UNIVERSITY OF KWA-ZULU NATAL

FACULTY OF HEALTH SCIENCES

INVESTIGATION OF EDUCATIONAL PREPARATION AND PRACTICE OF ICU NURSES IN PROVIDING PSYCHOSOCIAL SUPPORT TO FAMILIES OF ICU PATIENTS IN TWO EDUCATIONAL INSTITUTIONS IN KZN

Khan Thazaya

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INVESTIGATION OF EDUCATIONAL PREPARATION AND PRACTICE OF ICU NURSES IN PROVIDING PSYCHOSOCIAL SUPPORT TO FAMILIES OF ICU PATIENTS IN TWO EDUCATIONAL INSTITUTIONS IN KZN

A dissertation submitted

To

**The Faculty of Health Science, School of Nursing,
University of KwaZulu-Natal, Durban, South Africa**

IN

Fulfillment of the Requirement for the

RESEARCH MASTER'S DEGREE IN NURSING SCIENCE

BY

THAZAYA   KHAN (RAJES)

Supervised by

PROFESSOR BUSISIWE R. BHENGU

2010

DECLARATION

I declare that this research project entitled **" INVESTIGATION OF PRACTICE AND EDUCATIONAL PREPARATION OF ICU NURSES IN PROVIDING PSYCHOSOCIAL SUPPORT TO FAMILIES OF CRITICALLY ILL PATIENTS IN TWO EDUCATIONAL INSTITUTIONS IN KZN"** is my own work. It is being submitted for the Research Master's degree in nursing at the University of Kwa-Zulu, South Africa.

It has never been submitted for any other purposes. All references used or quoted have been acknowledged by means of referencing.

SIGNATURE: .... DATE .31..|.12.|.2010

THAZAYA KHAN (RAJES)

This study has been approved for submission by the supervisor of this study, Professor B,R. Bhengu.

SIGNATURE.................................... DATE .31..12..2010

B. R. BHENGU

DEDICATION

This work is dedicated to my late parents

for providing me with unconditional

love, and for supporting me in my pursuit of the nursing profession,

and to all the families who face & experience critical illness

ACKNOWLEDGEMENTS

ABSTRACT

Aim: The aim of this study was to investigate the educational shortcomings as evident in the literature reviewed with the intention of developing intervention/s thus contributing to practice, management, research and education.

Background: Literature identifies many limitations in psychosocial support to families of patients in ICU. Little is known about the continued educational support the ICU nurses receive, formally and informally, to empower them to provide psychosocial support to the families of ICU patients.

Methodology: The mixed method (concurrent triangulation design), was adopted using the survey for both the quantitative and qualitative approach. In-depth interviews, conversations, participative observation and the review of documents were used to collect data. Collection of data occurred simultaneously. A research instrument and guide were used to obtain quantitative and qualitative data respectively.

Setting: Purposive sampling was used for the selection of hospitals within which the chosen ICUs were located and the educational institutions which provided the formal education and training to ICU nurses who worked in these hospitals.

Participants: The qualitative arm involved interviews with a purposively selected sample of critical care nurses. Saturation was reached after nine interviews. A sample size of 34 (n=34) was used in the quantitative arm of the study. Convenience sample was used.

Data Analysis: A mixed method approach was adopted. The study applied a thematic analysis according to the qualitative analysis described by Creswell 2007. Descriptive statistics were used to summarize data and findings were presented in tables and graphs. The SPSS version 15.0 and STATA statistical package calculate non – parametric tests between selected study variables.

Findings: The main themes derived from the qualitative analysis and confirmed by the statistical data demonstrated the manner in which continued education preparation was inadequate, the lack of specific clinical accompaniment, the lack of direction in terms of the philosophy of the units, ICU nurses being left on their own to obtain educational preparation. The results indicated that the lack of continued informal education at the unit and hospital level influenced the ICU nurses' lack of implementation of psychosocial support to families of ICU patients. Statistical results and qualitative themes were converged and integrated during data analysis. Jamerson et al.'s (1996) model of family experience was used to contextualise the findings.

Recommendations: Recommendations arising from the study were made for improvements in nursing practice, nursing management, nursing education and future nursing research. A practice checklist was formulated and expert opinion was sought using the Nominal Group Technique.

LIST OF ABBREVIATIONS

ICU   Intensive Care Unit

F.P.S   Family Psychosocial Support

SPSS   Statistical Package for the Social Sciences

SANC   South African Nursing Council

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CHAPTER 1: INTRODUCTION, BACKGROUND, AND PROBLEM STATEMENT

1.1 INTRODUCTION AND   BACKGROUND

Man is an autonomous individual, capable of free and independent choice, who is thus responsible for those choices. Corey (2009) stated that as individuals, we are born into families within which we spend our entire lives. It is within this family that we form our identity, we grow and change; we give and receive support to survive. We formulate, maintain and often live by unspoken rules and routines that we hope will keep the family (each member within the family) functional. Based on this premise, the family systems' perspective claims that individuals are best understood through assessing the interactions between and among family members. The growth and behaviour of one family member is interwoven with the others in that family. The psychosocial development of the family is best facilitated by working with and considering the family or relationships as a whole (Corey, 2009).

The family is thus viewed as a functioning unit that is more than the sum of the roles of its members. The behaviour (good or bad) of any individual member will influence all the other members in the family, and the response will have a reciprocal effect on the other individuals (Corey, 2009). Any disturbance in any one part will create a disruption to the whole. This disruption is because an individual is part of a system and will therefore affect the family system as a whole (Neabel, Bourbonnais & Dunning, 2000). The family is empowered through the process of identifying and exploring internal, developmental and purposeful interactional patterns. Simultaneously, a systems' viewpoint recognises that individuals and families are affected by external forces and systems, which include illness, shifting gender patterns, culture, socioeconomic and psychosocial considerations.

Family systems' theory defines the individual as a system embedded within many other systems. This brings an entirely different perspective to assessment and treatment to restore equilibrium (Corey, 2009). Therefore, health care professionals are required to go beyond the individual to the family, because it is within this embedded system that the individual will return. The ill health of one member affects the health of others and *vice versa*, this is aggravated if the illness is of a critical nature.

Admission to the critical care environment indicates a life and death situation. The integrity of the family as a unit is threatened. The experience of patients and families in critical care units is a daunting and stressful one. The technology, urgency, uncertainty and conflict are interwoven into the culture of critical care nursing. The sudden emergent situation occurs without warning, and contributes to psychosocial stress for family members of the critically ill patient. The family experiences role and life style alterations, family disorganisation, disruption of routine, isolation, financial constraints, transportation problems; unfamiliar hospital environments and the uncertainty of the loved one's outcome. These factors amongst others induce family crisis and disequilibrium (Chui & Chan, 2007; Hughes, Bryan & Robbins, 2005; Verhaeghe, Defloor, Van Suuren, Duijnstee, & Grypdonck, 2005; Medina, 2005 and Engström, & Söderberg, 2004).

The admission to the ICU is usually a sudden and unexpected experience where treatment decisions are made under conditions of extreme urgency and uncertainty. This uncertainty adds to the emotional stress and responses of patients, their families, and critical care nurses, and impacts on the patients' outcome (Miracle, 2006; Rushton, Williams and Sabatienr, 2002). It is thus vital that health professionals provide care to patients, as well as to their families during this period of critical illness (Miracle, 2006; and Hughes, Bryan & Robbins, 2005).

O'Malley, Favaloro, Anderson, Anderson, Siewe, Benson-Landau, Deane, Feeney, Gmeiner, Keefer, Mains & Riddle (1991) concur that critical care nurses are responsible for meeting family needs during critical illness to provide holistic care. Covington (2001) adds that to meet patients' needs, culturally sensitive care is a priority to improve quality outcomes.

It is the family who are best able to interpret the patient's behavioural cues and reactions. They provide the health professionals with important assessment data and ultimately describe the impact of illness on the patient and themselves (Bucher & Milander, 1999). Molter (2003) affirms that families are the link between the patient and the external environment. The family is vital in achieving positive patient outcomes: Families and patients are assisted in understanding health concerns to solve problems, provide anticipated guidance, and are assisted with daily functions which they cannot perform, such as feeding, comfort, sleep and rest needs, grooming, mobility and elimination.

Jamerson, Scheibmeir, Bott, Crighton, Hinton & Cobb (1996) describe the families' experience in four phases when faced with critical illness. At first they are in the 'hovering' state and in disequilibrium, up to the point when they begin 'garnering resources' to meet their needs. In the 'hovering' phase, (confusion, shock, stress and uncertainty) the family members need to be provided with honest, accurate information about what is going on, and orientation to the ICU and the routine. The 'information seeking' phase is an active process of gathering information about the loved one. The family's need for proximity is overwhelming in order to engage in 'tracking', which is the process of observing, analysing and evaluating their loved ones' care, as well as the environment and health care professionals.

As Jamerson, et al., (1996) indicate, the family is assisted from their initial disorientation through to the phase of 'garnering resources'. In this process, the positive relationships of the family as a unit are strengthened, and they are offered love and comfort, thereby increasing self-esteem. The family moves to the final phase of 'garnering resources' which is the process of acquisition of what the family members perceive as needs for themselves or family members, for example, rest, privacy, nutrition, and support from other family members, friends and staff.

In summary these needs include feeling that there is hope, being close to the ill family member, receiving honest information regarding the progress of a loved one, reassurance and relief from anxiety, knowing that the loved one is receiving the highest quality care, to knowing that the critical care nurses are capable of providing this care (Miracle, 2006; Hughes et al., 2005 and Williams, 2005).

Hupcey (1999) claims that the family acts as a buffer for the patient's emotional stress, and that the health professionals need to actively involve the family in the decision-making process related to treatment. Critical illness of a member of a family could be a crisis due to role alterations, isolation from other family members, financial constraints, disruption of routine, transportation problems; unfamiliar hospital environments and the fear of losing their loved one. These are all factors which may induce family crisis and disequilibrium (Medina, 2005; Jamerson et al., 1996). Crisis is related to unplanned change in health states, roles, lifestyles, elevated anxiety states and family disorganisation. This unanticipated event creates emotional turmoil, shock, guilt, and an overwhelming feeling of helplessness in members of the families with a loved one in the critical care environment (Chui & Chan, 2007; Halligan, 2006; Hughes et al., 2005; Verhaeghe et al., 2005; Williams, 2005; Van Horn, Fleury & Moore, 2002; Rushton et al., 2002; Neabel et al., 2000 and O'Malley et al., 1991).

The family uses its existing resources to cope with the current critical care illness. It may fall back on patterns of responding to stressful events which have been successfully employed in previous situations. The family assigns meaning to the critical care illness and experience.

If the family can cope with the impact of this experience then crisis is avoided. Crisis occurs when the family systems' resources are unable to meet the demands of the critical illness of its member, and the experience becomes overwhelming. Families in crisis cannot solve problems in their usual way. Stressors at this time are perceived as a threat, not as a challenge (Bucher & Milander, 1999). Families' coping resources during this confusion are not readily mobilised. The critical cares nurses' focus is usually on the critically ill patient. The goal of care for families of critically ill patients is to help them move out of the 'hovering' state, by providing them with resources so that they can employ coping behaviours to restore and maintain their equilibrium during this experience of critical care illness. When families are maintained in equilibrium, then they can support the recovery of their critically ill family member.

Mitchell & Chaboyer (2010); Mitchell (2008); Van Horn et al., (2002); Appleyard, Cavaghan, Gonazalez, Ananian, Tyrell & Carroll (2000); Neabel et al., (2000); O'Malley et al., (1991) and Wooley (1990) agree that family support care in the ICU is vital in the outcomes of the critically ill member and the family. This includes:

- Decreasing the concerns of ill family members if they are aware that their family is receiving care.

- Allowing the family to be more supportive of the ill member which results in less disruption for the family system.

- Less anxiety is communicated to the ill family member by the family.

- The family provides a link to understanding patient needs and desires.

- Family support care as part of routine care in critical care nursing is required to enhance the promotion of family strengths and coping skills in order to achieve and maintain family health.

- Accommodate culture practices that influence health outcomes (Covington, 2004).

Family care has been defined over and over again since Molter's (1979) study. Hynes, Conlon, O'Neil and Lapinsky (2008) state from their experience that so far, nothing has been revealed to suggest that an absolute agreement on a certain concept is a prerequisite to meaningful engagement with patients and families, although some may think that the lack of consensus with the concepts may contribute to inconsistencies on how care is planned, organised and delivered. However, this debate is welcomed, in the belief that this would eventually be a theory versus practice debate. In the literature that was reviewed, there is no clear definition of the concept, but there appear to be factors associated with these concepts:

Family-focused care: health professionals are able to make a transition from patient-focused care to include family, in any given situation. Family-focused care appears to include family support. Medina (2005) suggests that family-focused care means that the nurses assess the needs of families and intervene to benefit the outcomes of patients and patients' families.

Family-centred care: the infrastructure/the family is considered during the planning and building of a health care institution to make it family friendly. Molter (2003) and Henneman & Cardin (2002) agree that family-centred care is a synthesis of philosophies, attitudes and approaches to care. This philosophy is based on the view that patients are part of a bigger "whole", and thus require a collaborative approach which includes the family (the expanded contemporary model of care). Shirey (2008) confirms that all of the above are contemporary care delivery models, and are used interchangeably while the expanded version is patient-family-centred care that incorporates a multidisciplinary approach.

Ponte & Peterson (2008) noted that, according to the Institute for Family-Centered-Care in the USA (a group dedicated to advancing the understanding and practice of patient-family-centred care) four core concepts of patient-centred care exist namely; dignity and respect, information-sharing, participation and collaboration. It is the role of nurses to link families with other professional support, for example, a social worker, pastoral care and a rehabilitation therapist within the ICU at the loved one's side, to enhance family psychosocial support (Henneman & Cardin, 2000). This author iterates further that for consistency there should be standard polices of care to support critical care nurses in being proactive in meeting the psychosocial need of families.

Family support care: This is also used as an umbrella term to include all the needs of patients and families. According to Shirey, (2008) it is a method of delivering care that acknowledges and respects the functional role of the family by assuming 'hands-on' care, thus involving the family members during the hospitalisation of the patients. Zarubi, Reily and McCarther (2008) also indicated that it is a method of delivering care that puts the patient and family at the centre of care. Families and patients are empowered to question policies and practices, and to offer their opinions/concerns so that the organisations reflect and evaluate better ways to meet their goals.

Family Psychosocial Support:- Azoulay, Pochard, Chevret, Lemaire, Mokhtari, Le Gall, Dhainaut & Schlemmer (2005) maintain that family members of patients in critical care units may display Post Traumatic Stress Disorders after the discharge or death of a loved one. Thus the appropriate concept used for this study would be Family Psychosocial Support which encompasses the biological, social, spiritual and psychological aspects of family care.

In the literature studied, Chien, Chiu Lai-Wah, & Wan-Yim (2006); Williams (2005); Hughes et al., (2005); Henneman & Cardin (2002); Leske (1992); Price (2004) and Molter (1979) have indicated that the families with relatives in critical care claim that families of patients in critical care units have special needs, for example, to feel that there is hope, to have proximity to the patient, to receive honest information regarding patient progress/prognosis, reassurance and relief from anxiety, to feel that the patient is receiving the highest quality care, to feel that the critical care staff care about the patient, and that reassurance and support is provided to the patient and family.

The literature reviewed in the form of Van Horn et al. (2002); Neabel et al. (2000); Appleyard et al. (2000); O'Malley et al. (1991), and Wooley (1990) has concluded that, while the needs of families have been identified, they were not met, or were inadequately met within the critical care setting. Verhaeghe et al., (2005) also conclude that health professionals do not do enough to meet these needs. Being knowledgeable of what families undergo will help the critical care nurse to provide family psychosocial support. However, Heyland, Rocker, Dodek, Kutsogiannis, Konopad, Cook, Peters, Tranmer, and O'Callaghan (2002) assert that a needs assessment is not synonymous with satisfaction, because unmet needs do not always translate into dissatisfaction, while meeting those needs does not guarantee satisfaction either.

