AINEISTO A.

	30–39	40–49	50–59	60–69	70–79	80+
Selkäkipu						
Miehet	49,5	50,2	43,4	41,5	34,3	45,3
Naiset	50,7	44,4	45,6	47,2	51,6	56,0
p^2						
lkm	*350 000*	*313 000*	*326 000*	*330 000*	*212 000*	*150 000*
Niskakipu						
Miehet	39,3	44,0	38,0	33,4	26,5	32,4
Naiset	59,1	52,7	51,3	46,9	43,6	40,5
p^3						
lkm	*343 000*	*319 000*	*328 000*	*300 000*	*174 000*	*108 000*
Olkapääkipu						
Miehet	28,6	39,2	41,9	39,8	33,4	38,6
Naiset	29,3	33,6	40,4	44,9	45,9	48,4
p^4						
lkm	*202 000*	*241 000*	*302 000*	*315 000*	*195 000*	*129 000*
Kävelyvaikeus tai ontuminen polven vaivan tai vian takia						
Miehet	13,1	19,9	27,2	25,2	21,2	35,1
Naiset	9,7	17,5	26,4	30,9	33,1	47,9
p^5						
lkm	*80 000*	*124 000*	*197 000*	*209 000*	*134 000*	*125 000*

	30–39	40–49	50–59	60–69	70–79	80+
Oma arvio elämänlaadusta (%)						
Miehet						
Hyvä	80,9	79,8	72,7	74,6	69,6	53,0
Kohtalainen	15,9	17,3	22,5	21,1	27,7	36,6
Huono	3,2	2,8	4,8	4,3	2,7	10,4
Naiset						
Hyvä	84,8	79,8	75,4	76,4	62,5	49,4
Kohtalainen	10,7	16,2	17,8	20,3	33,0	43,6
Huono	4,5	4,0	6,9	3,3	4,4	7,0
p^2						
Maailman terveysjärjestön elämänlaatumittari (keskiarvo, EUROHIS-QOL-8,						
Miehet	4,0	4,0	3,9	4,0	4,0	3,8
Naiset	4,0	4,0	4,0	4,0	3,9	3,8
p^3						
Taloudelliseen tilanteeseensa tyytyväisten osuus (%)						
Miehet	48,8	50,0	51,0	58,8	63,7	59,2
Naiset	45,4	47,9	52,0	56,2	59,9	53,4
p^4						
lkm	*330 000*	*323 000*	*378 000*	*427 000*	*298 000*	*159 000*
Niiden osuus, jotka ovat tyytyväisiä saavutuksiinsa elämässä (%)						
Miehet	64,4	67,2	66,9	65,8	68,1	67,1
Naiset	71,8	75,0	74,8	68,6	66,4	59,8
p^5						
lkm	*476 000*	*469 000*	*520 000*	*500 000*	*325 000*	*179 000*
Perhe-elämäänsä tyytyväisten osuus (%)						
Miehet	80,7	76,5	76,8	78,2	77,8	72,5
Naiset	79,7	78,9	78,0	79,0	71,8	63,5
p^6						
lkm	*561 000*	*514 000*	*569 000*	*584 000*	*360 000*	*191 000*

AINEISTO A.

	30–39	40–49	50–59	60–69	70–79	80+
Pitää yhteyttä ystäviin tai sukulaisiin harvemmin kuin kerran viikossa (%)						
Miehet	14,9	27,7	32,5	33,0	33,4	29,5
Naiset	5,9	10,3	13,7	12,7	13,2	15,5
p^2						
lkm	*74 000*	*126 000*	*169 000*	*168 000*	*108 000*	*58 000*
Ei yhtään läheistä ystävää (%)						
Miehet	11,4	17,3	21,6	17,5	15,4	14,3
Naiset	7,1	9,3	8,6	9,3	9,4	11,1
p^3						
lkm	*65 000*	*88 000*	*111 000*	*98 000*	*59 000*	*35 000*
Tuntee itsensä yksinäiseksi jatkuvasti tai melko usein (%)						
Miehet	6,5	4,0	6,3	6,7	4,7	12,2
Naiset	9,0	5,6	7,6	6,7	9,1	14,9
p^4						
lkm	*55 000*	*31 000*	*51 000*	*50 000*	*34 000*	*40 000*
Ei luota toisiin ihmisiin (%)						
Miehet	18,0	21,7	22,4	27,2	34,4	38,9
Naiset	16,2	17,1	17,2	26,5	32,1	34,0
p^5						
lkm	*120 000*	*129 000*	*145 000*	*199 000*	*160 000*	*103 000*
Ei luota vastavuoroisuuteen (%)						
Miehet	30,8	31,4	36,2	42,0	45,5	45,1
Naiset	26,9	25,2	28,5	32,3	44,1	35,9
p^6						
lkm	*202 000*	*187 000*	*238 000*	*275 000*	*217 000*	*112 000*

