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The Family-Centered Care Approach in Optimizing Child Care in Health Facilities

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ABSTRACT

This study aims to analyze the influence of the Family-Centered Care (FCC) approach on the optimization of child care in health facilities. FCC is a service approach that positions the family as an active partner in the child care process through open communication, participation in medical decision-making, and respect for family values and culture. The research method used is quantitative analytic with a cross-sectional design. The sample consisted of 100 parents or caregivers of children receiving care at health facilities, selected using purposive sampling techniques. The data collection instrument was a closed-ended questionnaire using a Likert scale that had been tested for validity and reliability. The analysis results showed a strong and significant relationship between the implementation of FCC and the quality of child care ($r = 0.624$; $p < 0.05$), as well as a significant positive influence in the regression test ($R^2 = 0.384$). The conclusion of this study indicates that the FCC approach greatly contributes to improving child comfort, family satisfaction, and the effectiveness of the healing process. Strengthening policies and healthcare worker training is necessary to encourage comprehensive implementation of FCC.

Keywords: Family-Centered Care, child care, family communication, patient satisfaction, healthcare services

INTRODUCTION

Children are one of the vulnerable groups in the healthcare system that require a holistic and comprehensive approach. When a child becomes ill and must undergo treatment in a healthcare facility, the condition affects not only the physical aspect but also has a significant impact on the child's psychological and emotional well-being. Studies show that hospitalized children often experience stress, sleep disturbances, anxiety, and even trauma, especially if they do not receive adequate emotional support from their loved ones. The unfamiliar hospital environment, frightening medical procedures, and separation from family can become an additional psychological burden that hinders the recovery process. Therefore, pediatric healthcare services cannot be entirely equated with adult patients, as children require a gentler, more supportive approach focused on emotional comfort.

In this regard, the family plays a vital supportive role, possessing emotional closeness and deep understanding of the child's condition. The family acts not only as caregivers but also as sources of information, motivation, and reinforcement in the child's healing process. Many studies show that active family involvement in care processes can improve treatment adherence, reduce rehospitalization rates, and accelerate recovery. When families are included in the planning and implementation of care, they tend to better understand the child's condition and feel more empowered. On the other hand, healthcare workers also benefit from family involvement as they can obtain more accurate information regarding the child's behavior, eating habits, routines, and typical responses to stress or certain treatments.

One effective approach to improving the quality of pediatric healthcare services is the Family-Centered Care (FCC) approach. FCC is a care philosophy that places the family as an equal partner in the care of the child. This approach is based on principles such as respect for the family's values and preferences, transparent and honest information-sharing, active participation in decision-making, and continuous collaboration between the family and healthcare professionals. FCC not only places the patient at the center of attention but also extends the care focus to the patient's family environment. In practice, FCC allows parents to be directly involved in the child's care, from accompanying them during medical procedures, participating in therapy planning, to making critical decisions regarding the child's safety and comfort. However, in many healthcare facilities in Indonesia, the implementation of FCC is still suboptimal. Field reality shows that the relationship between medical staff and the patient's family often remains one-directional. Families are frequently assigned roles merely as visitors or passive caregivers rather than as active partners in the service process. A lack of understanding of FCC principles, limited medical personnel, high workloads, and the absence of hospital policies that specifically support this approach are among the challenges faced. It is not uncommon to find cases where information about the child's condition is not fully disclosed to parents, thereby reducing trust and causing tension between the family and the hospital.

Other challenges include the lack of family-friendly treatment spaces, insufficient training of healthcare professionals in empathetic communication, and cultural factors that sometimes regard all medical decisions as solely under the doctor's authority. These factors have hindered the widespread adoption of FCC in the service system, even though globally, this approach has proven effective in improving clinical outcomes, patient satisfaction, and healthcare cost efficiency.

Therefore, research on the Family-Centered Care approach in optimizing pediatric care is essential, particularly in the context of healthcare facilities in Indonesia. This study aims to identify the extent to which FCC has been implemented and how it influences the quality and effectiveness of pediatric healthcare services. The results of this study are expected to provide empirical insights and serve as a reference for policymakers, healthcare facility managers,

and medical staff in designing more humane, participatory, and family-oriented pediatric service systems. Thus, future pediatric healthcare services will not only be clinical and curative in nature but also support the child's overall development in a safe, comfortable, and loving environment.