Several research studies including those of Fumis, Nishimoto & Deheinzelin (2008); Candela & Bowles (2008); Mian, Warchal, Whitney, Fitsmaurice & Tancrdei (2007); Williams (2005); Peel (2003); Rushton, Williams and Sabatienr (2002); Neable et al., (2000) and O'Malley et al., (1991) claim that educational support of the health professional is the key to achieving skills and clinical practice, thus demonstrating appropriate behaviours to providing psychosocial support to families of patients in ICU. As agreed by Hardcastle (2008) critical care nurses are required to apply advanced knowledge and technical skills to complex and ever-changing practice situations.

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This demands the development of critical and creative thinking to problem-solving in clinical practice which can be supported through education and experience.

Professional growth occurs through a combination of educational strategies that builds theoretical (systems, family and crisis) and knowledge development. The process is enhanced by the application of critical thinking skills in the clinical setting (Lane, O'Brien & Gooney, 2005). Peel (2003) claims that education in the area of the delivery of bad news is not given to health professionals, thus there is a further need for educators to target this deficit. Jamerson et al.'s (1996) model of family experience indicates that critical care communication skills are vital to accompany the family out of the 'hovering' phase, advocating role demands that the critical care staff display empathetic communication skills.

O'Malley et al., (1991) claim that nurses' perceptions of family needs are influenced by units worked, length of time practicing in the ICU, educational preparation and length of time spent in the nursing profession. The results of this study indicated that further education is needed for nurses to respond to grief and loss, and to meet the family needs which nurse's ranked as important. Lane et al., (2005) maintain that the psychosocial impact of illness and trauma on the individual and the family can be devastating, requiring the provision of nursing therapeutics that support human adaptation and coping.

Knowledge is drawn from key areas such as psychology, sociology, spirituality, culture and interpersonal communication. The study by Mian et al. (2007) provides evidence that nurses' attitudes change positively following their implementation of an educational program on family presence in resuscitation. The difference in the educational approach to physicians and nurses influences their attitude to the family presence during resuscitation. The teaching time for the physician was limited and was incorporated during staff meetings.

On the other hand nurses used a variety of teaching methods and had more flexibility with time to maximise attendance to these teaching sessions. As evidence produced by Mian et al. (2007) indicated, before the educational program, nurses were opposed to a family presence, however they experienced a change in attitude after witnessing the benefits of the family presence and established relationships with the family. This support (ongoing education) is also required by the critical care nurses, to achieve a therapeutic ICU environment.

Lane et al., (2005) maintains that preparing nurses to understand and apply knowledge requires a holistic educational framework informed by both the natural and behavioural sciences, thus enhancing this quality of care. Medina(2005) claim that family assessment and intervention demand expertise and theoretical knowledge. Nurses benefit from education on the issues of understanding the nurse-family relationship, coping with the situations that evolve from family interactions, and on improving the satisfaction of families with regard to care delivery. Neabel et al., (2000) add that nursing scholars (in the USA) have legitimised family nursing as a unique body of nursing knowledge. Williams (2005) agrees that for nurses to be effective in their role, they may need specific support and guidance. Nurses may require further education and/or clinical supervision to facilitate the development of competence in caring for patients' families. Nursing education programs need to be designed to prepare critical care nurses to cope and thrive in the workplace.

The process of reflection and clinical supervision could assist nurses in identifying their own cultural barriers, stereotyping, and ethnocentricity, thus ultimately improving care (Halligan, 2006). The present study aims to do this, and brings us to the question of whether critical care nursing specialists are adequately prepared, both through formal and informal education to provide psychosocial support to the families of ICU patients within this volatile environment.

As is evident from Mian et al.'s study (2007) regarding the training and education of critical care nurses working in the critical care unit, training should be emphasised during formal continuing education, and should be reinforced informally as part of an ongoing plan.

Critical care nursing is valued highly by both patients and families, but is this expert practitioner fully equipped with the knowledge, skills, compassion and empathy to care for the families of patients in the critical care units? On the one hand, it is argued that the knowledge and expertise is there, but the resources are not. O'Malley et al., (1991) affirms that nurses do not use other nurses as a resource when practicing, instead other members of the multidisciplinary team are called, e.g. a priest or a physician to deal with grief.

Clinically, nurses with more years of practice in ICU had a higher rating of family needs than ICU nurses less than three years in practice. The reason may be that nurses with more than six years experience may meet family needs with less conscious awareness because of the expert practise. New nurses are not as aware of patient outcomes in meeting family needs as are the expert nurses. The new ICU nurses focus in the patient – nurse relationship, and therefore family needs are ranked lower. The experienced graduate nurse may not value family needs as important. This attitude may be related to educational preparation received formally and informally on the psychosocial support of family of patients in the ICU (O'Malley et al., 1991).

The information on family needs may not have been available during the formal educational process because family needs research was just beginning in the late 1970s. However during the continued informal educational preparation graduated nurses failed to read the study reports on family centred care that became available (O'Malley et al., 1991). Due to this high-tech and stressful environment, the critical care nurse needs to be supported to acquire the necessary knowledge, practice skill, and to be developed professionally.

Critical care nursing educators have been developed themselves to facilitate the learning of nurses to acquire specific knowledge and skills that will equip them in this dynamic environment (Little, 2000).

Hardcastle (2008) states further that while informal education and training address the immediate practice safety concerns, the clinical employers (managers) look to formal education programmes to provide a theoretical basis for more generic critical care nursing knowledge base and practice development. However, Candela & Bowles (2008) indicate that on completion of a formal education program, employers should not expect an end product. Ironically managers are always telling nursing programs that their graduates are not nearly enough of a finished product

According to Holmboe, Rodak, Mills, McFarlane and Schultz, (2006) development of competency in practice-based learning can be facilitated by self-directed activities. Much learning can take place after formal training. They claim that learning is a result of the activity, context and culture in which it occurs. Learners are described as becoming embedded in practice, acquiring beliefs, practices and behaviours (making them their own) promoted by the other professionals (role-players) in the clinical area. As Holmboe et al. (2006) explains, their peers, or other members of the multidisciplinary team are often in a better position to judge their work ethic, professionalism and inter-personal communication skills. As noted by Beeby, (2000) all role-players need to work together to provide a service that values the caring given to patients in the intensive care unit, and caring should be displayed throughout their various roles.

Lecturers should ensure that curricula are developed which demonstrate the attachment of value to professional caring rather than the "care of" approach to nursing. Increasing education by the bedside in clinical practice will provide experience which will empower nurses in the process of caring. Actual experiences will help develop competence and confidence. Managers can find ways of working together to promote opportunities for caring attitudes (Beeby, 2000).

Studies show that family psychosocial support is misunderstood due to issues/misconceptions that critical care nurses have difficulty in unpacking. They feel that their work environment is threatened, view visitors as psychologically stressful to patients, and thus try to restrict visitation with the notion that they are protecting the patients (Kirchhoff, Pugh, Calame, & Reynolds, 1993).

Mian et al. (2007) claims that continuing education of the critical care nurse is imperative to overcome shortcomings. It would, therefore be interesting to investigate whether critical care nurses are adequately equipped during continuing education and training to provide psychosocial support to families as a unit facing critical illness.

1.2. PROBLEM STATEMENTS

The admission to intensive care is universally accepted as a crisis. Patients are part of families, therefore the family should be viewed as a unit facing this crisis (Bucher & Milander, 1999). Family members react through emotional turmoil, shock, disbelief and anxiety, yet families have to act and help health professionals to make treatment decisions at a time when stress levels are so high (Wasser, Matchett, Bryan & Pasquale, 2001).

The families' lack of understanding of the illness and treatment and uncertainty about prognosis leaves them no choice but to place their trust in unknown critical care nurses which can affect the family's equilibrium negatively (Chui and Chan, 2007). Families experience role and life style alterations, isolation from other family members, financial constraints and uncertainty, which induces family crisis and disequilibrium (Chui & Chan, 2007).

Michaelene, Mirr-Jansen, Nola & Schmit, (2003); Rushton, et al., (2002) and Walters (1995), amongst others have highlighted that family needs are not met in the ICU, citing reasons such as the following:

- Nurses are adapting to the medical model of critical care that focuses on disease, diagnosis and procedures to achieve quick rewards.

- The medical model compromises the nursing model of care that is the holistic care for patients and their families.

- The attitude of the critical care nurses' towards family care in the ICU, such as feeling that the family are invaders, or that the nurses are under scrutiny by the families, impacts on the delivery of care and the outcome of patient care.

- Critical care nurses' focus is on the patients' needs only (primary responsibility), due to the complex nature of the care required, and family care is secondary.

- Technology reduces the lived experience of the illness of patients and families. Nurses concentrate their energies on monitoring equipment to the detriment of humanistic caring.

- Critical care nurses' lack understanding of how the importance of family needs is related to patients' outcomes and this result in them viewing families as a threat.

Medina (2005) claims that family care demands expertise and theoretical knowledge. Hardcastle (2008) agrees that critical care nurses are required to apply advanced knowledge and technical skills to complex and ever-changing practice situations. Lane et al. (2005) maintain that preparing nurses to understand and apply knowledge requires a holistic educational framework. Shirey (2008) describes the Professional Practice Model (PPM) which serves as a framework for guiding and aligning clinical practice, education, and administration. Halligan (2006) claims that nursing education programs need to be designed to prepare critical care nurses to cope and thrive in the workplace. Furthermore, ICU nurses need continuing educational support to be equipped with the knowledge and skills to provide family-patient-nurse-centred delivery of care (Farnell & Dawson, 2006).

Mian et al. (2007) revealed that education is vital to practice change. As evident in a study conducted by Drenkard (2008), which shows that the Inova Health System was successful in the creation of the Inova Human Caring professional practice model using the principles of the Professional Practice Model. Their success was directly related to the extensive education sessions that nurses received regarding the creation of a healing and caring environment.

Critical care nurses are responsible for meeting the family needs within a stress-provoking environment thereby embracing holistic care (Chien, Chinu, Lai-Wah & Wan-Yim, 2006; Williams, 2005; Hughes et al., 2005; Henneman & Cardin, 2002 & O'Malley et al., 1991).

Studies including that of Neabel et al., (2000) reveal that critical care nurses are not educationally supported to provide psychosocial support to the families of critically ill patients. Lack of preparation coupled with an inability to respond to family needs has led to the perception that the care of a patient is a nursing responsibility while the needs of families belong to other role-players, e.g. management, medical team, social workers, etc.

Neable et al., (2000) states that nursing education has a limited focus on family nursing care thus the lack of education poses a barrier to providing family care in the ICU. Neabel et al., (2000) and Hardcastle (2008), amongst others, have indicated that a lack of educational preparation exists, and have recommended the direction of future research towards the educational preparation of health care professionals.

Previous studies related to psychosocial support to families of critically ill patients have been conducted in Western and European developed countries. These may not present as a reality in South Africa. Many of these studies have recommended that the continuing educational support of ICU nurse may be the answer to providing support to the families of critically ill patients.

Therefore this study aims to investigate the extent of practice of psychosocial support to the families of critically ill patients and the educational preparation, (formal and informal) with the intention of developing intervention(s), thus contributing to practice, management and education (Mian et al., 2007).

1.3. PURPOSE OF THE STUDY

To investigate the practice and the continual educational preparation (formal and informal) that the ICU nurse receives in order to provide psychosocial support to families of patients in the ICU.

1.4. OBJECTIVES OF THE STUDY

➢ To establish the extent of family psychosocial support practiced by the critical care nurses in the critical care units.

➢ To determine the formal educational preparation the critical care nurses receive in order to provide family psychosocial support in the ICU.

➢ To determine the managerial support critical care nurses receive in order to provide family psychosocial support in the ICU.

➢ In consensus with the experts, to develop intervention(s) which support the critical care nurse enabling him/her to provide psychosocial support to the families of the patients in the ICU

1.5. RESEARCH QUESTIONS

1. What is the extent of psychosocial support to families of ICU patients practiced by critical care nurses in the ICU?

2. What formal education and training is given to critical care nurses in order to provide psychosocial support to patients' families in the ICU?

3. What managerial support is given to critical care nurses in order to provide psychosocial support to the families of patients in the ICU?

4. What intervention(s), developed in consensus with experts, would support nurses in providing psychosocial support to the families of patients in the ICU?

1.6. SIGNIFICANCE OF THE STUDY

This study is investigating the practice of psychosocial support to the families of ICU patients and the continued educational preparation of the ICU nurses enabling them to practice psychosocial support to the families of critically ill patients. The study hopes to highlight the significance of the continued educational preparation of the ICU nurses enabling them to practice psychosocial support to families of critically ill patients.

Jamerson et al., (1996) describes families' experience in the first phase as the 'hovering' phase (confusion, shock, stress and uncertainty). A theme that emerges is: the patient takes precedence (Verhaeghe et al., 2005). The family involvement in the care process of their loved one is important, and has a positive influence on both the patient and the family in ICU (Burr, 1998).

This study hopes to contribute to the practice of family psychosocial support through informing the practice of:

  ➢ the extent of the implementation of psychosocial support to the families of ICU patients.

  ➢ the educational preparation to the ICU nurse enabling them to provide psychosocial support to the families of ICU patients.

  ➢ recommend management tools to promote the ICU nurses' role in this regard.

Gough, Johnson, Waldron, Tyler, and Donath's (2009:212) study provides the value of communication skills education, especially the measured improvement in participants' sense of 'preparedness' for practice, and their intention to take the learning into their practice. This study hopes to inform the formal educational preparation of the ICU nurses to practice psychosocial support to the families of ICU patients.

The literature (El-Masri & Fox-Wasylshyn, 2007) claims that supporting the critical care nurse to provide psychosocial support to the families of patients in the ICU is everybody's responsibility. This study will inform the informal preparation (from the view of all role players) of the ICU nurses to provide family psychosocial care, thus contributing to educational and management support

Mian et al., (2007) states that one educational program alone does not change practice. Ongoing strategies for practice are essential for reinforcement. A collaborative approach is required to implement strategies, and support and validation of staff as part of the strategies for successful implementation. This study aims to pursue one intervention, thus contributing to the direction or guidance of practice, educational and managerial support to providing psychosocial support to families of ICU patients.

Houser, (2008) asserts that there should be a link between interventions and outcomes. Thus there is a need for scientific support for nursing practice before it is implemented. The researcher therefore hopes that future research will subject the proposed intervention by the current study to scientific inquiry to support evidence-based practice.

1.7.   OPERATIONAL DEFINITIONS

1.7.1 Family: The family is regarded as people whose lives are very closely interconnected by certain emotions, e.g. love ties, marriage, as well as kinship by blood ties (Leske, 2002). In this special context, each member has their roles and functions (Hymovich, 1979). The nuclear family unit may be extended to include other related members. South Africans embrace the extended family unit, which is also adopted in this study.

1.7.2 Family Psychosocial Support (FPS): Erickson's model of the development stages of psychosocial growth describes psychosocial development as a continuum which begins at birth and extends to death (Bucher and Milander,1999). Each family member will experience the stress of their loved one's critical illness differently; depending on his/her stage of psychosocial development. These experiences include, amongst others, the ability/inability to express grief, anger, denial, irritability, trust, role alterations, powerlessness, spirituality and education (Bucher and Milander, 1999). The same definition is adopted in this study.

1.7.3 Critical Care Nursing: Critical care nursing involves caring for patients and families who are experiencing life-threatening illnesses or injury. Within the high-tech environment, nurses are required to have a broad knowledge base, display a higher level of decision-making skills, and demonstrate a high regard for patients and families who are in vulnerable circumstances (Bucher and Milander, 1999). The same meaning is adopted in this study.

1.7.4 Professional ICU Nurse: A professional nurse is an individual who is registered under Section 31 of the Nursing Act 33 of 2005. In this study, this person is a nurse who has received educational training at a SANC approved nursing school and has successfully completed the requirements for registration with the South African Nursing Council, (R425/ R284, as amended, 1985:2).

An ICU Nurse is a clinical nurse who functions at an advanced level of patient care in a multidisciplinary nursing environment; she may be informally trained – a registered nurse with no formal ICU qualification, or formally trained.

