97.4)
6. I ask family members to take part in discussions from the very first contact when a patient comes into my care	8 (20.5)	20 (51.3)
9. Discussion with family members during first care contact saves time in my future work	3 (7.7)	25 (64.1)
12. I always find out what family members a patient has	1 (2.6)	29 (74.4)
14. I invite family members to have a conversation at the end of the care period	4 (10.3)	25 (64.1)
15. I invite family members to actively take part in the patient's care	2 (5.1)	29 (74.4)
19. I invite family members to speak about changes in the patient's condition	(5)	33 (84.6)
24. I invite family members to speak when planning care	(10)	26 (66.7)
Family as a Burden (Fam-B)[c]		
2. The presence of family members holds me back in my work	26 (66.7)	3 (7.7)
8. I do not have time to take care of families	18 (46.2)	13 (33.3)
23. The presence of family members makes me feel that they are checking up on me	25 (64.1)	(18)
26. The presence of family members makes me feel stressed	25 (64.1)	(18)
Family as Its Own Resource (Fam-OR)		
16. I ask families how I can support them	2 (5.1)	27 (69.2)
17. I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves	1 (2.6)	(79.5)
18. I consider family members as cooperating partners	0 (0.0)	(82.1)
25. I see myself as a resource for families so that they can cope as well as possible with their situation	(0)	35 (89.7)

[a]Strongly disagree concerns nurses' responses of a 1 or 2. [b]Strongly agree concerns nurses' responses of a 4 or 5. [c]Subscale was reversed.

Table 3. Results for the Iceland Health Care Practitioner Illness Beliefs Questionnaire ($n = 38$).

Subscales and items	(Strongly) disagree[a] *n* (%)	(Strongly) agree[b] *n* (%)
I believe that . . .		
. . . I know *the cause* of the health situation that my patients and their families are now dealing with	1 (2.6)	32 (84.2)
. . . I know how much *control* my patients and their families have over the health situation	2 (5.3)	17 (44.7)
. . . I know how much *control* the health situation has over my patients and their families	1 (2.6)	17 (44.7)
. . . I would know what *the effect* would be (if any) on the health situation, if my patients and their families would agree on treatments	2 (5.3)	22 (57.9)
. . . I know who is *suffering* the most (if any), among my patients and their families, because of the changes in their family life due to the health situation	2 (5.3)	21 (55.3)
. . . I know what has been *the most useful thing* health care professionals have offered to my patients and their families, *to help them cope with their suffering* regarding the health situation	1 (2.6)	20 (52.6)
. . . I know what has been *the least useful thing* health care professionals have offered to my patients and their families, *to help them cope with their suffering* regarding the health situation	4 (10.5)	14 (36.8)

[a]Strongly disagree concerns nurses' responses of a 1 or 2. [b]Strongly agree concerns nurses' responses of a 4 or 5.

Table 4. Results for the Demand–Control–Support Questionnaire.

Subscales and items	(Strongly) disagree[a] *n* (%)	(Strongly) agree[b] *n* (%)
Psychological Demands ($n = 38$)		
1. I have to work very fast	3 (7.9)	35 (92.1)
2. I have to work very intensively	0 (0.0)	38 (100.0)
3. My work requires too much effort	8 (21.1)	30 (78.9)
4. I have enough time to do everythingc	34 (89.5)	4 (10.5)
5. My work often involves conflicting demands	16 (42.1)	22 (57.9)
Control–Decision latitude ($n = 37$)		
6. I have the possibility of learning new things through my work	1 (2.7)	36 (97.3)
7. My work requires a high level of skill or expertise	1 (2.7)	36 (97.3)
8. My work requires ingenuity and creativity	5 (13.5)	32 (86.5)
9. I have to do the same thing over and over again[c]	33 (89.2)	4 (10.8)
10. I have a choice in deciding how I do my work	8 (21.6)	29 (78.4)
11. I have a choice in deciding what I do at work	19 (51.4)	18 (48.6)
Social Support at Work ($n = 36$)		
12. There is a calm and pleasant atmosphere where I work	16 (44.4)	20 (55.6)
13. There is a good spirit of unity	3 (8.3)	33 (91.7)
14. My colleagues are there for me (support me)	1 (2.8)	35 (97.2)
15. People understand that I can have a bad day	4 (11.1)	32 (88.9)
16. I get on well with my superiors	2 (5.6)	34 (94.4)
17. I get on well with my colleagues	0 (0.0)	36 (100.0)
Satisfaction at Work ($n = 37$)		
18. In general, I am very satisfied with my present job	8 (21.6)	29 (78.4)
19. I can deal with complicated situations when they arise	4 (10.8)	33 (89.2)
20. I would encourage a friend to apply for a job in my unit	13 (35.1)	24 (64.9)
21. I trust my supervisor	2 (5.6)	35 (97.2)
22. I often think about quitting the job[c]	26 (70.3)	26 (29.7)

[a]Strongly disagree concerns nurses' responses of a 1 or 2. [b]Strongly agree concerns nurses' responses of a 3 or 4. [c]Items were reversed.

majority indicated that they had to work very fast (92%) and that their work required too much effort (79%).