	30–39	40–49	50–59	60–69	70–79	80+
Kerho- tai yhdistystoiminta (väh. kuukausittain)						
Miehet	27,7	28,0	22,9	25,0	37,8	31,4
Naiset	31,4	28,0	24,9	26,5	39,8	40,3
p^2						
lkm	*207 000*	*185 000*	*176 000*	*192 000*	*189 000*	*106 000*
Teatteri, elokuvat, taidenäyttelyt, urheilutapahtumat tms. (väh. kuukausittain)						
Miehet	40,3	35,0	28,0	22,1	24,0	16,2
Naiset	38,9	42,4	32,7	29,8	26,2	10,8
p^3						
lkm	*277 000*	*255 000*	*222 000*	*193 000*	*122 000*	*36 000*
Kirkko tai muut uskonnolliset tapahtumat (väh. kuukausittain)						
Miehet	5,2	5,7	7,6	7,1	10,2	20,5
Naiset	4,8	6,6	10,0	14,0	23,0	25,0
p^4						
lkm	*35 000*	*40 000*	*65 000*	*80 000*	*83 000*	*67 000*
Liikunta, ulkoilu, metsästys, puutarhatyöt tms. (väh. viikoittain)						
Miehet	72,0	72,5	68,0	69,2	71,7	54,5
Naiset	83,1	81,9	80,6	81,4	73,1	57,9
p^5						
lkm	*541 000*	*509 000*	*545 000*	*561 000*	*351 000*	*162 000*
Käsityöt, musisointi, valokuvaus, maalaaminen, keräily tms. (väh. viikoittain)						
Miehet	32,7	31,4	24,2	28,5	31,1	22,3
Naiset	47,0	42,4	48,8	56,7	59,8	44,7
p^6						
lkm	*277 000*	*243 000*	*268 000*	*320 000*	*227 000*	*106 000*

AINEISTO B.

Huom. taulukosta ei tarvitse huomioida [a,b,c] Merkintöjä

Index	Outcome	AMI			Hip fracture			Stroke			ED		
		n	Beta (95% C.I.)	*P*-value	*n*	Beta (95% C.I.)	*P*-value	*n*	Beta (95% C.I.)	*P*-value	*n*	Beta (95% C.I.)	*P*-value
QMSI[a]	TC	290	0.767 (−0.106, 1.640)	0.082	284	0.276 (−0.365, 0.918)	0.385	293	0.753 (0.186, 1.321)	0.011	372	0.325 (−0.290, 0.939)	0.283
	SC	294	0.775 (−0.041, 1.592)	0.061	281	0.382 (−0.342, 1.105)	0.291	303	1.179 (0.344, 2.014)	0.008	373	0.976 (0.155, 1.797)	0.022
	L	300	0.956 (−0.016, 1.927)	0.054	304	0.686 (−0.481, 1.853)	0.238	318	1.513 (0.384, 2.643)	0.011	391	1.089 (0.179, 2.000)	0.021
QMCI[a,b]	TC	290	−4.082 (−7.296, −.868)	0.016	284	0.110 (−2.139, 2.359)	0.916	293	0.244 (−1.843, 2.330)	0.807	372	0.132 (−1.647, 1.911)	0.878
	SC	294	−3.998 (−6.745, −1.25)	0.008	281	0.742 (−1.718, 3.202)	0.528	303	0.297 (−2.911, 3.505)	0.848	373	−0.204 (−2.596, 2.189)	0.862
	L	300	−2.645 (−6.456, 1.167)	0.161	304	1.215 (−3.019, 5.449)	0.548	318	0.201 (−4.146, 4.549)	0.923	391	−0.077 (−2.731, 2.577)	0.952
CQII[a,b,c]	TC	290	−0.017 (−0.891, 0.857)	0.970	284	0.338 (−0.226, 0.902)	0.240	293	−0.195 (−0.783, 0.394)	0.517	372	0.420 (−0.354, 1.194)	0.287
	SC	294	−0.385 (−1.121, 0.351)	0.305	281	−0.019 (−0.669, 0.631)	0.955	303	−0.559 (−1.422, 0.304)	0.204	373	0.618 (−0.420, 1.655)	0.243
	L	300	−0.461 (−1.509, 0.587)	0.389	304	0.329 (−0.772, 1.430)	0.559	318	−0.642 (−1.823, 0.538)	0.286	391	0.246 (−0.942, 1.435)	0.685