1.7.4.1 Formally trained ICU nurse: According to the South African Nursing Council, a critically trained nurse is a registered nurse who obtains an additional qualification in medical-surgical nursing: Advanced Medical and Surgical Nursing: Critical care (R212 and amended: 119:2). In this study, a critical care nurse is one who has had training at a SANC (1985) approved learning facility (university or college) under the R212 or informal training through orientation and in-service training.

1.7.5 Critically ill Patients: In this study, critically ill patients means those patients who are admitted to a critical care unit to be supported with technology and treatment that require intense monitoring, with the aim to prevent, or be rescued from complications that are life-threatening.

1.7.6 Intensive Care Unit/Critical care Unit: An adult intensive care unit (ICU) is a specially staffed and equipped hospital unit. The management is dedicated to rescuing patients with life-threatening illness, injuries or complications (Bersten & Soni, 2003: 3). In this study, the adult intensive care unit/critical care unit is used interchangeably although the meanings do differ. An ICU is a designated place in the hospital equipped with resuscitative/monitoring assistive devices that are used by skilled nurses, who are knowledgeable in treating adult patients undergoing life-threatening emergencies.

1.7.7 Continuing Education and Learning: This is a planned systematic learning experience or activity that occurs after basic nursing preparation. The American Nurses Association defines this as "those learning experiences intended to build upon the educational and experiential bases of the professional nurse for the enhancement of practice, education, administration, research, or theory development to the end of improving the health of the public" Rice (2001:25). It is also described as "a lifelong process of active participation in learning activities that enhance professional practice" Rice (2001:25 & 26). The same meaning is adopted for this study.

1.7.7.1 Educational Preparation: Ongoing strategies for the practice of providing psychosocial support to families of critically ill patients are essential for reinforcement. A collaborative approach is required to implement strategies, and support ICU nurses in providing psychosocial support to families of ICU patients. Educational preparation refers to the exposure both formally and informally of the ICU nurse to learning activities pertaining to providing psychosocial support to families of ICU patients.

1.8 COURSE OF THE STUDY

This chapter has presented the background to the problem, problem statement, purpose, objectives, research question and significance of the study including the operational definition of terms.

Chapter Two presents the literature that supports this study, which is examined and in which gaps are highlighted and recommendations noted. The conceptual framework that guided this study is also presented.

Chapter Three presents the procedures which were followed to investigate the educational preparation of the critical care nurse to provide psychosocial support to the families of critically ill patients in two educational institutions in KZN. This includes the study design, study population, study setting, sample size, sampling methods, and criteria for the selection of the sample, data collection instruments and academic rigor.

Chapter Four presents the demographic, qualitative and quantitative results of the data, and the descriptive and non-parametric analyses are presented according to the objectives of the study.

Chapter Five discusses the findings of the study on family support care in the ICU, and the educational preparation of the critical care nurse to provide this support. Recommendations are subsequently made relative to the findings and conclusions drawn.

Chapter Six presents the intervention of a checklist, through the approval of the nominal group using the nominal group technique. A description, the use, purpose and benefits of the checklist in health care delivery is also presented.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Neuman (2000) states that literature reviews is based on the premise that knowledge accumulates, and that we learn from and build on what others have accomplished. The goals of literature reviews are: to demonstrate a familiarity with whatever is already known on the particular subject, to establish creditability, to integrate, to learn from others so as to stimulate new ideas, to display the path of prior projects and how the current study is linked to those, and sum up what is known in an area.

In terms of this study the literature was reviewed from different aspects that varied in scope and depth, for example, the family as a unit facing critical care illness; the critical care environment; the needs of the family facing critical care; the concept, family psychosocial support; and the educational preparedness of the ICU nurses for psychosocial support to families of critically ill patients.

Several resources were consulted during the various phases of the literature review. I hand searched various Critical care Journals and textbooks. Electronic databases were searched including Google, Yahoo, University of Kwazulu-Natal Federated CINAHL, Medline, Pubmed, BNET, EbscoHost, BioMed Central, Elsevier and Science direct. The literature was used to generate understanding of the phenomenon of interest and in the case of this study, the variables of interest included family care, family-centred care, family psychosocial support, family centred care in critical care, intensive care nursing, educational support of the care givers of family support, formal and informal education of ICU nurse, family focused care in critical care, support, family needs in ICU, qualitative & quantitative methods.

Other variables of interest included check lists as intervention tools, Nominal Group Technique, and ICU nurse empowerment. The search included literature far back since Molter in 1979 which informed the nursing profession of the needs of family of critically ill patients (Burr 1998). Since then studies have focused on the needs of family members in various countries, cultural and health care settings (Agard & Harder 2006).

2.2 THE FAMILY AS A UNIT FACING CRITICAL CARE

The family is part of a larger whole, greater than the sum of its parts. Any change affecting a family member affects all family members and *vice versa.* The family is able to create a balance between change and stability. Change is normal, because family members work to maintain equilibrium to support their belief system and behavioural patterns, to grow and to develop. By working with the family system, one is able to observe how individuals act within the system and participate in maintaining the *status quo* (Corey, 2009).

The self-regulating function of the family has its limitations. When families have difficulty in regaining equilibrium then crisis may result (Bucher & Milander, 1999 and Neabel et al. 2000). Based on the family theory that is influenced by the general systems theory, Rennick (1995:258) iterates that families must be viewed by health care providers as the "unit facing illness." When one member is critically ill, the family as a unit is disrupted (Engström, & Söderberg, 2004) because critical illness impacts on the family unit (Mckiernan and McCarthy, 2010). Hoye and Severinsson (2010) made an apt summation that the family is the fundamental unit of society.

Jamerson et al. (1996) stated that when a member of the family is in the ICU, the family, as a unit, experiences many changes and stressors. The study revealed the four stage process of family experience during the critical illness of a family member.

'Hovering' is the first stage, as the family becomes aware of the loved one's admission to the ICU. The family members show shock, confusion and anxiety in reaction to critical illness. In the second stage, the family actively 'seeks information' about the predicament of the loved one. 'Tracking' is the third stage, whereby the families want to see for themselves what is going on, to ascertain the competencies of health professionals who are taking care of their loved one. 'Garnering of resources' is the final stage experienced by family members. The garnering of resources is the acquiring of what the family members perceive as needs for themselves and/or family members. These may include food, rest, sleep or support from friends, staff or other patients' families (Jamerson et al., 1996). These phases will be discussed in detail with the suggested interventions by the nurses and organisation in the conceptual framework of the current study.

2.3 CRITICAL CARE ENVIRONMENT/INTENSIVE CARE UNIT (ICU)

Over and above the seriousness and uncertainty of critical illness, Chui & Chan (2007); Hughes, Bryan & Robbins (2005) & Verhaeghe et al. (2005) Takman (2004); Henneman & Cardin (2002); Palazzo (2001); Neabel et al. (2000); Jamerson et al. (1996); and Walters (1995) describe the critical care environment as frightening, with alarms buzzing and lights flashing. Chui & Chan (2007) & Williams (2005) claim that sophisticated technology has contributed to the advancement of health care delivery to critically ill patients. However, patients are attached to high technology with the uncertainty of being rescued, due to the nature of patients' injury or illness, and, although death is not an option, the probability could nevertheless be a reality. On the other hand, there is a wide shortage of trained professionals; many ICUs must regularly cope with understaffing, an excessive workload and overtime. The continual exposure of the ICU nurses to these alarms also contributes to an environment of increased stress and frustration for the ICU nurses (Alameddine, Dainty, Deber and Sibbald, 2009).

Vandijck, Labeau, Geerinckx, Puydt, Bolders, Claes & Blot (2009) concur that the experience for both patients and their families is stressful, and may trigger various unwanted physical and psychological effects. The critically ill patient is unable to make decisions regarding the treatment and care being provided, therefore family members act in the best interests of their loved ones (Oberley & Hughe, 2001; Neabel et al., 2000). Supporting the family of patients in the ICU is the primary responsibility of health care professionals which influences the quality of care in the critical care unit (Mckiernan and McCarthy, 2010; Medina, 2005). Miracle (2006) adds that including the patients' families in the care of their loved one may help to humanise the critical care environment.

2.4 NEEDS OF FAMILIES OF CRITICALLY ILL PATIENTS

In an exploratory descriptive study by Molter (1979) who identified the needs of family members, a list of 45 need statements was developed. The findings in this study indicated that the needs: "to feel there is hope"; "to feel personnel care about the patient" and "to have the waiting-room near the patient"   were ranked as the highest (Molter, 1979 : 334).

A subsequent follow-up study by Molter and Leske (1983) reshaped these 45 need statements into a tool known as the Critical Care Family Needs Inventory (CCFNI). This tool was used to rank and quantify the needs of families. The CCFNI has five categories namely: assurance, information, proximity, comfort and personal needs. Amongst other quantitative studies, King-Lee and Lau (2003); Bijttebier et al. (2001); Burr (1998) and Mendoca & Warren (1998) found that assurance, information and proximity were considered the most important. Maxwell, Stuenkel and Saylor, (2007) did a second survey in which the Needs Met Inventory (NMI) was developed to determine the extent to which these needs were perceived as met within 36 to 48 hours after admission.

Through the decades, qualitative studies throughout the world have found that the experiences of family members were characterised by themes such as: stressful emotional reactions and provision of information (Plakas, Cant, & Taket, 2009; Kutash & Northrop, 2007; Hughes et al., 2005); the need to be near the loved one (Mackiernan & McCarthy, 2010; Plakas et al., 2009; Kutash & Northrop, 2007); to support and be supported by other family members (Kutash & Northrop, 2007; Burr, 1998; Jamerson et al., 1996); caring and support (Mackiernan & McCarthy, 2010; Plakas et al, 2009) the need to receive good care (Kutash & Northrop, 2007; Jamerson et al., 1996); the desire to protect the dignity of their loved one (Plakas et al., 2009; Burr, 1998); the provision of a comfortable waiting-room where families can spend a lot of time (Kutash & Northrop, 2007). Other studies included making sense of it all (Mackiernan & McCarthy, 2010; Jamerson et al., 1996); religiosity (Plakas et al., 2009); enduring uncertainty (Agard and Harder, 2007); the changed identity (Plakas et al., 2009); and the need to know things (Mackiernan & McCarthy, 2010 & Agard and Harder, 2007).

However, both quantitative and qualitative approaches have consistently highlighted that families have some common needs across all cultures throughout the world that must be met, in order for them to cope thus maintaining their homeostasis as a family unit.

2.5 FAMILY PSYCHOSOCIAL SUPPORT (F.P.S.)

Through all the literature reviewed for this study the concepts "family-centred care," "family-focused care," "family support care" and "family psychosocial support" have been used interchangeably, to refer to care delivery in the ICU that includes the family as a unit facing critical care. There was no clear distinction made between these concepts. Family care has been redefined since Molter's (1979) initial study; however, a universal concept appears to remain indefinable.

2.5.1 Defining the Concepts

Hynes, Conlon, O'Neill, & Lapinsky, (2008) state that, from their experience, so far, nothing has been revealed to suggest that an absolute agreement on a certain concept is a prerequisite to meaningful engagement with patients and families, although some may think that the lack of consensus with the concepts may contribute to inconsistencies on how care is planned, organised and delivered. However this debate is welcomed in the belief that this would eventually be a theory versus practice debate.

Family-centred Care

Family-centred care is incorporated into planning the infrastructure of the building where space is provided to accommodate family members, twenty-four hours a day. Molter (2003:304) and Henneman & Cardin (2002:14) describe family-centred care as a synthesis of philosophies, attitudes and approaches to care. This philosophy is based on the view that patients are part of a bigger "whole", they require a collaborative approach, which includes the families.

Barclay & Lie (2007) indicated that for family-centred care to be fully realised, the family members and surrogate decision-makers must become active partners in multi-professional decision-making and care. Support for the psychological and spiritual health of the family is essential for the critically ill patient. Henneman and Cardin (2002) describe the family-centred care in the ICU as a philosophical approach that recognises the needs of families and their loved one, and which goes beyond theoretical acceptance in viewing the family as a unit, to be included in the care planning and delivery in respect of their loved one.

➢ **Family Focused Care (FFC)**

Medina (2005) sums up that family focused care means that the nurse assesses the needs of families and intervenes to benefit the outcomes of patient and family. The provision of family-focused care is advantageous for the optimal levels of family functioning which is supported by everyone because the responses of families to critical illness and psychological stress have implications for the patient, family members and health professionals.

Family Support Care

Family support care is used as an umbrella term to include all the needs of patients and families. According to Shirey (2008) it is a method of delivering care that acknowledges and respects the functional role of the family by actively rendering care to the family members. According to Leske (2002) providing family support requires the establishment of a relationship that is mutually respectful, trusting, empathetic and collaborative in nature. Molter (2003) agrees that family support care is a synthesis of philosophies, attitudes and approaches to care. Molter (2003) reveals that families are the major source of the belief system for the individual members. They give practical assistance to each other, as well as emotional and physical support or energy to heal. The family is a critical support to its individual members. The family collects and disseminates information about the world for its members. They provide feedback about behaviour in terms of family value systems, and guide each other in problem-solving, or assume this function for an individual member as required.

Hatrick, Lindsey & Hills (1994) claim that a philosophy is the driving force behind any decision-making and any action that includes, amongst others, the beliefs that all people have strengths and are capable of determining their own needs, finding their own answers, and solving their own problems. People are their own experts, and the power of defining health problems and needs belong to those experiencing the problems, while uniqueness/diversity is positively valued, more so within South African (S.A.) society. The assurance needs of family members are met with interventions that encompass caring and compassionate attitudes, and answering the questions families have in an honest and consistent manner. Nurses should show respect for anxiety levels, by repeating information as required, offering to listen to concerns, and gently accompanying the family through their experience (Maxwell, Stuenkel and Saylor, 2007).

Mackiernan & McCarthy (2010); Maxwell, Stuenkel and Saylor, (2007); King-Lee & Ling-Lau (2003); Bijttebier,Vanoost, Delva, Ferdinand and Frans (2001); and Mendonca & Warren (1998) reveal that the families of ICU patients have a tremendous desire to receive accurate information and knowledge about progress, and to be informed about any changes in the condition of their loved ones timeously. Family support care, according to Jamerson et al. (1996) is the accompaniment of the family members through their experience when faced with critical illness, and suggested interventions. In the 'hovering' phase, the family anticipates information. The 'information seeking' stage is the process of giving information that includes what has been done, what needs to be done, the patient's progress and an update on any changes that occur in respect of the patient. Somehow the information needs become focused in this phase, and families require a waiting-room as a place to which the family can retreat and cry in comfort/privacy (Jamerson et al., 1996). Maxwell, Stuenkel and Saylor (2007) indicates that information needs may be met by assessing family concerns, giving clear, consistent verbal and written explanations, and assuring direct communication with the attending doctors.

Health care professionals need to be encouraged to document in the progress notes of patients the specific information that was shared with the family members to ensure consistency in information-sharing. Families should be able to access computers in the waiting area for information regarding policies, staff, etc. Hand-outs should be provided in the form of pamphlets which contain valuable information that the families can refer to as required.

Proximity of the family members to the patient has been identified as a family need by many research studies, including those of Mckiernan & McCarthy (2010); Williams (2005); Bergbom and Askwall (2000); and described by Plakas et al., (2008) as vigilant attendance.

Proximity means permitting access so that families can be near their loved ones, and in so doing, instilling a feeling of reassurance, while at the same time family members are able to see what is happening around their loved one.

Family proximity to the loved one enables the process of tracking. Maxwell, Stuenkel and Saylor, (2007) suggests that proximity may be met by open, flexible visiting. Nurses need to obtain a family contact person and a preferred time for that person to be called for updates on the loved one. Interdisciplinary care conferences and patient rounds can be scheduled to include the family in the planning of patient care. Special consideration should be given to accommodating families who need to stay overnight, as this may reduce the anxiety of a confused patient or a patient with language barriers. Agard and Harder (2007) indicated that family members spoke about the importance of being with their loved one at all times. The family members endure difficulties just to be with their loved ones. At the bedside, they need to know what is going on, and whether they can be of help. The family expects high-tech nursing care given by competent nurses, displaying appropriate organisational abilities, confidence, anticipation of, and responsiveness to physical and emotional needs, privacy and respect, dignity, kindness, communication and interpersonal skills (Jamerson et al., 1996).