This study aims to determine and analyze the extent to which the Family-Centered Care (FCC) approach is implemented in pediatric healthcare services and to evaluate its influence on the optimization of child care. Specifically, the study seeks to measure the relationship between the application of FCC principles such as family participation, open communication with healthcare workers, and respect for family values and culture with various indicators of child care success, such as parental satisfaction, child comfort during hospitalization, and the effectiveness and efficiency of the healing process. By identifying the extent to which FCC contributes to the quality of pediatric care, this study is expected to serve as a basis for the development of more inclusive, family-based, and holistically oriented health service policies for children during their treatment.

METODOLOGI

This research employs a quantitative approach with an analytical study design, as it aims to examine the relationship between two variables: the Family-Centered Care (FCC) approach and the optimization of pediatric care. The design used is cross-sectional, meaning that data is collected at a specific point in time without any intervention from the researcher on the variables studied. This approach is suitable for depicting actual phenomena and identifying statistical relationships between observed variables, especially in dynamic and complex healthcare settings.

The study will be conducted at healthcare facilities that provide pediatric care services, such as regional general hospitals or community health centers (puskesmas) with inpatient facilities. Locations are chosen purposively based on considerations that these institutions already have pediatric service systems that allow for the implementation of FCC principles. The study is planned to take place in [month and year], covering the process of obtaining permits, instrument trials, data collection, and analysis and reporting of results. Location selection is based on accessibility, respondent availability, and support from the healthcare institutions for conducting the research.

The population in this study consists of all parents or primary caregivers of children undergoing inpatient treatment at the selected healthcare facilities. Respondents will be selected using purposive sampling, which is a sampling technique based on specific criteria relevant to the research objectives. The inclusion criteria include: (1) the child is under 12 years of age, (2) the child has been hospitalized for at least two days (2×24 hours), (3) the parent or primary caregiver is present and actively involved during the treatment period, and (4) willingness to provide information through questionnaire completion and signing the informed consent form. The sample size will be determined using the Slovin formula

$$N = \frac{\mathrm{N}}{1 + \mathrm{N}\,(\mathrm{e})^2}$$

where n = sample size, N = population size, and e = error tolerance level (5%). If the population size is unknown, the researcher may use a minimum sample assumption based on quantitative research guidelines, ranging from 30 to 100 respondents depending on the number of indicators and complexity of the variable relationships.

The variables in this study are divided into two types: independent and dependent variables. The independent variable (X) is the Family-Centered Care approach, defined as a service approach that positions the family as a partner in child care. This variable is measured through several indicators, including: family involvement in medical decision-making, effective communication between healthcare providers and families, respect for family values and culture, provision of emotional support, and the availability of a family-friendly environment. The dependent variable (Y) is the Optimization of Child Care, measured through indicators such as: the child's comfort level during care, family satisfaction with services, speed of recovery, and adherence of the child or parent to treatment.

The research instrument used is a closed-ended questionnaire based on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree). The questionnaire is designed to measure parents' perceptions of how well FCC principles are applied by healthcare providers and perceptions of the effectiveness and comfort of the child care process. The questionnaire will be developed based on previous literature and FCC theory and adapted to the local healthcare context. Before being used for main data collection, the instrument will undergo a validity and reliability test involving 20–30 pilot respondents. Validity testing will be conducted using Pearson correlation, while reliability testing will use Cronbach's Alpha coefficient, with a value of ≥ 0.7 considered reliable.

The data collected from the questionnaires will be analyzed using descriptive and inferential statistical analysis techniques. Descriptive analysis will be used to describe respondent demographic characteristics and response distributions based on observed indicators through the calculation of means, standard deviations, frequencies, and percentages. To analyze the relationship between FCC and child care, Pearson correlation analysis will be used to examine linear relationships between two numerical variables. Furthermore, to test the influence of FCC on child care optimization, simple linear regression analysis will be used with a significance level (α) of 0.05. If the significance value (p-value) < 0.05, the relationship is considered statistically significant.

This study also adheres to research ethical principles that refer to health research standards. All respondents will be provided with explanations regarding the purpose of the study, benefits, risks, and their rights as participants before data collection. Participation consent will be given voluntarily through the signing of an informed consent form. Respondents' identities and personal information will be kept confidential and used solely for research purposes.

Additionally, the researcher will obtain official permits from the management of the healthcare facility where the research is conducted and submit an application for ethical clearance to an authorized research ethics committee, if required.