Control over Work. The Control or Decision Latitude subscale assesses the opportunities and/or resources that an organization provides to a professional to make decisions regarding the performance of their work. The mean score was 18.46 ($SD = 1.92$; TR = 6–24; Table 4). Regarding the use of skills, the majority of nurses (97%) (strongly) agreed that they have the possibility of learning new things through their work and that their work required a high level of skill or expertise. Regarding decision-making autonomy, although the majority of respondents (78%) indicated that they can decide how they do their work, only half (49%) were (completely) in agreement that they can decide what they do at work.

Social Support at Work. The Support subscale measures the social atmosphere in the workplace, that is, relationships with colleagues and superiors. The average subscale score was 18.72 ($SD = 2.17$; TR = 6–24; Table 4). All nurses (strongly) agreed that they get along well with their colleagues. In addition, the majority (strongly) agreed that the relationship with their superiors is good (94%).

Satisfaction at Work. The mean subscale score was 15.11 ($SD = 2.47$; TR = 5–20; Table 4). Seventy-eight percent of the participants indicated being satisfied with their current job, although only 65% would encourage a friend to apply for a job in their unit.

Correlation Coefficients. The correlation between beliefs (evaluated with the ICE-HCP-IBQ) and attitudes (evaluated with the FINC-NA) was positive and moderate ($r = 0.46$, $p < .01$). With greater confidence in nurses' understanding of the meaning that the disease has for the family, the attitude of nurses toward including the family in clinical practice was more positive.

Likewise, positive and moderate correlations were found between the beliefs of the professionals (evaluated with the ICE-HCP-IBQ) and the Control ($r = .41$, $p < .05$), Support ($r = .45$, $p < .01$), and Satisfaction at Work ($r = 0.38$, $p < .05$) subscales of the DCSQ. Therefore, greater confidence of

Table 5. Correlations Between Nurse Demographic Variables and Instruments.

Instruments	Age	Time since graduation as RN	Years working in the current service	ICE-HCP-IBQ[a]	Demands	Control	Support	Satisfaction
ICE-HCP-IBQ[a]	−.166	−.142	−.029					
Demands	−.086	−.075	.355*	−.044				
Control	−.107	−.068	−.291	.412*	−.283			
Support	−.068	−.091	.032	.453**	−.079	.284		
Satisfaction	−.192	−.193	−.387*	.382*	−.345*	.668**	.346*	
FINC-NA[b]	.135	.104	−.034	.455**	−.060	.496**	.539**	.649**

Note. RN = registered nurse; ICE-HCP-IBQ = Iceland Health Care Practitioner Illness Beliefs Questionnaire; FINC-NC = Families' Importance in Nursing Care–Nurses' Attitudes scale.
[a]Higher scores indicate greater confidence of the nursing professional in their beliefs about the understanding of the meaning that the illness has for the family [b]Higher scores indicate more positive attitudes toward the importance of including the family in nursing care.
*$p < .05$. **$p < .01$.

nurses in their belief that they understood the meaning that the disease had for the family was correlated with a greater perception of control over their work, greater social support from colleagues and superiors, and greater job satisfaction (Table 5).

Similarly, the attitudes of professionals (evaluated with the FINC-NA) was positively and strongly correlated with the Control ($r = .50$, $p < .01$), Support ($r = .54$, $p < .01$), and Satisfaction at Work ($r = .65$, $p < .01$) subscales of the DCSQ. Therefore, the positive attitudes of nurses toward the importance of including the family in nursing care are correlated with a greater perception of control over their work, greater social support from colleagues and superiors, and greater job satisfaction. Significant correlations were not observed for the other variables (Table 3).

Qualitative Results

The analysis of the open-ended questions on the ICE-HCP-IBQ resulted in three main categories: (a) cancer, a long and terminal disease; (b) the family, a central element of oncological disease; and (c) barriers to implementing a family approach in oncology.