'Garnering of resources' involves the acquisition of what families perceive as needs for themselves or their family members, for example, physical needs such as rest, nutrition, diversion activities and personal space or privacy. The psychosocial needs include support from other family members within the extended unit, (Halligan, 2006) or families of former patients, (Sacco, Stapleton & Ingersoll, 2009) friends, health care workers (Stayt, 2007) and from family members of other ICU patients in the unit (Halligan, 2006). Access to the loved one, as in flexible visitation and the ability to network and collaborate with family members regarding treatment and discharge plans are other factors which would assist during this phase (Maxwell, Stuenkel and Saylor, 2007; Halligan, 2006 & Jamerson et al., 1996). This phase extends to resources such as waiting-rooms with family friendly amenities such as refreshments like tea, water, even nutrition, and which could include a play area for children (Halligan, 2006; Vint, 2005; Jamerson et al., 1996).

Vint (2005) suggests a play box/play area and staff to facilitate children's visit by using teddies and bandages to describe a little of what they can expect to the very young, as well as having a plan of action if a child needs to visit a family member in the ICU. Bergbom and Askwall (2000) indicated that it should not be the nurses who decide who should be allowed to visit because any visit may be of huge importance to the family as a unit.

What is not Family Support Care: Simply allowing a family member to be at a patient's bedside 24 hours a day does not mean that the staff members are supporting the family. If family members are present in a situation in which critical care nurses are not equipped to meet their needs, this could, in the end, have adverse consequences. Family members are stressed out if they are ignored by a nurse, or are made to believe that they are somehow in the way, or are interfering with the patient's care.

The confusion over family care contributes to frustrations of critical care nurses who think that family care may not be in the best interest of either patients or nurses. Family care does not mean that the patients lose their rights to privacy or control over their environment (Henneman & Cardin, 2002). In addition, Heyland, Rocker, Dodek, Kutsogiannis, Konopad, Cook, Peters, Tranmer, and O'Callaghan, (2002) asserts that needs assessment is not synonymous with satisfaction, because unmet needs do not always translate into dissatisfaction, while meeting those needs does not guarantee satisfaction either.

> **Family Psychosocial Support**

It is universally accepted that when a family member is admitted to the ICU the family is confronted by psychological, cognitive and social stressors which may include anger, denial, guilt, financial constraints, disruption of routine, role conflict, and fear of death.

Stressors experienced by families of patients in critical care units produce many specific needs (Johansson, Fridlund & Hilding, 2005; Verhagehe et al., 2005; Williams, 2005; Jamerson et al., 1996 and O'Malley, Favaloro, Anderson, Anderson, Siewe, Benson-Landau, Deane, Feeney, Gmeiner, Keefer, Mains, & Riddle, 1991). Neabel et al. (2000) maintain that the essential components of an assessment and intervention framework of family systems nursing include: listening to the family, engaging in participatory dialogue between the nurse and family members, recognising patterns, and envisioning action and positive change. This would help the ICU nurse to work with the strengths of family members and promote family health. The nurses must ascertain whether they have previous experiences with the ICU, and they should be orientated to the routine in the ICU, while the nurses should support them appropriately as suggested by Plakas et al. (2009). On the other hand, McAdam and Puntillo (2009) indicated that general interventions, for example, informational booklets and support groups are not as effective as more individualised interventions.

Individualised interventions target the family members' specific needs, using a specific proactive communication technique to reduce the psychological symptoms experienced by family members. Maxwell, Stuenkel and Saylor, (2007) suggests that reassessment of family needs may provide insight into the current and future family care practice. Nurses are the primary resources for the family members, and thus many interventions are nurse-driven.

This is concurred with by Stayt (2007); Miracle (2006); Williams (2005); Medina (2005) and Mirr-Jansen & Schmitt (2003) amongst others, who suggest that families of critically ill patients have a clear, defined expected set of needs. In addition, McAdam and Puntillo (2009) further elaborate that family members faced with a critically ill family member have potential stressors, for example, changes in family relationships, multiple conflicts about family roles, and that the lack of communication within the family unit could cause psychological symptoms and the family could all suffer from clinically diagnosable psychological conditions. Azoulay, et al., (2005) maintains that families of patients in critical care units may display Post Traumatic Stress Disorders after the discharge or death of a loved one. Thus the concept of family psychosocial support is used in the current study because it encompasses the biological, social, spiritual and psychological aspect of family care.

2.5.2 Benefits in meeting Families' Needs

Amongst others, the following studies, Mckiernan and McCarthy (2010); Vandijck (2009); Van Horn et al. (2002); Jamerson (2002); Mirr-Jansen & Schmitt (2003); Appleyard et al. (2000); Neabel et al. (2000); O'Malley et al. (1991) and Wooley (1990) maintain that family care in the ICU is vital in benefiting the critically ill patient and the family members. Mckiernan & McCarthy (2010); Neabel et al. (2000) and Jamerson et al. (1996) indicate that the implementation of family support as part of routine care in critical care nursing is essential.

Concerns related to ill family members would decrease if they were aware that their family was receiving care, allowing the family to be more supportive of their loved one which would lessen the disruption for the family as a system, and cause less anxiety to be communicated to the patient by family members.

Hupcey (1999) agrees that a family's wellness is one of the significant factors affecting a patient's wellbeing during the course of an illness. The family acts as a buffer for the patient's emotional stress, plays the role of a caregiver and actively involved in the decision-making process related to treatment. This is supported by Hewitt (2002), who claimed that families are of tremendous value, to the patient in helping to prevent the ICU syndrome (psycho-affective disorder). During this vulnerable period, the patient is supported by family members, ultimately shortening the ICU stay of their loved ones; therefore support for the family members is very necessary.

Mckiernan and McCarthy (2010);EL-Masri (2007); and Williams's (2005) findings indicated that the family members give vital emotional support to their loved ones, with a desirable contribution to the patients' recovery. Maxwell, Stuenkel and Saylor, (2007) also states that meeting the family's needs would help reduce anxiety, build family confidence in the health care system and improve patient outcomes.

2.5.3. Strategies to meet Family Needs

The strategies of meeting the family needs are based on the understanding of family needs during the different stages of family experience. Jamerson et al. (1996) have suggested interventions during each stage of family experience when faced with critical illness.

In addition, Maxwell, Stuenkel and Saylor, (2007) also suggested interventions for the identified categories of needs, namely: assurance, information, proximity, comfort and personal needs. In 'hovering', the initial stage, the family members require some information about their loved one's condition as well as orientation to the ICU and the routine (Jamerson et al., 1996). To meet the need for assurance, the families and nurses indicated that accommodation and compassion were essential. In addition, the nurses mentioned that giving explanations, using interpreters, and maintaining continuity of care were important to augment feelings of support and guidance (Maxwell, Stuenkel and Saylor, 2007). 'Information seeking' is the next stage. The sources of information such as information booklets, message boards and signage, help families collect information required and include families in discharge planning (Jamerson et al., 1996).

Both nurses and families indicated that direct communication with the doctors and nurses is vital in meeting informational needs. Family members appreciated timely appropriate information from the doctors when something was done either temporarily, or permanently. Family members also felt good when the nurses were knowledgeable, and could relay information, even without questions to prompt them from doctors, discuss test results, and offer explanations of procedures and equipment with which they were working (Maxwell, Stuenkel and Saylor, 2007). 'Tracking' is the process of observing, analysing, and evaluating the patient care, as well as the environment and health care professionals (Jamerson et al., 1996). Tracking requires proximity.

Strategies to increase proximity to patients includes open, unrestricted visitation, accommodating individual members' needs, for example, children's, to reduce anxiety (Maxwell, Stuenkel and Saylor, 2007). 'Garnering of resources' is the final stage experienced by the families in the ICU.

Family members acquire resources themselves to meet their perceived needs, for example, rest, nutrition, personal space and privacy, support from other members of the family or from families of other patient, friends and staff (Jamerson et al., 1996). Strategies to meet the need for support and comfort, by both the nurses and families included a comfortable physical environment, and responses from interdisciplinary team members, chaplains, volunteers and case managers. Nurses also perceived that a holistic attitude emphasises family involvement in the care, and that, on the other hand, families wanted to feel accepted and welcomed by staff (Maxwell, Stuenkel and Saylor, 2007).

2.5.4. Guidelines for Family Support in ICU

Barclay & Lie (2007: 1 & 2) report that The American College of Critical Care Medicine (ACCM) and The Society of Critical Care Medicine (SCCM) convened a task force to review articles published from 1980 to 2003. They reviewed 300 related articles. The ACCM task force used the Institute of Medicine (IOM) principles and released guidelines for Family Support in the Patient-Centred ICU: these principles included the following:

Family members are to provide direct care to their loved ones and should be encouraged to do so. Ample information should be given to them. Formal spiritual counselling by a chaplaincy service should be provided. Open, flexible visitations are to be encouraged. Pre-visit education may be provided to families. Way-finding and family-friendly signage should be visibly displayed to reduce stress in the environment. The waiting-rooms should be close to the critical care units with the inclusion of family-friendly amenities.

Shared decision-making must be encouraged to reduce family stress and help families to cope. Families should be allowed to be present on rounds, and at resuscitations, and to ask questions relevant to the patient's care. Allowing family members to be present during resuscitation might help them to cope better with the death of the loved one. Families' understanding of prognoses, treatment and plan needs to be assessed, and families should be educated about clinical manifestations of approaching death in a culturally appropriate manner. Bereavement services and follow-up care should be made available after the death of the patient. Procedure guidelines should be created for pet-assisted therapy, for example, pets that are properly immunised should be allowed into the critical care units. Policy and procedures should be formulated to debrief and support family members after a witnessed resuscitation, and before, during and after death. Health Care Professionals should receive training in meeting family stress needs. Health Care Professionals should be informed of patient treatment goals.

Communication skills of health professionals should be enhanced, and consistent messages should be received by family members. Education and debriefing of health care professionals, to reach emotional maturity should be promoted, thus minimising the effect of family interaction on their health.

Health care providers require training to provide culturally competent care with an emphasis on addressing truth-telling, cultural norms, respect for patient decision-making and respect for privacy, thus creating a conducive, family-friendly environment. Health care professionals require education to provide spiritual support, encouraging and respecting prayer. Allowing the adherence to cultural traditions helps patients and families to cope with illness, dying and death. Training in palliative care should be a formal part of critical care education.

2.5.5 Controversies/Challenges related to Family Psychosocial Support (F.S.P)

F.P.S. is misunderstood due to issues/misconceptions that critical care nurses have difficulty in unpacking. Stayt (2007) highlights an obstacle to family care in critical care units. Nurses caring for families of critically ill patients experience conflict between their role expectations and the realities of their everyday work. Caring for families and addressing their emotional, physical, biological and social needs, whilst caring for critically ill patients, places heavy demands on nurses. There is great role ambiguity and role conflict associated with caring for families of patients in critically care units. The issues of personal versus professional engagement mean that some nurses invest their personal self in the nurse-patient-family relationship allowing them to become emotionally involved, thus coming into conflict with their professionalism which requires emotional maturity.

The issue of cultural differences further increases the pressures of this nurse-patient-family relationship. Covington (2001) states that ignoring cultural differences allows room for "cultural blindness", encouraging nurses to relate to patients and family members from an ethnocentric perspective. Failure to realise that one operates in a culture, allows others to be viewed as deviants, and, as a result, there is no need to know about or value others. Therefore, acquiring cultural knowledge is essential, because it places an emphasis on a theoretic foundation for culturally diverse world views, beliefs, values, lifestyles, and problem-solving strategies. Hoye and Severinsson, (2010) state that nurses need to be sensitive to the families' cultural customs in order for them to meet the families' expectations in a respectful way.

Communication has been revealed as an area of contention which is aggravated when providing care to a culturally diverse population. Hoye and Severinsson, (2010) state that irrespective of cultural characteristics, nurses are legally obliged to provide accurate and understandable information to the patients and their families. The study by Hoye and Severinsson (2010) revealed that families modified the information for their loved ones. The information according to cultural values may be withheld, or untruths told to protect their loved ones. These inaccuracies lead to communication dilemmas in terms of truth-telling for ICU nurses. This may contribute to nurses shying away from giving information and offloading the responsibility on other health professionals. Zaforteza et al.'s (2005) study revealed that the control of information resided with the physician in most institutions. This could contribute to nurses not adopting proper interpersonal skills when imparting information. Williams, (2005) stated that the nurses' communication skills affected their interaction with the family members'.

Every family's experience is unique, but their needs, as humans in crisis, may be common. Jamerson et al., (1996:471) describes phase three as 'tracking' which is the process of observing, analysing and evaluating their loved one's care, as well as the environment and health care professionals involved. This can only be fulfilled when the need for proximity to the loved one is met. The flexibility of visitation to the ICU poses a controversy (open versus restricted visitation) for the ICU nurses to solve. ICU nurses are the gate-keepers, and ultimately decide how the visitation should be implemented. Who decides how involved families should be in the multidisciplinary care of their loved ones? Do family members take this cue from those in authority? There are no clear-cut answers to these questions. Critical care nurses assess each case often arriving at subjective conclusions. This adds to the confusion, as critical care nurses are resistant to change, because of perceived concerns and fears to include the family in the delivery of care.

ICU nurses feel that the work environment is threatening, for example, nurses view visitors as psychologically stressful to patients, therefore family visitation is restricted with the notion of protecting the patients (Kirchhoff, Pugh, Calame & Reynolds, 1993).

Vint, (2005) stated that there is still a lack of support available for children who have a desire to visit their loved one. In addition, nurses are challenged due to the lack of time to meet the needs, thus some needs may be ignored or forgotten, the focus being on the patient's needs only. Henneman and Cardin (2002) added the following factors: the lack of strong leaders, caring staff, the lack of time and patience, and the lack of support within the multidisciplinary team.

2.5.6 Barriers to the Implementation of F.P.S of Patients in the ICU

▪ **Problem-Based Nursing Care**

Hatrick et al. (1993) agree that the delivery of care has been nurse-driven and individualistic in nature, i.e. the nurses collect patient data, analyse patient data, and formulate a nursing diagnosis. This process is focused on identifying problems. This is known as problem-based nursing practice. The focus is on problems that are managed until solved. Families are not included in these problems, therefore they are excluded and merely given information on a need-to-know basis. Added to this is disintegration arising from critical care nurses' daily practice of reporting and documenting data by organ systems individually, which imparts no meaning to the data in the context of the patients' and families' goals.

This view misses the holistic view of patients as entities who have desires, feelings, and reasons for being, and who also, at times, need to let go of their being and spend final moments with families (Rushton, Williams & Sabatienr, 2002).

- **Primary Responsibilities**

The family members experience intense psychological pressure when they are faced with critical illness due to the sudden changes in their social and economic lives (Williams, 2005; Kirchhoff et al., 2004). They are then exposed to the ICU environment with unfamiliar rules and routines (Hughes, Bryan & Robbins, 2005; Jamerson et al., 1996). Bailey, Sabbagh, Loiselle, Boileau, & McVey (2010) state that attending to the unstable condition of the patient who requires complex care often takes precedence over attending to the needs of the family.

However, the attention to the family's psychosocial needs is an integral part of comprehensive critical care. O'Malley et al. (1991) adds that timing is an important factor, because on admission, and in the first six to eight hours, time is spent on patients' needs, which the critical care nurses perceive as their main responsibility, thus very little, or no contact is made with family members during this period. Holden, Harris, and Johnson (2002) and Burr (1998) also maintain that other activities related to patient care take precedence over the assessment and care of the families of patients in the ICU in the initial hours after admission to the ICU.

As indicated by Plowright, (1998) the family's access to their loved one is restricted because the patient's condition is very critical, and the family may get in the way at busy times. Family members are focused on trying to understand the events surrounding them while also thinking about how they will cope with an uncertain outcome. This is what Jamerson et al. (1996) equate to the 'hovering' stage indicating that the family, with the lack of interventions, are kept frozen in this stage. Nurses have to find a balance between caring for the family, and safely managing their patient who requires complex care.