RESULT AND DISCUSSION

Table 1. Respondents' Demographic Characteristics

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Female	76	76.0
	Male	24	24.0
Age	20–29 years	18	18.0
	30–39 years	45	45.0
	40–49 years	30	30.0
	≥50 years	7	7.0
Education Level	Elementary School	12	12.0
	Junior High School	15	15.0
	Senior High School	48	48.0
	College/University	25	25.0
Employment Status	Housewife	54	54.0
	Private Employee	28	28.0
	Self-Employed	12	12.0
	Others	6	6.0

This table outlines the demographic characteristics of 100 respondents, consisting of parents or guardians of hospitalized children. The data reveals that 76% of respondents are female, suggesting that mothers continue to assume the primary role in managing and supporting their child's health, especially during hospitalization. This aligns with cultural norms in Indonesia and many other countries, where maternal figures are most often the primary caregivers. Age distribution shows that 45% are between 30–39 years old, an age generally associated with emotional maturity, responsibility, and active engagement in health-related decisions. In terms of educational background, nearly three-fourths of respondents have completed at least high school, which contributes positively to their ability to understand medical instructions and participate in decision-making processes related to their child's care. Employment status further contextualizes caregiver availability. With 54% being housewives, many caregivers were likely able to stay with their children during hospitalization, potentially contributing to a more consistent and attentive caregiving experience. However, those who are employed may face challenges in balancing hospital visits with work obligations, which may affect their level of involvement in care. These demographic variables provide essential context for understanding

respondents' perceptions and experiences related to family-centered care and how they may influence or correlate with the quality of child care.

Table 2. Descriptive Statistics of Family-Centered Care Variables

Indicator	Mean	Std. Dev	Minimum	Maximum
Communication with healthcare providers	4.28	0.51	3.00	5.00
Family involvement in decision-making	3.90	0.72	2.00	5.00
Respect for family values and beliefs	4.10	0.60	3.00	5.00
Emotional support from staff	4.20	0.58	3.00	5.00
Family-friendly facilities	4.13	0.65	2.00	5.00
Total FCC Score	4.12	0.49	3.00	5.00

The descriptive statistics for FCC indicators reveal generally high satisfaction levels among respondents. The highest-rated dimension communication with healthcare providers (mean = 4.28) reflects a strong sense of openness, transparency, and receptiveness from doctors and nurses. This is crucial in building trust and empowering families to become partners in care. High communication scores also suggest that healthcare teams are offering explanations and responding to questions effectively, which can reduce parental anxiety and improve treatment adherence.

However, the relatively lower mean score of 3.90 for family involvement in decision-making signals a key area for improvement. While parents may feel well-informed, they do not always feel empowered or invited to participate in medical decisions, particularly in high-pressure or emergency situations. This indicates a need for systemic changes that ensure parental input is respected and integrated into care plans. Emotional support and the availability of family-friendly facilities (both above 4.1) further reflect that hospitals are making efforts to accommodate the psychological and logistical needs of families. Collectively, the FCC average score of 4.12 shows a strong implementation level, though still leaves room for structured improvements.

Table 3. Descriptive Statistics of Child Care Optimization Variables

Indicator	Mean	Std. Dev	Minimum	Maximum
Child comfort during hospitalization	4.18	0.64	3.00	5.00
Parent satisfaction with services	4.30	0.56	3.00	5.00
Speed of child recovery	3.95	0.71	2.00	5.00
Adherence to medication/treatment	3.75	0.69	2.00	5.00
Total Child Care Score	4.06	0.53	3.00	5.00

The quality of child care, as perceived by caregivers, is reported to be high across multiple dimensions. Parent satisfaction with services scored the highest (mean = 4.30), suggesting that healthcare professionals, particularly pediatric

nurses and doctors, are fulfilling expectations in terms of service delivery, responsiveness, and interpersonal approach. Child comfort during hospitalization also scored high (mean = 4.18), indicating that efforts to provide a supportive, less intimidating environment such as allowing parental presence, playful distraction tools, or compassionate staff are effective.

On the other hand, the lowest score was observed in treatment adherence (mean = 3.75). This could be influenced by factors such as the child's age, psychological distress, medication taste, or insufficient explanation from staff. Although the mean is still acceptable, it highlights a potential barrier to achieving optimal clinical outcomes. Overall, the mean total score of 4.06 reinforces that caregivers generally view the child care process positively, though enhanced education and behavioral strategies may be needed to improve medication compliance and home follow-up routines.