Lyhenteiden selitteet:

AMI = Myocardian Infraction
ED = Emergency Department

Organisaatiotason laadunhallintajärjestelmien vaikutusta arvioitiin seuraavilla mittareilla:
QMSI = Quality Management Systems Index
QMCI = Quality Management Compliance Index
CQII = Clinical Quality Implementation Index

Osastotason muuttujat:
TC = Teamwork Climate
SC = Safety Climate
L = Leadership

n = otoskoko

Beta (95% C.I.) = Luottamusväli kertoo millä välillä todellinen perusjoukon tunnusluvun arvo on tietyllä todennäköisyydellä.
P-Value = Todennäköisyys havaita keskiarvojen välinen ero, joka on yhtä suuri tai suurempi kuin keskiarvojen välillä laskettiin havaituista keskiarvoista. Tilastollisesti merkitsevällä yhteydellä tarkoitetaan enintään 5 % riskitasoa, eli $p < 0.05$.

AINEISTO B.

Methodology

Concept analyses are intended to comprehensively elucidate the elements of a concept of interest, define its characteristics, assess its function and organization, and expand the body of knowledge regarding that concept. This concept analysis of family-centered care in the hospital environment was guided by the methodology described by Walker and Avant (2005). This method of concept analysis contains 8 steps which begin by selection of the concept to be examined and identification of the purpose of the analysis. Subsequent steps of this method identify the uses and qualities of the concept, develop model, borderline, and contrary cases to best exemplify the concept, recognize antecedents and consequences of the concept, and ultimately define "empirical referents". Empirical referents "are classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself." This methodology best fit the objectives of this concept analysis.

Data Sources

Multiple databases were searched to obtain information for this concept analysis: CINAHL (Cumulative Index of Nursing and Allied Health Literature), PedMed, and ProQuest: Nursing and Allied Health. Key words used during searches included family-centered care, family-centred care, and family nursing, in combination with hospital setting, hospital environment, and hospital, as well as pediatric patient. References that were written in English or provided English translation were included. Many combinations of key terms yielded results that were too large and abstruse to adequately analyze. For example, the ProQuest search of family-centered care and hospital setting generated 4484 results. The terms family-centered care combined with hospital environment or hospital setting yielded the most applicable results that ranged from 359 to 22 depending on database and were more relevant to this analysis. In order to eliminate references that were not constructive to the analysis, sources with a foci of home care, primary care, or adult patients were excluded. A total of 37 references were found to be rich in content and utilized for the concept analysis.

Assumptions

The concept of family-centered care of hospitalized pediatric patients contains various underlying assumptions. First and foremost, family-centered care assumes that parents and other family members have the desire to participate in the care of the child, have continual information and communication from health care providers, and take part in the decisions for their hospitalized child. Nurses must be educated on the principles of family-centered care and are comfortable negotiating the care of the patients they care for. Nurses must also acknowledge the importance of family collaboration and participation in the child's recovery. To give customized family-centered care, nurses must assess first family dynamics, strengths, cultural values, and family roles.