- **Critical Care Nurses Stress Levels**

The need for critical care and trained ICU nurses has evolved over the years. The health industry is continually experiencing difficulty in recruiting and retaining health care professionals. The ICU environment is challenged by issues that include an aging workforce, lengthy time to train professionals and staff retention. In addition, the ICU nurses are faced with unfriendly lighting, annoying noises, awkwardly placed equipment and overcrowding.

Visual and auditory alarms are built into almost all types of equipment that the ICU nurses must respond to immediately when triggered (Alameddine, Dainty, Deber and Sibbald, 2009). The ICU nurses' stress originates from the exposure to the high levels of work intensity which is very typical of a busy ICU.

The vigilant caring may not always produce the desired outcome, thus affecting the ICU nurses. They experience feelings of grief, fear of failure and suppressed anger and frustration. At the same time, the ICU nurses are expected to balance conflicting feelings such as hope versus reality, decisiveness versus uncertainty and compassion versus professionalism. They desire to be healers, and dislike seeing patients and their families in distress (Alameddine, Dainty, Deber and Sibbald, 2009). Neabel et al. (2000) add the following challenging factors, e.g. budget cuts that result in limited resources which result in less nurses and less time available to meet the psychosocial needs of the family because of the immediate physical care required for the critically ill patient. In addition, Ball and McElligot (2003) claim that the ICU nurses make a huge contribution to the care and survival of critically ill patients in the ICU. The ICU nurses make a difference to the survival of critically ill patients, which exceeds the number of tasks they perform which can be observed and measured.

Ball and McElligot (2003) further showed evidence that, although the knowledgeable and experienced nurses are more resilient to the pressure imposed by the context they were working in, they felt that their care was not of their expected standard, when the context of care placed an additional burden on the manner in which they delivered care at the bedside, increasing their stress and lowering their morale.

Fouchè (2006) states that Thautology (death education) is what the critical care curriculum does not teach nurses. ICU nurses want to ensure that dying patients experience a dignified death, which is not always possible. There are several barriers to providing a good death in the ICU, namely, difficulties with the ICU environment (designed to rescue lives), a lack of sufficient quality time for ICU nurses to care for dying patients and their families, staffing problems, communication challenges, unrealistic expectations of patients' families, inappropriate treatment decisions, health professionals being less truthful and/or unrealistic about patients' prognoses. Less stress would be experienced if nurses are supported to understand that death is a natural process and not a direct reflection of a failure of their skills or care (Fouchè, 2006).

Including the family in this cramped workspace adds to the ICU nurses' stress levels. Mian, Warchal, Whitney, Fitsmaurice & Tancrdei,(2007) indicates that resuscitation providers have concerns about the potential for the family to be disruptive to resuscitation attempts. In addition, resuscitation providers also have concerns about the traumatic effect that witnessing procedures could have on families. There is the concern that the family members would scrutinise the procedures followed for staff incompetences, or misinterpret the team's activities, for example, teaching staff members, and thus widen the margin of risk and litigation. However, Mian et al., (2007) indicated that research studies have shown that such concerns and fears typically are not justified.

- **Cultural Competencies**

Flowers (2004) stated that to provide the best possible care for all ICU patients, the ICU nurses must have expertise and skill in the delivery of culturally appropriate and culturally competent nursing care. ICU nurses must take an active role in obtaining information upon which to base intervention. Therefore, the family members prove vital in supplying this information.

Demographics are changing; therefore nurses are pressured to be knowledgeable and skilful enough to practice in a multicultural society. Differences need to be recognised and responded to appropriately. Critical care nurses are expected to master skills necessary for assisting patients and their families through critical illness that is life-threatening. Culture affects family dynamics, coping styles, spiritual needs, and perceptions of death and dying. Cultural competency acknowledges and incorporates the importance of culture in meeting the unique needs of patients and their families. Nurses need to be aware of their own values because self-awareness facilitates more insightful interpretations of others' behaviours and attitudes.

Knowledge of every culture is impractical, however, nurses should display a willingness to learn about, respect, and work with persons from other cultures to provide care that is compatible with their values and traditions (Covington, 2001). Communication is the means of conveying culture. A person's cultural orientation influences the way information is processed, perceived and communicated, verbally and nonverbally. These differences can interfere with the nurse-family and patient relationships. Thus nurses need to display cultural sensitive communication skills. It is through listening that misunderstanding can be eliminated. Cultural information should be critically examined and appropriately used in the context of individual relationships (Covington, 2001).

- **Role of the Interdisciplinary Team**

Baggs, Norton, Schmitt and Sellers (2004) noted that to achieve better patient outcomes, collaboration is the key activity of any team. A lack of collaboration from nurses and physicians views seemed to be related to the power differential between the two professions, status/authority, responsibilities, training and cultures. There is evidence that ICU nurses and physicians who both value and believe in a collaborative team approach would lead to better outcomes for patients and their families, but barriers to collaboration need to be conquered. Collaboration and communication may provide support and reassurance to family members. Due to the complexity of illness, patients who survive invariably need to be taken care of at home within the family unit (Adamson, Murgo, Boyle, Kerr, Crawford, & Elliot, 2004). This means that the families have a need to be part of the multidisciplinary team, and to be educationally supported to acquire skills in order to take care of their loved ones while in the ICU.

2.6 EDUCATIONAL PREPARATION OF THE ICU NURSES TO PROVIDE PSYCHOSOCIAL SUPPORT

Family needs of patients' in critical care have been explored extensively; resulting in the development of the Critical Care Family Needs Inventory (CCFNI) by Molter (1979) used by nurses worldwide (Mirr-Jansen, 2003; Miracle, 2006; Stayt, 2007). Psychometric testing of the tool has been established worldwide (Mirr-Jansen, 2003). Williams (2005) claimed that the CCNFI failed to address the more subjective or less tangible aspects of families' experiences. Verhaeghe et al. (2005) agreed that relying totally on the CCNFI has prevented additional aspects of experience from emerging, and suggest that qualitative studies can help fill the gaps. O'Malley et al., (1991) maintain that the tool may not be sensitive enough to measure the difference in the relationship to the variable of education.

O'Malley et al., (1991) suggest further analysis before conclusions can be drawn about nurses' perceptions of family needs related to educational preparation. As evident in this study by O'Malley et al., (1991) nurses' attitudes (do not value family needs) could be related to family needs information received during the educational process. However, Hardcastle (2008) maintains that whilst the advance practice focus of many post-graduate programmes may be appropriate for experienced nurses seeking to further their development growth, it should not be assumed that this level of preparation is relevant, and therefore effective, for practice in the ICU.

Hardcastle (2008) further indicates the essence of educational preparation and practice development should be to improve the delivery of nursing care to critically ill patients and their families. However, the correct approach to educational delivery and evaluation has not been clear, and the literature has failed to enlighten readers as to how nurses actually use learning to develop their practice.

Wigens, (2000) states that changes in nurse education over the decades have led to a split between interpersonal and practice skills, whereby the practice skills have been awarded secondary importance. Wigens, (2000) iterates further that the ICU is an area where trained nurses are mainly involved in care delivery, compared to general ward-based nurses. This means that shaping the educational preparation of ICU nurses in response to their role directly influences the care rendered.

Medina (2005) claims that family care demands expertise and theoretical knowledge. This is agreed with by Wigens (2000) who states that the assessment of practice within the clinical setting is pivotal to ensuring the quality of education provision for ICU nurses. ICU nurses need continuing educational support to be equipped with the knowledge and skills to provide family-patient-nurse-centered delivery of care (Farnell & Dawson, 2006).

Nursing education programs need to be designed to prepare critical care nurses to cope and thrive in the workplace. Little (2000) states that, due to this high-tech and stressful environment, the critical care nurse needs to be supported to acquire the necessary knowledge, practice skill, and to be developed professionally, to make that difference in the ICU. The process of reflection and clinical supervision could assist nurses in identifying their own cultural barriers, stereotyping, and ethnocentricity, thus ultimately improving care (Halligan, 2006). Shirey (2008) describes the Professional Practice Model (PPM) which serves as a framework for guiding and aligning clinical practice, education, and administration.

Lane et al. (2005) maintain that preparing nurses to understand and apply knowledge requires a holistic educational framework that is informed by both the natural and behavioural sciences, thus enhancing this quality of care. The process of reflection and clinical supervision could assist nurses in identifying their own cultural barriers, stereotyping, and ethnocentricity, thus, ultimately improving care. Agard & Harder (2007) also recommend that ICU nurses develop educational programmes that acknowledge the complexity of providing psychosocial support to the families of patients in the ICU. Learners are described as becoming embedded in practice, acquiring beliefs and practice promoted by the other professionals in the clinical area. Lave & Wenger in Huggins (2004) claim that learning is a result of the activity, context and culture in which it occurs.

Hardcastle (2009) iterates that clinical practice demands that ICU nurses be critical thinkers and problem-solvers who are capable of applying knowledge and technical skills to a complex and dynamic practice situation. Although nursing education programmes foster such claims, disparity exists, nevertheless, concerning the content, delivery, academic and clinical requirements of each programme.

2.6.1 Recommendation

The literature recommends the following on empowering or preparing nurses to enhance psychosocial support to families of patients in critical care units.

2.6.1.1 Formal Educational Preparation

Farnell and Dawson (2006) maintain that working in the critical care environment is challenging, and at the same time different from working in the general wards. The basic educational programs in many countries do not prepare the nurses educationally to function in the ICU, thus leaving nurses feeling intimated by the ICU. A lack of formal ICU education & training causes the ICU nurses to handle families inconsistently when they are faced with critical illness (Hupcey, 1999). According to Beeby, (2000) ICU nurses who lack training and experience need to develop skills in physical caring for the patients, before being prepared to provide psychosocial support of families from diverse cultural backgrounds. Vint, (2005) indicated that the nurses knowledge of child's psychosocial needs according to their developmental stage, is essential because children are important part of the family unit.

Gilmer (2002) recommends that medical and nursing school content be developed to focus on aspects in needs assessment, symptoms management, grief and loss, special dimensions in life and illness and complementary health care. The teaching of family support does not require a change in the curriculum, but cites the application of practice and using teachable moments. The same could be said for the education and training of critical care nurses. O'Malley et al., (1991) concluded that further education is required for nurses to respond to grief and loss. This is a need ranked as very important by nurses in O'Malley's et al., (1991) study. If implemented, critical care nurses could achieve emotional maturity.

Gough, Johnson, Waldron, Tyler & Donath (2009) reveal that an educational programme to prepare nurses to feel better equipped for difficult clinical conversations did make nurses feel better prepared as compared to the pre-programme.

Paucity in most of the studies on providing family psychosocial support does indicate that the educational preparation (formal & continuing training) of the critical care nurses related to family care is lacking. Studies including those of Mian et al. (2007); Halligan (2006) and Neabel et al. (2000) recommend future research on the educational preparation of critical care nurses, but no studies have filled this gap.

2.6.1.2 Informal Educational Preparation

Plowright (1998); Price (2004) and Williams (2005) indicate that the family presence at the bedside has a positive effect in reducing anxiety, and calming the patient through the critical illness trajectory. In providing this emotional support, and with active involvement in the care of their loved one, the family would produce a positive outcome. This active involvement of families in their loved one's care is a strategy to meet families' needs. O' Malley et al., (1991) showed that the critical care nurses are challenged to provide family psychosocial support by the following contributing factors, namely, a lack of knowledge about family needs, a lack of understanding of the importance of family needs related to patients' outcomes, family needs not being perceived as a nursing responsibility. Quinn (1996b) recommended that the needs of families in the ICU should be part of the formal education curriculum of critical care nurses.

O'Malley et al., (1991) showed that research is required to assess the influence of the length of time spent in nursing educational and the clinical environment on nurses' perceptions of family needs. Further research can clarify how family needs are related to patients' outcomes, and can provide direction for nursing practice and education. The participants in the study by Maxwell Stuenkel and Saylor, (2007) maintain that, in participating in the study, they were made more aware of how important the ICU nurse's role is, and how significant nurses are to the family. The participants further iterate that most of the families' needs were met, informally based on their training experiences and inclinations, and that there is no baseline training of the staff in these needs.

The current study is thus motivated by the gap identified in the literature as a lack of studies on the education preparation of nurses for their psychosocial support role for the families of critically ill patients.

2.7 CONCEPTUAL FRAMEWORK

Figure 2.1 below was created by the researcher in order to help organise ideas. Jamerson' et al., model on family experience has been included.

2.7.1   Stages of Family Experience in the ICU

Jamerson et al.'s (1996) description of the four stages of a family's experience when a loved one is admitted to the ICU has been included in the conceptual framework for the current study. These stages include:

Hovering: At first the family gets to know of their predicament. The family as a unit is affected; the entire family enters the ICU. The family is overwhelmed with feelings of shock, confusion, stress, uncertainty, and a feeling of helplessness prevails (Jamerson et al., 1996).

The family is pushed beyond the normal adaptation mechanism; each member's wellbeing is affected by their emotional and psychological experiences of the ICU environment. Their adaptation depends on the support they receive from the health professionals of the ICU.

Ascertaining whether the family has had previous exposure to the ICU and providing the family with information about the loved one's condition/prognosis and orientating them to the environment and the routine is essential. At organisational level, support to the ICU staff could be provided by providing volunteers, pastoral care, or ancillary staff to provide information on loved ones' status (Jamerson et al., 1996).

Information Seeking: The second stage is the active process of seeking for information about the loved one's condition (Jamerson et al., 1996). ICU nurses must anticipate the family's need for information and provide updates at regular intervals from admission to discharge. At the organisational level, message boards, welcome messages, vision and mission statements, printed booklets for orientation and signage indicating amenities and visitation hours should be provided. Successful adaptation in this stage allows the family to move out of the hovering stage; however limited access to information will keep the family in the hovering stage. Somehow the information needs to become focused in this stage (Jamerson et al., 1996).

Tracking: In the tracking stage, the families observe, analyse, and evaluate their loved one's care, including the environment and health professionals in attendance. The ICU nurses at this stage provide basic as well as high-tech nursing care, and show respect and dignity to the family as a unit.

The ICU staff members are required to maintain flexible and open communication, and assign a consistent caregiver. At organisational level, the ICU environment needs to provide for privacy. The provision of in-service training to maintain the skill and knowledge of nursing staff is essential (Jamerson et al., 1996).

Garnering of Resources: The garnering of resources is the final phase experienced by the families of the patients' in the ICU. It involves the acquisition of what families perceive as needs for themselves or their family members, for example, physical needs such as rest, nutrition, diversion activities and personal space or privacy. The ICU nurses provide individual flexible visitation, assess the need for family gate-keepers, provide open, constant and honest information, collaborate with families regarding treatment and discharge planning and allow families to assist with non-technical care. The psychosocial needs include support from other family members (Halligan, 2006) or families of former patients (Sacco, Stapleton & Ingersoll, 2009), friends, health care workers (Stayt, 2007) and other ICU patients' family members (Halligan, 2006). Access to the loved one, as in flexible visitation and the ability to network and collaborate with family members regarding treatment and discharge plans are other factors that would assist during this phase (Halligan, 2006 & Jamerson et al., 1996). This phase extends to resources such as waiting-rooms with family-friendly amenities such as tea, water, even nutrition, which could include a play area for children (Halligan, 2006; Vint, 2005; Jamerson et al., 1996).

2.7.2 Disequilibrium and Equilibrium

The delivery of care has been evolving through the decades. Patients coming into the ICU need complex care and constant vigilance by the ICU nurses. On admission, there are times when the family may feel ignored because the ICU nurses are usually continuing with resuscitative measures when the patient care is complicated (Maxwell, Stuenkel and Saylor, 2007).

Other factors which may add to the burden of the situation are factors such as heavy workload, staffing shortages, frequent exposures to death and dying people (Pryzby, 2005; Neabel et al., 2000). Priorities in treatment and patient management can divert the nurses' attention away from realising the family's needs in the ICU environment.