Cancer, a Long and Terminal Disease. The majority of oncology nurses maintained a negative perspective of oncological diseases. They agree that it is a serious health problem that changes the life of the patient and his or her family. This is reflected in the following excerpt from a nurse:

> The health problem that has been presented to them has changed their life and that of their family, and they begin a very hard period, which will influence their day to day. (Nurse 2)

In addition, nurses indicated that the patient can die in a short period of time or that, on the contrary, the illness can lead to a long and terminal illness, requiring long hospital admissions and frequent hospital visits. Thus, the diagnosis is associated with negative aspects such as suffering and death, as stated by a nurse:

> Unfortunately, death will come to a high percentage, and the corresponding suffering will come to their relatives, along with the frustration of the wasted effort. For others, the death and absence of the loved one will put an end to suffering. Another percentage will survive with sequelae, with greater or lesser consequences in daily life and impacts on their environment. It will be a victory with a toll to pay. (Nurse 4)

Due to this negative perspective of the disease and its prognosis, some nurses indicated that their action was limited to focusing only on the present, responding to the needs of the current situation, and not thinking about establishing long-term objectives, as indicated by a nurse:

> In many cases, time runs against them, and the important thing is to focus on the present since it is the only thing we are certain of. (Nurse 30)

The Family: Central Element of Oncological Disease. The nurses in this study considered oncological disease a "family affair" that affects not only the patient but also the rest of the family members. This was expressed by a nurse:

> I keep in mind that the family participates in the disease process because when one member becomes ill, the whole family does so. (Nurse 20)

Therefore, to cope with the illness, nurses recognize that the family should be included in the care provided and that the adaptation of the patient and the family should be promoted, with the nurse serving as a source of support in this process, as indicated by a nurse:

> I think that the health problem is a turning point for the patient and his or her family. We need to reorganize their lives and their roles and provide much support; we nurses are there. The

> health problem is a great unknown, despite being socially known. It produces much fear, insecurity, lack of knowledge; that is where the nurse has a fundamental role. It is a chronic disease to which the patient has to adapt together with his or her family. (Nurse 15)

Likewise, nurses reported that to provide quality care to patient and their families, two key aspects should not be lacking: a relationship of trust and good communication between the professional and the family. In fact, the nurses indicated that a lack of communication generates distrust and false expectations and even hinders the establishment of therapeutic measures. In this sense, when a relationship of trust is established, nurses believe that they obtain a greater understanding of the situation, their work is eased, and the presence of prejudice toward the family is avoided, as revealed by a nurse:

> A good relationship opens the doors to discover the world of the patient and his or her family. When there is a relationship of trust, the patient and the family open up almost unconsciously and show the nurse how it has affected them and how they are living their disease process, what is most important for them, their experiences. Through a deep relationship, you come to understand the patient and his family, you understand the behaviors they have and avoid "negative" judgments about them. (Nurse 15)

However, the data revealed that the action of nurses with families is oriented toward a more practical and instrumental dimension of care, as reflected in the following quote from a nurse:

> I believe that the basic pillar of the nurse-patient-family relationship should be communication and confirmation that the information about the treatment, care and medication that should be taken at home . . . has been understood. I always try to repeat explanations, give the option to ask questions and make sure that they have understood all the information that has been given to them. (Nurse 16)

In addition, some nurses considered that the attitude of the family toward the disease process and attempts to protect their sick relative can be obstacles to the care process. They argued that this attitude may be due to the lack of information about the health process or the tension caused by the disease and the hospitalization situation. However, as shown in the following quote, nurses reported that this attitude of the family is an "extra" challenge in clinical practice:

> I perceive situations of great stress that entail moments of anguish and maladjustment that, in turn, cause tension in the family context. This is an "extra" challenge in daily practice since it hinders the intervention or establishment of therapeutic measures. (Nurse 33)

Barriers to Developing a Family Approach in Oncology. This category reflects how nurses recognize that not having the knowledge and skills necessary to work with families affects the quality of care, as reflected in the following quote:

> The health problem raises questions in the patient and the family that often have no answer. These questions about vital things are posed, on numerous occasions, to nurses. I am often afraid of not knowing how to answer them or not knowing how to act, and that can make my work difficult. I think that the health problem requires that the nurse empathize with the patient and the family. That empathy, sometimes, causes me suffering, and this suffering can cause me not to cover conflictive or vital issues for the patient and the family. (Nurse 35)

In this sense, nurses believe that to provide adequate care, it is essential that professionals be educated in family nursing competence, that is, knowing how to gather the necessary knowledge, skills, and attitudes to be able to carry out the process of care for the family in a satisfactory way, as confirmed by a nurse:

> . . . it is important to be a good professional, prepared in theory and practice when developing my work. Professional competence and empathy with the family . . . lead to greater trust. Family members should feel safe and that they are treated very well, professionally and as people. (Nurse 8)