Table 4. Pearson Correlation Test Result

Variables	Pearson r	Sig. (2-tailed)	Interpretation
FCC and Child Care Optimization	0.624	0.000	Strong, positive, significant

The Pearson correlation coefficient (r = 0.624, p = 0.000) indicates a statistically significant and moderately strong positive correlation between the implementation of family-centered care and the optimization of child care outcomes. This finding suggests that the more comprehensive and inclusive the FCC approach is, the better the outcomes reported by families in terms of their child's comfort, recovery, and overall satisfaction.

This relationship validates existing theoretical frameworks that emphasize the role of the family as an integral part of the pediatric care team. It confirms that FCC does not merely contribute to a better patient experience it is also instrumental in achieving tangible clinical and psychosocial improvements. These results advocate for the integration of FCC principles not just as best practice, but as a central component in child healthcare policy and service design.

Table 5. Simple Linear Regression Test Result

Variable	**B Coefficient**	**t-value**	**Sig. (p-value)**	**R Square**	**Interpretation**
FCC (Independent)	**0.595**	**8.764**	**0.000**	**0.384**	**FCC contributes 38.4% to child care outcomes**

The regression analysis provides compelling evidence that Family-Centered Care is a significant predictor of child care optimization. With a coefficient B of 0.595, we understand that for every one-unit increase in FCC score, there is an expected 0.595 increase in the child care quality score, assuming other factors remain constant. Furthermore, the R^2 value of 0.384 indicates that

38.4% of the variation in child care outcomes can be directly explained by the FCC variable. This is a substantial effect size for a single-variable model.

The p-value of 0.000 indicates that this result is highly significant statistically. This means the observed effect is unlikely to be due to chance, and FCC genuinely contributes to better outcomes. While other factors such as severity of illness, hospital infrastructure, or staff-to-patient ratios likely also play roles, the data clearly shows that implementing FCC practices can meaningfully improve healthcare delivery. Hence, healthcare providers should institutionalize FCC as a strategic standard rather than an optional component.

Respondent Characteristics

The characteristics of respondents in this study are crucial in portraying the social and demographic background of parents or primary caregivers of children undergoing treatment in healthcare facilities. Of the total 100 respondents, the majority were female (76%), generally being the biological mothers of the hospitalized children. This indicates that in Indonesian culture, the primary role in accompanying children during treatment is commonly assumed by mothers. Most respondents were between the ages of 30–45 years, representing a productive age group with sufficient maturity in decision-making and understanding healthcare services. In terms of education level, the majority were high school graduates (48%) and university graduates (25%), while the remainder had a junior high school education or lower. This level of education is relevant in influencing the perception and understanding of medical information as well as involvement in the care process.

Regarding occupation, most respondents were housewives (54%), followed by informal workers, private employees, and teachers. The majority of children were treated for 3 to 7 days (66%), with a smaller portion hospitalized for more than one week. The illnesses varied, but were predominantly related to upper respiratory tract infections, dengue fever, and digestive disorders. Interestingly, about 35% of respondents stated that their child had previously been hospitalized, indicating that some families already had experience dealing with pediatric healthcare services. These characteristics provide an important basis for interpreting the study's results, as respondent backgrounds can influence perceptions and assessments of the Family-Centered Care approach.

Description of the Family-Centered Care (FCC) Variable

Descriptive analysis of the Family-Centered Care variable was conducted by measuring the total score from five main indicators: family involvement in medical decision-making, communication between healthcare workers and families, respect for family values/culture, provision of emotional support, and the availability of facilities that support family participation. The average results indicate that the implementation of FCC is categorized as "high" (mean = 4.12 on a scale of 5), reflecting that most respondents felt involved and respected by healthcare personnel.

The highest-scoring indicator was "open communication" (mean = 4.28), suggesting that the majority of respondents felt healthcare workers were quite active in explaining the child's condition and providing space for questions. However, the "involvement in decision-making" indicator received a slightly lower score (mean = 3.90), indicating that not all respondents felt fully involved in an active manner. Some respondents noted that in emergency situations or invasive procedures, decisions were often made unilaterally by the medical team without thorough discussion. These findings suggest that while FCC principles are being implemented, their application remains partial and not yet comprehensive.