The ICU nurses who are the external resource could reduce family anxiety and stress by providing psychosocial support to the families. However, there is this imbalance, because the ICU nurses prioritise the patient care which is complex, over that of their family members.

They view the patient as their primary responsibility as O'Malley et al., (1991) revealed that some of the reasons the ICU nurses may not perceive family needs as important, and are not able to meet these needs, are the lack of time and the fact that ICU nurses may not understand the family needs being met as directly related to patient outcomes. This imbalance in care delivery emerges as the family faces the ICU and 'hovers' because what is happening to the patient is unclear to them (Blanchard & Alavi, 2008). This creates disequilibrium with the family, and in the care delivery as depicted in the conceptual framework. Blanchard & Alavi (2008) state that this asymmetry emerges because the family may take the perspective that the staff in the ICU have power over them, their friends, as well as their loved one. The nurse needs the family, because the family has knowledge of the patient that the ICU nurses need, in order to provide holistic care. The family work to interact with their loved one and the ICU nurses caring for the patient (Blanchard & Alavi, 2008).

The family that is 'hovering' is trying to seek information and assurance (Jamerson et al. 1996) and may be misunderstood and misinterpreted as invaders by the staff. The family may be unable to establish an effective relationship with the ICU staff as they become pre-occupied with establishing the needs of the family as a whole (Blanchard & Alavi, 2008).

The ICU staff members are focusing on the patients and they forget that the family has needs that must be met, thus disequilibrium occurs in the care implemented. To establish equilibrium within the family and in the delivery of care studies, Mckiernan & McCarthy (2010); Pryzby (2005) and Ball & McElligot (2003) indicated that the family needs can be understood and the need to involve the family in the care can be recognised. In addition, Blanchard & Alavi (2008) state that to establish a symmetrical relationship between the staff and the family, good information is essential. It is the family which integrates unique relationships such as emotional, spiritual, and biological connections with their loved one. As evident in the study by Blanchard & Alavi, (2008) the participants agreed that the family members were not just visitors or a separate entity from the patient, but should be included in the patient care. To be able to support the family to achieve participation in patient care requires the nurse to develop an understanding of the family, and to help to redress the asymmetrical relationship (Blanchard & Alavi, 2008) thus achieving equilibrium.

2.7.3 Therapeutic Environment

In addition to creating equilibrium in the ICU and within the family unit and symmetrical relationships, a therapeutic environment needs to be created.

In Figure 2.1 the family arrives at the ICU as a unit facing critical illness. Hoye and Severinsson(2010) indicate that the family has been declared the fundamental unit of society. The impact of the critical illness impacts on the family as a whole. The ICU is depicted as dehumanising because of the advanced technology, e.g. ventilators, monitors and numerous IVI lines which make the families distressed. The families cannot maintain the equilibrium by themselves, they are now powerless, and feel useless because they cannot help their loved one, and thus blindly trust the health professionals (Johansson, Fridlund & Hildingh , 2005).

The critical care nurse is the main role player who is with the patient constantly. S/he is required to accompany the family as a unit from the 'hovering' phase to the 'garnering of resources' (independence) and to a state of equilibrium, that is, as they move through the various phases, 'hovering', 'information seeking', 'tracking' and 'garnering resources' (Jamerson et al., 1996). Miracle (2006) states that ICU nurses have the potential to develop, implement, test and evaluate strategies to help families of critically ill patients. To create a therapeutic environment the following strategies need to be implemented: orient the family to the ICU and the routine; provide the family with information on the loved one; give family members written materials containing adequate and appropriate information; obtain contact numbers and contact the family to keep the members updated; maintain flexible/open visitation; provide a comfortable waiting-room with amenities close to the ICU.

They need to be able to use volunteers to staff the waiting-rooms; to conduct daily meetings (formally/informally) between the family and ICU nurses/doctors; to allow children to visit; to allow the family on rounds; to allow the family to assist with the care of their loved one; and to ensure proper signage to and from the ICU (Miracle, 2006).

2.7.4 Educational Preparation of the ICU Nurse to Provide Psychosocial Support

Quinn (1996) iterates that the continuing educational curriculum should include family needs. Hardcastle (2008); Candela (2008); Shirey (2008); Drenkland (2008); Mian et al. (2007); Halligan (2006) and Lane et al. (2005) further highlighted that practice changes require continuing education.

Plakas, Cant and Taket, (2009) concluded that there is a need for organising support programmes, and provide education to ICU nurses on family care issues for families of ICUs.

It is evident as depicted in the conceptual framework that the key to achieving equilibrium within the family is delivering a balanced care so that the family is accompanied through the experience from 'hovering' to 'garnering of resources' smoothly.

Continuing education is the key to enhancing the relationship of nurse, patient and family members. In a study by Quinn, et al. (1996a) and Quinn, et al. (1996b) nurses identified themselves as the group most suitable to meet the support needs of families of critically ill patients. Blanchard & Alavi (2008) conclude that, through the action research, there resulted a change in the way nurses include and think of families in the clinical environment.

The ICU nurses need to adopt a positive outlook and attitude towards family support, thus they themselves need to be supported psychologically, socially, culturally and educationally to be able to support families (Institute of Family Care, 2008; Jamerson et al., 1996). The current study intends to provide insight about the need for ongoing educational preparation of the ICU nurses in relation to providing psychosocial support to families of critically ill patients and looks at their practice from the ICU nurses' perspectives.

As recommended in the literature reviewed, it his assumed that through continual educational preparation of the ICU nurses, they may be equipped to lift the family to a state of equilibrium through appropriate interventions as depicted by Jamerson's et al (1996) and balancing the care provided to the patient and his/her family, thus creating a therapeutic environment.

PROFESSIONAL PRACTICE ENVIRONMENT CREATED

EQUILIBRIUM MAINTAINED

GARNERING OF RESOURCES: Perceptions of what they and their loved one require, and are able to find a means to get.

Guidelines implemented to meet family needs

Continuing Education and Training support of ICU Nurses to render psychosocial support to families of ICU patients

Family as unit facing critical illness

TRACKING: Interacting Observations Analysing

INFORMATION SEEKING: Active

What is going on?
To be informed
Kept updated

Central focus on the patient

DISEQUILIBRIUM

HOVERING: Exposure to ICU Confusion Uncertainty Separation Stress

Lack awareness of family needs

FAMILY EXPERIENCE

PATIENT WITH CRITICAL ILLNESS

ENTRANCE INTO THE CRITICAL CARE ENVIRONMENT
(High-tech, dehumanising and huge stressor)

FIG. 2.1 CONCEPTUAL FRAMEWORK

2.7.5 Assumptions from Jamerson, et al.'s (1996) model and the Conceptual Framework

- The experience of families of critically ill patients is divided into four stages namely, hovering, information seeking, tracking, and garnering resources.

- To make a successful transition through these stages, nurses need to support the families through these phases accordingly.

- For the ICU nurses to support the families through these stages successfully, they require support themselves, namely, psychologically, physically, emotionally and spiritually through the process of educational support.

- Educators and the management of the hospital can provide educational support through education, training, and in-service education over and above the necessary infrastructure, human resource, equipment and amenities.

- There is a direct relationship between the psychosocial support of families' of the critically ill patients and the outcomes of the critically ill patient.

2.8 CONCLUSION

This chapter examined the studies and the literature on the effects of the admission of a loved one to the ICU, on the family as a unit facing critical illness, the experience and needs arising from these effects, family psychosocial support by the ICU nurses, the challenges, the barriers to providing F.P.S. and the continual educational preparation of the ICU nurses in order to provide F.P.S. Admission of a family member to the ICU is a stressful experience for the families due to the complex care required. The environment is designed for the rescue of a patient with high-tech equipment, with alarms and lights flashing, that are intimidating to family members. Families have basic needs which include assurance, information, hope and close proximity to the loved ones. The ICU nurses have the potential to reduce families' stress by meeting these needs.

However, the ICU nurses are challenged in providing F.P.S. by harbouring perceptions of families as invaders, because the families want to be with the patient all the time, limited time to attend to the family due to a lack of staff, or the patient requiring the ICU nurses' undivided attention. In addition, the lack of continued educational support of the ICU nurses related to F.P.S. has been highlighted, and further research of this aspect recommended.

CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN

3.1 INTRODUCTION

The research design is a blue-print for doing the study that will control factors that could interfere with the validity of the findings. Academic rigor is imperative to increase the probability that the study design is an accurate reflection of reality (Burns & Grove 2005). This study investigated the educational preparation of the critical care nurse to provide psychosocial support to the families of patients in the ICU.

3.2 RESEARCH PARADIGM

The researcher comes from the pragmatic worldview whereby the concern of the research is what works and what does not work, including the use of all approaches to understanding the problem (Creswell, 2009: 10). The following assumptions are associated with the pragmatic paradigm:

- Pragmatism is not committed to any one system of philosophy and reality

- Individual researchers have freedom of choice.

- Pragmatists do not see the world as an absolute unity

- Truth is what works at any given time

- Pragmatists look at what and how to research based on intended consequences

- Pragmatists always agree that research always occurs in a social, historical, political and other contexts

- Pragmatists believe in the external world independent of the mind (Creswell, 2009 : 11)

Therefore, pragmatism is open to multiple methods, different worldviews and different assumptions including different forms of data collection and analysis (Creswell, 2009:10-11). Mixed methodology researchers believe that biases inherent in any single method could neutralise or cancel biases of other methods (Creswell, 2009:14). This approach accommodates not only convergence but also integration and connecting quantitative and qualitative data. Furthermore, the mixing and merging of qualitative and quantitative data into one large database occurs, and the results can be used to reinforce each other, for example, qualitative quotes can support statistical results (Creswell, 2009: 14).

3.3 MIXED METHOD APPROACH

A mixed method study is an approach that collects, analyses and integrates the quantitative and qualitative data in a single study in order to resolve research problems based on pragmatism (Creswell et al., 2004). A mixed method approach was adopted to investigate and describe the continued educational preparation of the critical care nurse to practice psychosocial support to families of patients in the ICU. The combination of these methods complement each other and allow for a vigorous analysis.

The current study uses the mixed method approach with equal weighting given to both the quantitative and qualitative components. The two methods established the current practice of psychosocial support including the formal and informal educational support of ICU nurses to provide this aspect of care (Tashakkori & Teddie, 1998). Furthermore, the mixed method approach accommodates the potential strength of observation, self-reports (questionnaires and interviews), document review and biophysical measures as main approaches whereby the nurse collects data, although in the current study the latter approach was not used (Creswell, 2009).

3.4 CONCURRENT MIXED METHODS

Creswell (2009) suggests three types of strategies that can be used within the mixed method approach, namely, sequential mixed methods, concurrent mixed methods and transformative mixed methods. The current study followed the concurrent mixed method, whereby the researcher used both quantitative and qualitative methods for convergence to provide a comprehensive analysis of the research problem (Creswell, 2009). In using concurrent mixed method, Creswell (2009) further advocates the use of three concurrent designs, namely concurrent triangulation, concurrent embedded and concurrent transformative.

The current study used the concurrent triangulation design. In the concurrent triangulation design the researcher collects both quantitative and qualitative data concurrently, and then compares the two databases to determine whether there is convergence, differences, or some combination. This approach uses separate quantitative and qualitative methods as a means to offset the weakness found within the single method, that is, the strength of one method adds to the strength of the other. The mixing was implemented during the analysis and in the discussion related to the literature and the conceptual framework. The two streams of data were merged, that is, data were integrated with each other so that they could be compared. The advantage of convergence is that the results are well validated with substantiated findings (Creswell, 2009).

3.5 THE CONTEXT OF THE STUDY (STUDY SETTING)

The study was conducted in two hospitals and two nursing educational institutions. The latter were chosen because the bulk of the ICU students that enrol for post registration qualification are seconded from the two hospitals, designated A & B for the purpose of this study. The researcher hoped to be able to trace the students back to their original hospital workplace to determine their educational preparation to render psychosocial support to the families of ICU patients.

In the Medical and Surgical Nursing Science Program, the elective Critical Care Nursing is offered in two public institutions in KZN. These institutions serve the whole of the KZN population in providing formal continuing education to interested registered nurses under the R212regulation of the SANC, as amended by No. R.74 in terms of the Nursing Act 50, 1978.

3.6 POPULATION

Burns and Grove (2005:746) define a population as comprising all of the elements (objects, events, individuals) that meet the sample criteria for inclusion in a study. It comprises an "entire aggregation of cases in which a researcher is interested" (Polit & Beck, 2004: 289). The population that a researcher studied is referred to as the accessible population or the study population (Brink, 2006:123). The target population includes the entire population of interest (Polit & Beck, 2004:734).

The population in the quantitative aspect of the study included registered nurses working in critical care within Hospital A & B. The qualitative aspect used the same critical care nurses in the chosen hospital and the managers of the same units including the educators from the respective nursing education institution. The study population also included the documents used in the study settings. The managers, educators and documents were utilised for the purpose of data triangulation.

Burns & Grove, (2005) advocate for data triangulation where the intent is to obtain information about the phenomenon under study for the purpose of validation.

3.7 SAMPLE AND SAMPLING PROCEDURE

"A sample is a subset of the population that is selected for a study. Sampling includes selecting groups of people, events, behaviours or other elements with which to conduct a study" (Burns and Grove, 2005:746). Purposive sampling was used for the selection of the hospitals A and B within which the chosen ICUs were located. The educational institutions, that is Institution A and Institution B which provided education and training to Critical Care Nurses from these ICUs were also purposively chosen.

To establish the formal preparation of ICU nurses to render psychosocial support to families of ICU patients, the researcher chose the ICU nurses who were trained. The researcher was also interested in establishing the educational support within the workplace, therefore the non-ICU- trained nurses were added to the sample. The study was however not interested in the comparison of ICU & non ICU trained nurses or the comparison of the two nursing educational institutions or the comparison of the two hospitals, therefore, no such comparisons were made.

The criteria for inclusion in this study were that:

- Participants had to be working in the chosen study setting.

- Participants had to have worked for more than a year in the ICU.

- Respondents participated on a voluntary basis.

The sample size in the quantitative component of the study was (34) participants secured by availability. The sample size realised by data saturation in the qualitative aspect of the study was nine (9) participants. A lecturer, domain and operational manager were included in the qualitative component of the study forming part of the above mentioned nine participants.

The latter participants were chosen because they were working in educational and critical care units respectively where the main study participants were found for data triangulation and validation. Both the recruited managers and lecturer were the authors of the documents selected for review.

For the qualitative aspect of the study, purposive, together with theoretical sampling was used to achieve saturation of data (Mouton, 2007). In this approach, sampling continued until nine nurses were interviewed when data saturation was achieved. Sample size was based on informational needs, and sampling was done to the point where no new information was obtained and redundancy was reached (Polit & Beck, 2004).

A non-probability convenience sample was used for the quantitative aspect of the study. Convenience sampling is a selection of the most readily available persons as participants in the study (Polit & Beck, 2004). The convenience sample was adopted because of the small student population size of the ICU and the time limit. However, the researcher determined strict criteria for sample selection and used two hospitals with multiple ICUs – a general ICU in one hospital and a cardiothoracic, coronary, medical and a multidisciplinary surgical ICU in the other hospital.

3.8   DATA COLLECTION PROCEDURES

Polit & Beck (2004: 716) state that data collection involves the gathering of information to address a research problem. Burns and Grove (2005: 431) state that data is collected on research subjects by observing, questioning, recording, participant observation, semi-structured interview schedule, and document review or any combination of these methods, as used in the current study. This variety of data sources assisted in checking for trustworthiness as will be discussed in the relevant sections.

Once permission was granted (Appendices 6, 7B, 8B, 9C, 10B and 11B), the researcher visited the two hospitals to meet the people in charge of the selected units, and to request access for nurses to participate in the study. Letters of permission to conduct the study in their setting were presented. An explanation of the purpose of the research and the process to be followed were provided. The information sheets (Appendix 4) and consent forms (Appendix 5) were subsequently handed over to participants. Participants were given the opportunity to ask questions after which they were then asked to sign the consent.