Finally, nurses described some of the contextual factors that act as barriers to including families in their daily clinical practice. Specifically, the perception of a lack of time, due to the workload and the dynamics of the service, leads nurses to prioritize patient care. This results in an approach that does not address the needs of the family, although nurses recognize its importance, as described by a nurse:

> Family support is essential to cope with the disease. In the day hospital, we have a few hours with the patient, and it is difficult to delve into aspects of family care due to the dynamics of the service. (Nurse 9)

Discussion

This is the first study to map personal and contextual factors in relation to the implementation of a family nursing approach in oncology care. The results of this study provide new knowledge about the attitudes and beliefs of oncology nurses toward the importance of including the family in care, as well as the barriers and facilitators present within the context of clinical practice when implementing a family-oriented approach to care in oncology.

In general, the majority of oncology nurses reported having a supportive attitude toward including the family in nursing care as well as a medium amount of confidence in their belief that they understand the meaning that the disease has for the family, a finding that is consistent with previous research among registered nurses in other nursing settings (Benzein et al., 2008; Gusdal et al., 2017; Luttik et al., 2017).

This is a relevant finding because as indicated by the evidence (Duhamel et al., 2015; Wright & Bell, 2009, 2021), maintaining a supportive attitude toward the family is a prerequisite for inviting and involving them in nursing care. In addition, consistent with the finding reported by Alfaro-Díaz et al. (2020), the results reveal that the positive attitudes of nurses toward the importance of including the family in their clinical practice are positively correlated with greater confidence of the professional in their belief that they understand the meaning that the disease has for the family. These results provide empirical support for the Illness Beliefs Model (Wright & Bell, 2009, 2021), which emphasizes the synergy between holding facilitating beliefs when working with families and a positive attitude toward including families in clinical practice.

A notable finding of this study is that although oncology nurses recognize the importance of the family in the care of patients with cancer, attitudes toward inviting the family to participate in care are less positive. Nurses are aware of the impact that the disease has on the family unit and the value of the information that the family can provide for patient care. However, only half of the nurses reported asking families to participate in discussions regarding the patient and their satifaction with the care the patient received. These results support the findings in other studies (Caty et al., 2001; Gusdal et al., 2017; Luttik et al., 2017), confirming that although nurses support the inclusion of families and recognize the importance of family in the health and recovery of patients, they do not effectively include families in their clinical practice.

Similarly, oncology nurses recognize that prior knowledge of the values and beliefs of families is essential to be able to establish an effective therapeutic relationship and help the family during the disease process. As indicated by various experts in the field of family nursing (Duhamel & Dupuis, 2003; Wright & Bell, 2009, 2021), nurses believe that when a therapeutic relationship is established, the professional achieves a greater understanding of the situation, which avoids certain prejudices toward the family. However, despite recognizing the benefits of this knowledge, only half of the nurses indicated that they believed they knew which family member was suffering the most due to the impact of the oncological disease, and less than half believed they knew the degree of control that the family had over the disease or the disease had over the family.

As indicated by the studies conducted by Broekema et al. (2018) and Hoplock et al. (2019), the discrepancy between the beliefs and positive attitudes of nurses toward the importance of including families in patient care and the current approach to the inclusion of families in clinical practice can be attributed, in part, to the lack of professional competence of nurses to use family nursing theory in their practice. Most nurses in this study indicated that they had not received education in family nursing and did not have sufficient confidence in their abilities to work with this approach, thus limiting their skills when interacting with families. Hallgrimsdottirr (2000) and Luttik et al. (2017) point out that despite recognizing family needs, if nurses do not have the competence to work with families, it is more difficult for them to initiate or establish a therapeutic relationship with family members. This is also supported by the International Family Nursing Association Position Statement on Graduate Family Nursing Education (2018) that upholds the importance of teaching theoretical knowledge and skills based on practice and evidence in family nursing educational programs, which are then developed clinically through supervised practice experiences (IFNA, 2013, 2015, 2017). In this way, nurses' competence and confidence in effectively promoting the health of families is nurtured. Therefore, these findings support the need to provide family nursing education to oncology nurses, with the objective of acquiring the knowledge and skills necessary to carry out effective family nursing care (Caty et al., 2001; Gusdal et al., 2017; Luttik et al., 2017).

This study also identified negative beliefs and attitudes toward the family, which was a barrier to working with a family approach. Specifically, based on the quantitative data, only half of the nurses agreed that the presence of family members reduced their workload, and based on the qualitative results, some nurses saw the family as a burden. These findings are consistent with the results of a study conducted by Benzein et al. (2004), who found that this view of the family as a burden is related to the idea that the professional is the expert and, therefore, knows what is best for the family. However, as reported by other authors (Angelo et al., 2014; Benzein et al., 2004; Feeley & Gottlieb, 2000), this view does not allow understanding the experience of illness and hinders the development of a collaborative nurse–family relationship.