Definitions

Family-centered care in the hospital environment can be defined theoretically and operationally. Family-centered care can be theoretically defined as a philosophy of care that recognizes the family as central to the patient's life, views the patient in the context of the unique family, and supports family members in their role as caretakers. Operational definitions concentrate on a partnership where health care providers, such as nurses, and family members collaborate to construct the plan of care, negotiate patient care, make health care decisions, and continually evaluate care being provided to the patient. The following are key terms related to family-centered care in the hospital environment:

- Family- a unique group of people who provide mental, emotional, physical, or social support for each other. A family defines who the members of their family are.
- Collaboration- relationship between multiple parties with the goal of planning, developing, implementing, and/or evaluating an activity.
- Cultural diversity- variety in race, ethnicity, socioeconomic class, religion, and life experiences.
- Negotiation- discussions aimed at making decisions together or reaching an agreement.
- Open communication- The exchange of information which is transparent, comprehensive, and unbiased. Open communication is supportive and truthful with equal opportunity among parties for participation.

Characteristics

The characteristics of family-centered care in the hospital environment are multifaceted and multidimensional. Within family-centered care, the care provided is holistic and planned around the family as a whole. Family-centered care recognizes the family as a constant in the child's life and the crucial role of family. The partnership between health care providers and family members is mutually beneficial and maintains dignity and respect. Family-centered care respects cultural diversity and views each family as unique. It also includes the deliberate involvement and encouragement of participation of family members at all levels of care. Family-centered care encompasses multiple levels of support of family members, including emotional, physical, spiritual and peer-to-peer. Communication within family-centered care is unbiased, constant, comprehensive, honest, open, respectful, and encouraged among all participants. Finally, nurses and family members negotiate the care of the patient.

Antecedents

Antecedents can be defined as “those events or incidents that must occur prior to the occurrence of a concept.” Multiple antecedents must exist in order for family-centered care to be put into practice. At baseline, family must be present during the patient's hospitalization and have the desire to be involved in the child's care. Nurses must be willing to incorporate family-centered care into nursing practice, must be educated on the principles of family-centered care, and be competent in the implementation of those principles into practice. Without the proper training and understanding of family-centered care applied to the hospital environment, nurses are unable to provide nursing practice centered around the patient-family unit. Finally, the responsibilities of patient care are ultimately to be shared within the family-nurse partnership, therefore, both parties must be willing to share that responsibility.

There are precursors to family-centered care regarding the management of time in the hospital setting. Sufficient time for communication between nurses and family members is needed for effective family-centered care to be provided. The provision of comprehensive patient care is often demanding, leaving insufficient time for families and nurses to develop inclusive, open, and collaborative dialogue. Communication within the partnership of nurses and families also needs to be open and honest for family-centered care to ensue.

The hospital environment itself must contain certain characteristics to promote family-centered care. The hospital atmosphere must be welcoming and inviting to parents and families and their participation in care. Visitation policies must be open and provide family members access to the patient. The patient's hospital room should allow family members to be physically present and to room in if desired. The physical environment must also promote communication and offer families, patients, and all healthcare providers a safe area that promotes open discussion. All of these facility requirements foster the presence and participation in care of family members.

Consequences

Consequences within concept analysis are the outcomes resulting from an occurrence of the concept. Primarily, the intended consequences of family-centered care are improved functioning within a family during a child's hospitalization. The integrity and unity of the family should be maintained throughout hospitalization. Families should feel empowered to participate in care and make informed decisions regarding their child's care. Family-centered care should increase family comfort and confidence in the care of the patient. Increase in family function and participation can improve family satisfaction and decrease experienced stress and anxiety. Nursing satisfaction also has the potential improve with the integration of family-centered care in nursing practice.

In working relationships communication is paramount. Therefore, a consequence of the developed partnership between nurses and families, a vital component of family-centered care, is optimal communication between both parties. Within the continual collaboration of the nurse-family relationship, nurses assess the family's uniqueness and cultural values leading to individualized family and patient care. Family-centered care seeks to improve the functional relationships between nurses, family members, and patients, thus creating an environment of support and healing.

While the goal of family-centered care is to improve nurse-family relations, improve patient and family outcomes as well as the family experience, there are potential negative consequences of its use as a model of care. A systematic review by identified potential disadvantages of family-centered care in the care of children 0–12 such as delivering communication that families are not yet ready to hear as well as having expectations of parents that are beyond their capabilities. Parents may also feel they are expected not only to be present but constantly vigilant also stated that parents may experience negative consequences when their expectations for maintaining control and autonomy are not met.