The field was prepared and contact was made with the participants to establish social relations (Neuman, 2000). Critical care nursing is a specific sub-culture within nursing. The focus was on observing and documenting interactions with people (patient-nurse-family) engaged in daily living influencing relationships, (multi-disciplinary team) and within a context (Burns & Grove, 2005).

The researcher engaged herself in non-continuous participant observation as supported by Mouton (2007) and immersed herself in the setting for two weeks, for three to six hours per day, totalling eighty-six hours. Participant observations were conducted. Critical care nurses were observed in practice, as well as the educational support received concerning the provision of psychosocial family support to families of patients in the ICU. In participation observation, the researcher becomes part of the sub-culture being studied in a low-profile manner so as to induce as little change as possible (Henning, 2004). Mouton (2007) maintains that in participant observation, the researcher shares as intimately as possible in the life and activities of the setting under study, to be able to develop an insider's view of the actual occurrences. Any method that yields information about the way of life (support to the critical care nurses to enable them to provide family support) is used. This includes interviewing, scrutinising documents, other tools and observing the group by means of their conversations and documentation, etc.

Direct observation notes were written immediately after leaving the field and other types of notes were added to these later (Neuman, 2000). Inferences were recorded in a separate section that is keyed to direct observations. Good note-taking was essential, and the following guidelines were followed: The researcher made sketchy notes at first and did not trust memory; notes were taken down directly regarding what was being observed, or as soon as was feasible thereafter, as the researcher could not at that stage decide what was important or less important, until the review and analysis of the data (Mouton, 2007). Interview notes were kept separately. During this period, the researcher watched attentively what happened, listened to what was said, and recorded whatever data regarding psychosocial support to families of ICU patients became available.

A researcher knows that his/her own background shapes his/her interpretations. The researcher furthermore placed herself within the study recognising that interpretations would flow from her own experiences and background, (in this study I am a critical care trained nurse with experience in a critical care setting). The researcher intended to make sense of (to interpret) the meaning others have about the world (Creswell, 2007: 21).

Quantitative data was collected while working as a participant observer. The researcher went through the same procedure of securing consent as mentioned above. Participants were then asked to complete the questionnaires. The researcher remained at a distance from participants while they were filling in the questionnaires independently. The researcher however assured the participants of her availability to answer any questions that they might have regarding the questionnaires. Some participants indicated that they would return their questionnaires the next day. This was respected, and the researcher came back to collect the questionnaires as requested by the participants.

3.9 DATA COLLECTION INSTRUMENTS

The study adopted a questionnaire (see Appendix 1) using the guideline that was released by the American College of Critical Care Medicine (ACCM) task force (Barclay and Lie, 2007). The questionnaire (Appendix 1) was labelled a competency checklist, and consisted of a total of 119 questions. It was divided into sections:

➢ Questions 1 to 56 represented the current practice by the ICU to render psychosocial support to the families of ICU patients.

➢ Questions 57 to 119 pertained to continuing education. There were 15 to 16 repeated questions with slight variations that were placed on different levels, that is, formal and informal as follows:

❖ Questions 57 to 73 referred to lessons received during formal training.

❖ Questions 74 to 119 referred to informal education, that were further divided as follows:

🞤 Questions 74 to 89 referred to relevant topics that the ICU nurses received at unit level

🞤 Questions 90 to 104 referred to relevant topics that the ICU nurses received at hospital level.

🞤 Questions 105 to 119 referred to relevant topics that were presented by the ICU nurses either at hospital level and/or unit level.

Every question was ranked by a five point Likert scale: 0 = don't know, 1= disagree, 2= partially disagree, 3= partially agree, and 4= agree. Participants were asked to choose the most appropriate single statement from each question. The interviews (See Appendix 2) were conducted in English, since the official language in the study setting was English. A qualitative interview is a conversation. The interviewer established the direction for conversation and pursued specific issues raised by the participants (Mouton, 2007).

To gain insight, the questions became broad and general so that the participants were able to construct the meaning of a situation. This thus lent itself to more open-ended questions as the researcher listened attentively to what participants had to say or do in their work setting relating to their educational support to render psychosocial support to the families of ICU patients.

Asking questions and noting answers is a natural process for all people. The wording of questions did not put pressure on the participants to maintain a particular image. Probes were used to gain more in-depth answers, and the researcher listened attentively. Individual in-depth interviews were used to co-create meaning with interviewees by reconstructing perceptions related to continuing educational experiences linked to the practice of psychosocial support to the families of ICU patients. Each interview lasted 40 to 60 minutes. The interviews were tape-recorded with permission for verbatim transcription later. Due to the problem of the availability of participants and the area chosen, one interview was conducted per day. The researcher approached suitable participants and made appointments to meet and interview them at the time most convenient for them.

In addition to interviewing, participant observations (Appendix 3.2) and review of documents that were used to guide the practice of ICU nurses providing psychosocial support to the families of ICU patients (Appendix 3.1) were conducted. These documents included those pertaining to the philosophy of the unit/hospital, protocols, guidelines, pamphlets, newsletters\reading materials given to patients' families, sign-boards, notice boards and patients' charts, curricula, registers, clinical accompaniment records and test papers. This allowed for meaning and understanding to be established from various sources as they emerged.

Thus mutually enriching each method, and providing a deeper understanding in order to converge on an accurate representation of the reality of the nature of the educational support the ICU nurse received, which could not be achieved through the use of one method (Burr, 1998; Polit & Beck, 2004).

3.10 VALIDITY OF THE RESEARCH INSTRUMENT

Validity refers to whether or not an instrument accurately measures what it is supposed to measure (Polit & Beck, 2004). The two methods used to validate the research instrument in this study were face validity and content validity.

3.10.1 Face validity

This refers to whether the instrument looks as though it is measuring the appropriate construct (Burns and Grove, 2005: 423). It would appear to be an adequate means of obtaining the desired data (Brink, 2006: 202). The instrument was constructed so that it could measure the attributes to be studied, that is, the current practice and the continued educational preparation of the critical care nurses in practice to provide psychosocial support to the families of patients in ICU. To ensure face validity the interview schedule was subjected to scrutiny and assessed for representation and the relevance of the questions. At the proposal presentation, academics at the School of Nursing at UKZN reviewed the questionnaire and interview schedule items to ensure that the questions were relevant, unambiguous and clear.

3.10.2 Content Validity

Content validity is an assessment of how well the instrument represents all the components of the variable to be measured. It is the degree to which an instrument covers the scope and range of information that is needed (Brink, 2005).

In this study, the content of the interview schedule was derived from the literature on family care in critical care nursing. More content was obtained from networking with critical care nurses, lecturers and management personnel. This is discussed further in the information provided concerning the pilot study. It included information on demographics from the researched population, their practice of providing psychosocial support to families of ICU patients, what experiential learning they had received during training, how much emphasis was placed on the psychosocial support of the families of ICU patients, and what educational support they received, and what further assistance they would elect to receive to render psychosocial support to the families of ICU patients.

For the quantitative aspect of the study, a questionnaire (see appendix 1) derived from the guideline released by the American College of Critical Care Medicine (ACCM) task force was used, (Barclay and Lie, 2007) thus content proved valid. See Tables 3.1 and 3.2 for the matching of study objectives, document checklist, questionnaire, interview guide and conceptual framework.

TABLE 3.1: -Matching Research Objectives, Interviews Guides, Questionnaire and Document   Review

Study Objectives	Questionnaire	Interview Guide	Document Checklist
Establish the extent of family psychosocial support in the critical care units by the critical care nurses.	1 to 56	2	1,2,3,4,5,6
Determine the extent of formal educational support to critical care nurses to enhance family psychosocial support in the ICU.	57 to 73	1	7,8
Determine the extent of managerial support critical care nurses receive to enhance family care in the ICU.	74 to 119	3	9,10
Develop an intervention to support the critical care nurse to enhance family care		4	

TABLE 3.2:- Matching Conceptual Framework and Interview Guide & Questionnaire (Competency Checklist)

CONCEPTUAL CONCEPT	Questions - Interview Guide	Questionnaire (Competency checklist)
Current Practice (accompaniment of family through, Hovering, Information Seeking, Tracking and Garnering of Resources to create a therapeutic environment)	2	1 to 56
Formal educational preparation of ICU nurse	1	57 to 73
Informal educational preparation of ICU nurse	3	74 to 119

3.10.3 Pilot Study

The researcher conducted a pilot study (a small-scale study) before the main study (Brink, 2006). The pilot study was conducted using four participants who met the criteria for the main study, two in the qualitative approach and two in the quantitative approach. The purpose of the pilot study was to test appropriateness and relevance for the interview guide, and to review documents used to provide educational support to the ICU nurses to enable them to provide psychosocial care to the families of critically ill patients, to elicit the desired responses. Adjustments were made to the original format of the questionnaire to remove any ambiguity after conducting the pilot study, that is, questions were separated where they included an "and" for example questions 14 & 15, 22 & 23. The results from the pilot study did not form part of the data in the main study.

However, given the nature of the study in which data analysis coincided with data collection in the qualitative component, this resulted in probing as the researcher learned more about the participants. The researcher did not depart from the planned questionnaire used in the quantitative component of the study as this instrument was not used in previous studies.

3.11 DATA ANALYSIS

Data analysis included preparing and organising the data for analysis. The aim of data analysis is to transform information into an answer to the original research questions. The quantitative data was captured by a computer statistical package which was endorsed by the university. The SPSS, Version 15.0 (SPSS. Inc, Chicago, Illinois, USA) was used for analysis with the help of a statistician.

This included: descriptive statistics and non-parametric analysis, that included the best score, Cronbach's Alpha Reliability Scores, Spearman's rank correlation coefficient and Mann-Whitney-Wilcoxon.

Qualitative researchers "learn by doing" data analysis. Critics claim that qualitative research is intuitive, soft, and relativistic, or that the data analysis falls back on insight, intuition and impression as claimed by Dey, cited in Creswell (2007:148). Data analysis means a search for patterns in the data, recurrent behaviours, objects, or a body of knowledge. Once a pattern was identified, it was interpreted in terms of the setting where it occurred (Neuman, 2000).

Creswell (2007:148) claims that although the writers of qualitative research craft each study differently, they conform to a general contour that is represented in a spiral image. The researcher moved in analytic circles. The researcher entered with data of text or images and exited with a story, while in-between she touched on several facets of analysis and circles.
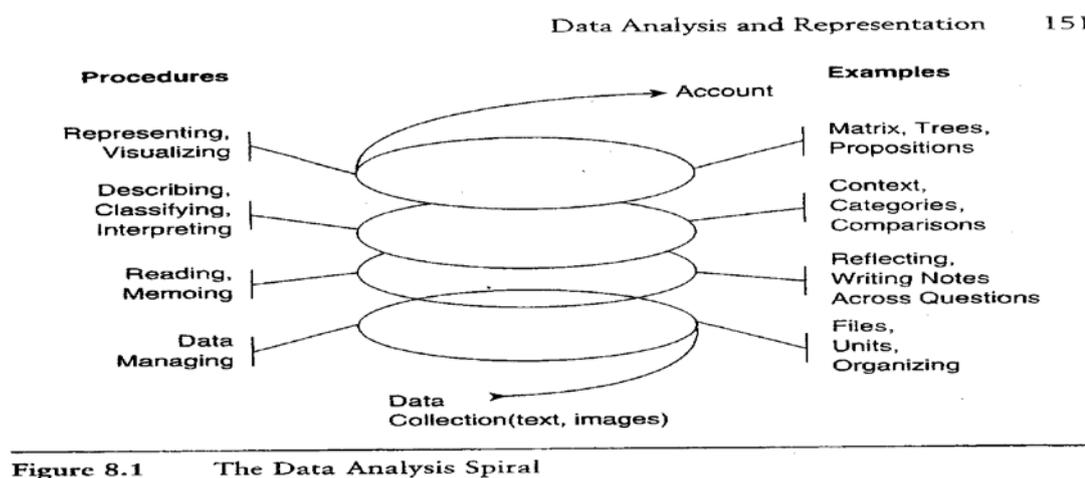
Figure 3.1: Spiral image in Data Analysis (Creswell, 2007:151)

Data management is represented in the first loop. Data was organised into files and folders. Files were used to convert the data into text units, for example, word phrases for analysis to get the sense of the whole database (Creswell, 2007:150).

The researcher moved on to the next spiral, reading and memo-making from the text units, and became immersed in the details to get a sense of the whole before breaking it into parts and segments. This meant writing notes, transcribing, creating short phrases, ideas, or key concepts that arose (Creswell, 2007:150). This was extended to memos that the researcher wrote to herself while collecting data (Neuman, 2000). The researcher, through memo-making, linked ideas, proposed conjectures and developed the themes (Neuman, 2000). This gave a running account of the researcher's attempt to give meaning to field observations. This was the initial cycle through the current data.

The researcher then moved into the next spiral, describing, classifying and interpreting data (Creswell, 2007:150). The second cycle through the data began with an organised set of initial themes. The researcher moved forward, organising themes and identifying the key concepts in analysis. The focus was on themes more than on data. Themes were identified in an attempt to condense masses of data. The themes were then combined into broader categories and displayed in a Table. This began with a list of concepts (from the conceptual framework, objectives of the study, field notes, interviews, etc). Miles and Huberman, cited in Neuman (2000: 423) stated that themes should relate to one another. Themes were examined in greater depth (Neuman, 2000: 423). During this cycle, the researcher looked for categories that clustered together the themes according to relationships or topics of interest. This stimulated thinking about linkages between the themes and gave rise to new ideas.

In the final spiral the researcher then consolidated the themes, located evidence in this qualitative data, and built on a web of supporting evidence in the quantitative data. The researcher then presented the current data in a text tubular form which created a visual image of the collected information (Creswell, 2007; Neuman, 2000).

3.12 DATA MANAGEMENT

Data from the study will only be used for the purpose of completing this study, and, as such, crude data will be kept under lock and key and placed with the research supervisor for five years after which it will be destroyed. Analysed data will be saved in computer files that are protected with a password known only to the researcher.

3.13 ACADEMIC RIGOR

Academic rigor refers to logic, accuracy, and the trustworthiness of research outcomes related to openness and thoroughness in data collection with respect to the qualitative design. To ensure the quality of data and findings in qualitative research, the researcher must establish the trustworthiness of the data. The criteria used were credibility, dependability, confirmability and transferability of the data (Polit & Hungler, 1999:427).

3.13.1 The Measure of Trustworthiness

❖ **Dependability:**

Dependability is the process of detailing consistency, reasonable stability over time, and conditions. The convergence of various methods and data sources, for example, observations, interviews and document review contributed to trustworthiness. Personal involvement at the site with the participants through participant observation provided an opportunity to experience the insight necessary for detailed descriptions which are imperative in qualitative data. As an employee and someone known to the participants, the researcher was able to gain the insight necessary for detailed data collection, and gave feedback randomly for verification of data, analysis and interpretations.

Mixed method concurrent triangulation design was used for this study. Triangulation is a measure of dependability. It allows for the combination of the two approaches within a single study. This provides a basis for convergence on the truth, thus striving to distinguish true information from information with error (Brink, 2006).

❖ **Credibility:**

Credibility refers to the authentic quality of the data, that is, whether the data reveals what one is looking for. The context, plausibility and adherence to the theoretical perspective of the approach used, including convergence of conclusions, are some of the factors considered in connection with credibility (Burns and Grove, 2005). Credibility can be enhanced by triangulation, member checking and thick description (Polit & Beck, 2006). In this study, triangulation, member checking and thick description were all used to ensure credibility.

• **Triangulation**

Triangulation refers to the use of multiple references in order to draw conclusions about what constitutes (Polit & Beck, 2004). There are various types of triangulation, namely method, space and data, the truth to overcome bias, and to capture a complete and contextualised portrait of the phenomenon under study (Brink, 2006)

➢ **Method Triangulation**

Method triangulation was applied to collect data, by participant observations, interviewing, survey and review of documents containing policies/guidelines on the educational support the ICU nurses receive to render psychosocial support to the families of ICU patients. See Appendix 3.1 for documents reviewed and Appendix 3.2 for participant observations. Thus method triangulation allowed for meaning and understanding to be established from various sources as they emerged.