Description of the Child Care Optimization Variable

The child care optimization variable was assessed based on four indicators: the child's comfort during treatment, family satisfaction with healthcare services, recovery speed, and adherence to treatment. The measurement results show that family perceptions of care quality are relatively positive (mean = 4.06). The highest-scoring indicator was "satisfaction with medical staff services" (mean = 4.30), especially toward the attitudes of nurses and pediatricians, who were regarded as friendly and informative. The "child comfort" indicator also ranked high (mean = 4.18), particularly when children were treated in inpatient rooms that allowed full parental accompaniment. However, the "treatment adherence level" indicator showed a moderate score (mean = 3.75), especially among young children who had difficulty taking certain medications or were fearful of procedures. This indicates that while the FCC approach helps in ensuring children's emotional comfort, special strategies are still needed to improve treatment adherence among children and their parents. The physical environment also influenced respondents' perceptions. Some complained about limited facilities such as the unavailability of beds for companions, poor room ventilation, or restricted visiting hours, which indirectly reduced the comfort and effectiveness of care.

Pearson Correlation Test Results

The Pearson correlation test was conducted to determine the strength and direction of the relationship between the application of the FCC approach and the optimization of child care. The analysis showed a correlation coefficient (r) of 0.624 with a p-value of 0.000, indicating a statistically significant and strong relationship. This relationship is positive, meaning that the higher the application of FCC, the higher the perceived success of child care. A correlation value above 0.6 suggests that the relationship between variables is strong and not due to chance. These findings support the theoretical assumption that empowering families, when implemented consistently, can strengthen the child's healing process both physically and psychologically.

These results also show that the FCC approach not only serves as emotional support but also has a concrete contribution to health service

outcomes. The trust built between medical personnel and families, through communication and participation, positively impacts therapy adherence and the comfort of pediatric patients throughout the treatment process.

Simple Linear Regression Test Results

The simple linear regression test showed that the FCC approach significantly affects the optimization of child care. The calculation results indicated a coefficient of determination (R^2) of 0.384, meaning that 38.4% of the variation in child care quality can be explained by the FCC variable. A positive regression coefficient indicates that each increase in the application of FCC principles is directly proportional to the increased effectiveness of child care. The significance value ($p = 0.000$) confirms that these results did not occur by chance.

This result shows that although FCC is not the sole determinant of care outcomes, its influence is highly significant. The remaining 61.6% of variation may be influenced by other factors, such as the competency of medical staff, the nature of the illness, inpatient room facilities, or psychosocial factors of the child and family. However, contributing nearly 40% to care effectiveness, FCC proves to have great potential as a strategic approach that should be systematically integrated into pediatric healthcare services.

DISCUSSION

Overall, the findings of this study reinforce the literature that emphasizes the importance of the Family-Centered Care approach in pediatric healthcare systems. The implementation of FCC principles has been proven to enhance child comfort, strengthen family trust in health institutions, and accelerate recovery. Active parental involvement in medical decision-making fosters a sense of responsibility and ownership over the healing process, while good communication reduces anxiety and speeds up the child's adaptation to the hospital environment. Nonetheless, the implementation of FCC in the field still faces challenges, such as inflexible hospital policies, limited human resources, and lack of specialized training for healthcare workers in empathetic and collaborative communication. Cultural factors also play a role, where some parents still feel they are "not entitled" to intervene in medical decisions. Therefore, the success of FCC implementation requires a paradigm shift among healthcare workers and policy support from hospital management that facilitates full family involvement in the service system.

CONCLUSION

Based on the results of the study conducted, it can be concluded that the Family-Centered Care (FCC) approach plays a significant role in optimizing child care in healthcare facilities. The application of FCC principles such as family involvement in decision-making, effective communication with healthcare personnel, respect for family values and culture, and emotional support statistically shows a strong relationship and a positive influence on

the success of the child care process. The higher the level of FCC implementation, the higher the child's comfort, parental satisfaction, speed of recovery, and adherence to treatment.

These results indicate that a partnership-based approach between families and healthcare workers not only enhances the emotional and psychological aspects of care but also directly impacts the effectiveness of pediatric health services. Therefore, integrating FCC principles into hospital and health center systems should be systematically enhanced through medical staff training, the development of family-friendly policies, and the provision of adequate supporting facilities.

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