In addition to the above and as evidenced by other studies carried out in the hospital context (Gusdal et al., 2017; Østergaard et al., 2020), this discrepancy could explain, in part, to the barriers present within the context of clinical practice in oncology. Evidence confirms that due to oncological disease severity and the complexity of treatments, oncology units are considered very stressful clinical environments for health professionals (Bakker et al., 2000). In this sense, the results of this study indicate that the majority of oncology nurses perceived that they were exposed to high psychological demands in their work. In keeping with other literature (Benzein et al., 2008; Saveman et al., 2011; Shajani & Snell, 2019; Wright & Leahey, 2013), nurses identified the lack of time and the dynamics of the service as barriers to providing adequate care to families. According to Benzein et al. (2008), when demands are high, nurses must prioritize their work tasks, and it is possible that they put the care of the patient and their pathology before the care of the family. Likewise, nurses may experience tension between their own values and the objectives set by the workplace (Hoplock et al., 2019; Sharp et al., 2018).

On the other hand, the results indicate nurses perceive that they have a moderate level of control over their work. Specifically, although professionals can decide how to do

their work, they cannot decide what they do. That is, they perceive low decision autonomy. These results are consistent with the findings presented by Sigurdardottir et al. (2015) and Svavarsdottir, Sigurdardottir, et al. (2018), who point out that high demands and low decision autonomy are barriers to implementing the knowledge of family nursing in clinical practice in oncology (Sigurdardottir et al., 2015; Svavarsdottir, Sigurdardottir, et al., 2018). In addition, the results of this study highlight that the perception of greater control of nurses over their work is significantly related to more positive attitudes and beliefs toward including the family in care. Therefore, this finding should be taken into account when devising a strategy for the implementation of FN in clinical practice in oncology (Sigurdardottir et al., 2015; Svavarsdottir, Sigurdardottir, et al., 2018).

Finally, with respect to social support at work and job satisfaction, the majority of oncology nurses reported that the relationship with their colleagues and supervisors was good and that they were satisfied with their current work. In keeping with the findings reported by Hori et al. (2020), the results in this study show that social support and job satisfaction are significantly correlated with the beliefs and attitudes of nurses. Therefore, to promote more positive attitudes and beliefs, these factors should be strengthened (Naef, Kaeppeli, et al., 2020; Naef, Kläusler-Troxler, et al., 2020).

Limitations

The use of self-assessment instruments may generate a bias of social desirability and constitute a threat to the validity of the results (Krumpal, 2013). In addition, although the study was carried out with all the nursing professionals who were part of the oncology staff of the hospital and voluntarily wished to participate, the size of the study sample was small, which affected the statistical effect of the analyses performed; therefore, the results should be interpreted with due caution.

Conclusion

This study provides new knowledge about the attitudes and beliefs of nursing professionals toward the importance of including families in care, as well as the barriers and facilitators present within the context of clinical practice in order to implement a family nursing approach in the field of oncology.

The findings of this study highlight that oncology nurses maintain positive attitudes and beliefs toward the importance of the family in the care of the patient and recognize the impact of diseases on the family unit. However, attitudes toward inviting the family to participate in care are less positive. This is due to the lack of professional competence to work with a family approach to care as well as to the variables present within the context of clinical practice that act as barriers to implementing family focused care, such as lack of time and workload.

In addition, this study highlights how oncology nurses perceive that in their workplace, they are exposed to high psychological demands and that their level of autonomy in decision making is low, making it difficult to include families in their clinical practice.

Implications for Research

The knowledge gained through this study can be used to inform the design of a family nursing education program adapted to the context of clinical practice that promotes the confidence and security of professionals to provide family-oriented care and thus promotes more inclusive care for patients and their families. Indeed, evidence from research and clinical practice suggests that a combination of implementation strategies, such as education, learning opportunities, and mentoring supported by organizational structures, are essentials to implement family-oriented care in care settings (Naef, Kaeppeli, et al., 2020; Naef, Kläusler-Troxler, et al., 2020).

It is essential for the knowledge gained herein to be used when designing and carrying out strategies that address and, if possible, reduce or eliminate the barriers that may hinder the implementation of family nursing knowledge in practice. Likewise, these findings should be taken into account when implementing strategies aimed at reinforcing the identified facilitators so that the implementation of knowledge is carried out in a systematic and sustainable manner across time.

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Supplemental Material

Supplemental material for this article is available online.

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