These mutually enriched each other to provide an in-depth understanding so as to converge on an accurate representation of the reality of the nature of the educational preparation of ICU nurses; which could not have been achieved through a single method (Polit & Beck, 2004; Burr, 1998).

➢ **Space Triangulation**

Space triangulation was applied by collecting documents on the same phenomenon in two settings: the place of work of the ICU nurses in hospitals A and B and from two educational institutions A and B, in order to validate data by testing for cross-site consistency (Polit and Beck, 2004).

➢ **Data Triangulation**

Burns & Grove (2005) advocate data triangulation where the intent is to obtain information of the phenomenon under study for the purpose of validation. Data triangulation was applied by collecting data from different nurses at different levels, for example, the managers, lecturers and documents from the two settings were utilised for the purpose of data triangulation with the aim of validating data through multiple perspectives (Polit, & Beck, 2004).

▪ **Member Checking**

Member checking is communication with the study participants regarding data analysis and conclusions of the study for validation of the study from their perspective. In member checking, rich and 'thick' descriptions of data were provided. After obtaining in-depth data through observations, interviews, document review and interpretation, data were validated randomly with the participants (Polit & Beck, 2004).

- **Thick Descriptions**

The researcher was able to render 'thick' descriptions that captured the everyday practices, rituals and actions of the participants within the chosen setting. 'Thick' descriptions were used to make clear the detailed patterns of cultural and social relationships and then put them into context. 'Thick' descriptions aim to give readers a sense of the emotions, thoughts and participants' experiences. In this study the researcher needed to think and reflect about the social relationships (patient, family members and critical care nurses who are equipped with appropriate education) and then describe, analyse and interpret the data. The design of a conceptual framework helped to identify the patterns that existed in the social setting.

- ❖ **Confirmability:**

Confirmability refers to the objectivity of the research process and the outcome; that is, achieving freedom from the researcher's biases by ensuring that the conclusion depends on the participants and conditions of enquiry, rather than on the investigator. The researcher ensured accuracy through field notes and tape-recording. Since the researcher was known to the participants, she was able to gain insight and provide feedback randomly for verification of data, analysis and interpretations.

- ❖ **Transferability:**

Transferability refers to the applicability of the study from one context to different contexts. It is the responsibility of the researcher to provide sufficient descriptive data in the research report for the audience to evaluate the applicability of the data to other contexts. The researcher described the context/setting, the research process and the findings in detail to enable readers to decide on the applicability of the current study to their context.

3.14 ETHICAL CONSIDERATIONS

Right to Self- Determination: The proposal was submitted first for ethical clearance to the Ethics Committee of the University of KwaZulu-Natal (UKZN) before the study was conducted (Appendix 6). Permission to conduct the study was requested (see letter attached) and obtained from the Department of Health (Appendix 8a), and from the respective institutions (Appendix 9a, 9b and10a).

The right to self-determination is based on the ethical principle of respect for persons. Humans are capable of controlling their own destiny and therefore should be free to live their lives as they choose (Burns and Grove, 2005). Research participants were treated as autonomous individuals by being informed about the process and the purpose of the research study, and also by being made aware that participation was voluntary. They were entitled to withdraw from the study at any time without being penalised.

Right to Respect and Dignity: Self-respect, dignity and the health of individuals was maintained through the protection of human rights, (Burns and Grove, 2005). The researcher had an ethical responsibility to recognise and protect the rights of the human participants. The human rights that were protected during this study were the right to: self-determination, fair treatment, confidentiality, privacy, protection from discomfort and harm.

Right to truth-telling (Veracity): Deception was avoided through keeping all processes in this study overt, as all knew about the study, and understood why the researcher kept appearing at various times in their work space. As the researcher was known to all, the ICU nurses did not find the researcher's presence intimidating. All participants met the criteria and were invited to participate; although some interested ICU nurses were invited, they were not eager to be interviewed. This was respected.

Two participants who started completing the questionnaire did not finish due to being busy, and after two attempts to get them to complete which failed, they were excluded.

The right to fair treatment: The essence of the right to fair treatment is based on the ethical principle of justice. This means that individuals should be treated fairly (Burns and Grove, 2005).The sample included various ages, cultural backgrounds and experience, thus this principle was applied by treating all participants with different attributes equally.

Right to anonymity: All identifying information from the participants and records such as their names, addresses and contact numbers were removed. The report portrays figures, statistics and discussions, but no names. The researcher allocates new numbers for the purposes of the study. The interview schedules did not include names, though anonymity is not guaranteed in interviews.

Right to Confidentiality: The promise of confidentiality is a pledge that any information obtained from the participants will not be publicly reported in a manner that identifies them, and will not be made accessible to others (Polit & Beck, 2004). The participants were guaranteed confidentiality of all information that they had shared, and only the researcher and the supervisor had access to it. Data was kept in a locked cabinet and the electronic data in a password-protected computer.

Right to Privacy: Interviews were conducted in a private room with a label outside the door indicating "no disturbance"

Protection from Discomfort and harm: The right to comfort and no harm are based on the ethical principles of beneficence and non-maleficence which promises that one promotes doing good, and above all does no harm. The researcher protected participants from harm by ensuring that no physical or psychological harm would be inflicted on the participants. These principles were adhered to in this study, and the following steps were followed: Once the participants were identified they were approached, and, as the study required face-to-face interviews with the participants, an oral explanation, together with the information sheet was given to participants. The researcher allowed participants time to elaborate and ask questions. Participants were informed that the benefits of this study could improve the care of patients and families thus improving the standards of care in critical care, including the possible advantages and inconvenience of participating in the study given the nature of their circumstances, they could withdraw at any time and this would not affect their placement in the ICU. However, they were informed that although anonymity could not be assured due to the face to face interview, the strictest confidentiality and privacy would be maintained.

3.15 DISSEMINATION OF FINDINGS

Copies of the final report will be submitted to the University of KwaZulu-Natal library in South Africa. It is the researcher's plan to publish the study in a peer-reviewed journal for evidence-based practice. Lastly, the researcher will use local, regional, or international conferences or seminars/workshops to disseminate results in order to reach the majority.

3.16   CONCLUSION

In this chapter, the process undertaken to conduct the study was presented, in keeping with the chosen concurrent triangulation design in the mixed method strategy. The chapter further describes the process for selecting the sample, including the setting, data collection and anaylsis for the study. Measures to meet the ethical requirements for the study, including academic rigor were presented to avoid errors of conclusion and interpretation of the data. Chapter Four presents the findings of the study.

CHAPTER 4:   PRESENTATION OF   FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the study. The aim of the study was to investigate the continuing educational preparation of the ICU nurse in order to provide psychosocial support to the families of ICU patients in two educational institutions. The qualitative data was analysed manually through thematic analysis. The quantitative aspect consisted of thirty-four questionnaires completed and collected from the two selected educational institutions. The quantitative data was analysed using the SPSS, Version 15 software with the help of a statistician. This analysis included both descriptive and inferential statistics.

4.2 FINDINGS OF THE STUDY

The qualitative and quantitative findings are subsequently presented according to demographic data including the integration of the mixed method approach to data collection.

4.2.1 QUALITATIVE COMPONENT OF THE STUDY

4.2.1.1 Qualitative Demographic Data

Biographic data reflects the personal information of the participants and respondents (Polit & Hungler, 2003). The qualitative data included nine (9) ICU nurses aged between 26 and 49 years. One was a male and eight were females. Two participants were not formally trained under R212. Their work experience ranged from 2 to 17 years. Four participants had obtained a B Cur degree. Six participants were ICU nurses working hands-on in the ICUs and two were managers (domain & operational manager) in the two hospitals. One participant was a lecturer who was active in facilitating the formal critical care programme. The participants' demographic data is summarised in Table 4.1 below

TABLE: 4.1: Participants' Demographic Data					
Participant	Gender	Age	Formally ICU Trained	Work experience	Degree
1	Female	40 yrs	no	2 yrs	-
2	Female	41 yrs	yes	17 yrs	B Cur
3	Female	41 yrs	yes	13 yrs	-
4	Female	46 yrs	yes	12 yrs	B Cur
5	Female	46 yrs	yes	5 yrs	-
6	Female	36 yrs	yes	7 yrs	-
7	Male	30 yrs	no	4 yrs	-
8	Female	42 yrs	yes	10 yrs	B Cur
9	Female	49 yrs	yes	10 yrs	B Cur

4.2.2 Presentation of Findings from the Qualitative Approach of the Study

In the qualitative data, ICU nurses were allowed to express their views and demonstrate actions in their natural working environment. The researcher was thus engaged in observation of the participants, in practice, listening to their conversations, conducting interviews and verifying the data so as to capture a more in-depth understanding of the educational preparation of ICU nurses in order to practice psychosocial support to families of ICU patients (Henning, 2004). From the transcribed interviews, participative observation, (see appendix 3.2), and document reviewed, (see appendix 3.1), several themes emerged. This process was achieved by reading and re-reading the narratives across the participants, including notes of observations made during participation. Only themes relevant to the study objectives were grouped together to form categories according to research objectives (Polit & Beck, 2004) as discussed hereunder.

These categories were:

- The practice of psychosocial support to families of ICU patients in the ICU.

- The extent of formal educational preparation of the ICU nurses to empower them to provide psychosocial support to families.

- The extent of informal educational preparation of the ICU nurses to empower them to provide psychosocial support to families.

- Interventions to support the I.C.U nurses in order to provide psychosocial support to families.

4.2.2.1 CATEGORY A: The practice of psychosocial support to the families of ICU patients.

Three themes emerged from this category of data as follows:

> **Theme1: …..*family support is not included in the unit philosophy…***

> **Theme2*: …we can involve the family but the family cannot always be there because this is an ICU.***

> **Theme3   ….. *the patient comes first and the relatives would be secondary that is the truth….***

> **Theme4 …*children under 12…not allowed…***

> **Theme1: …..*family support is not included in the unit philosophy…***

On interview, most of the participants indicated that the unit philosophy did not cater for the family as illustrated by the following excerpt: *"…caters only for patient care."*(Participant 2) The unit philosophy was handed to the researcher for review, and indeed it did not cater for the family psychosocial support but focused on the patient. Speaking to the family appears to be the doctor's responsibility as noted in these quotes:

"It's the doctors, because they normally explain to the patients and their relatives about the operation." (Participant 4)

"...most of the times the doctor is present explaining the condition of the patient and the prognosis..." *"......the doctors always call the family.... and tell them what is happening?"* (Participant 7)

As confirmed through observation, (see appendix 3.2), it was the doctor who approached the family for contact details and invited them to a private room to speak to them about their loved one and their issues. During this interaction there was no ICU nurse accompanying the family. On establishing the actual role of the ICU nurses in this phase, the participants responded as follows, *"...as nurses we just reinforce what the doctor said."* (Participant 1) *"...to explain more if the relatives have further questions to ask because you know doctors sometime use these medical terms which the relatives don't understand especially the black patients..."* (Participant 3)

> **Theme2: …we can involve the family but the family cannot always be there because this is an ICU.**

ICU nurses indicated that the families cannot be involved in physical care as indicated in these excerpts: *"…we are not compliant in engaging the families in providing physical nursing care to the relative, no never"*. (Participant 4) *"...what can they do, they stand by and watch as they are anxious."* (Participant: 2). Participants indicated that the family is not always present in the ICU. ICU nurses viewed families as visitors, and having them in the ICU all day is apparently not a good idea, as noted in these excerpts: *"...they* (families) *disturb when we are doing procedures ..."* (Participant 7) *"… they would disrupt the doctor's round..."* (Participant: 6).

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On the other hand, ICU nurses do regard families as important to patients as indicated in this excerpt: *"...the relatives are needed especially with the critically ill patient, unconscious patient you need the relatives to be there...."* (Participant 3)

This was confirmed through participative observation: during visiting time an ICU nurse was saying to relatives who were standing nearby to their loved one: "… *please do not wake him* (the patient) *as he will become restless and pull out his tubes and drip*". Thus the family just took turns to see their loved one.

Some participants perceived allowing the families to stand by and watch as protection to patients' family members, because the ICU nurses cannot control how the family members would react to certain procedures that were performed in their presence, for example, suctioning, putting up intravenous lines, or cleaning and securing the endotracheal tube as indicated in this quote: *"...they may react differently...putting up all the lines....and say they never want to see it again...."* (Participant 3)

Participants also indicated that some family members do come to visit outside of visiting hours, but they wait a long time outside as stated in this excerpt: *"...relatives would wait outside for hours without seeing patients......it disrupts the routine...."* (Participant 3) On the other hand, restricted visiting time posed a problem to providing support to the families of critically patients as noted in this quote: *"... the family is not here all the time they only come at visiting time ... maybe at that time we are busy and we can't talk to each and every one of them..."* (Participant: 5).

This was confirmed on observation (see appendix 3.2). The principles of managing an ICU patient are on-going and at times the nurses may work through the scheduled visiting times.

The ICU nurses politely asked the family members to wait outside; they were called in once the procedure (suctioning) was over. Visiting time was not extended, even if the families were disturbed during their visit (time with loved ones is shortened) to conduct a procedure.

It was observed that ICU nurses interacted with families differently, for example, when families came in, some ICU nurses would provide chairs/benches for them to sit on and would answer their questions, others did not even greet the families nor did they provide any seats. Families came in; watched their loved ones then left to accommodate their other family members waiting outside. It was noted that the doctors contacted the families if required, but at one given time an ICU nurse did make arrangements for a family to see the doctor.

➤ **Theme3** *…..the patient comes first and the relatives would be secondary that is the truth….*

All participants in this study stated that they were very busy, and had no time to invest in family psychosocial support. They concentrated on the patient as indicated in the following excerpts: *"…it depends on how busy we are.…"* (Participant: 1). *"….when we are busy we do not have time to talk to relatives.…"* *"…our work is not routine…we do emergencies most of the time…"* *(*Participant 2); *"…we are so busy and we do forget about this psychosocial support to the families, yet it is very important that it is dealt with…"* (Participant: 4).

The ICU nurses nevertheless indicated that they would give the patients priority as indicated in this excerpt: *"…they* (families) *always come second, patient care comes first .…"* (Participant 5) *"……the relatives would be secondary, that's the truth, if you are busy with the patient you cannot leave your patient and attend to relatives…..*" (Participant: 3).

Some ICU nurses were aware of the need for families to be around the patient, as indicated in this quote: *"…most of our patients are unconscious, so we relate and communicate with the relatives so they form the bigger part of our care"* (Participant 3).

When conducting the document review (see appendix 3.1), entries made indicated that the patient was visited by the family thus assessing the psychosocial needs of the patient. No report was made as to what was done for the family and how the family coped with this situation.

The delivery of care was focused on the patient. This was confirmed by the following observations: About 45 minutes into open-chest resuscitation, the researcher heard an ICU nurse speaking to another ICU nurse about contacting the relatives, but no one took the initiative to actually contact the family. In this situation, the patient was handed over to the operating theatre nurse and the surgeons to continue, so time was not an issue, but nobody called the family. Sadly, the patient passed away. The researcher heard the doctor saying that the family should be contacted, but he was caught up in paperwork and did not do so. About 10 minutes after the resuscitation, the family called to enquire about their loved one. The call was handed over to the surgeon who informed the family that their loved one was no more, and that they could come over. ICU nurses did not involve themselves with the family of this patient.

> **Theme4 …*children under 12…not allowed…***

On the notice-board, signage was displayed explaining the criteria for visiting times in the ICU which read as follows: ONLY TWO VISITORS ALLOWED, CHILDREN UNDER 12 YEARS NOT ALLOWED IN ICU, PLEASE WAIT AT THE … SHOP – THIS (AREA OUTSIDE THE UNIT) IS NOT A WAITING AREA

All participants agreed with this policy and their practice was guided by this policy. This tends to compromise the social relationships with the families as indicated in this excerpt: *"….some relatives insist they want the children under 12 to see the loved ones……we do advise them….it is not allowed…ICU has got so many infections……"* (Participant: 3).

The researcher confirmed that the participants (ICU nurses) held the perspective that they were protecting the young and vulnerable against infection and the psychological impact of the ICU environment, which has not been substantiated by research.

From observation (see appendix 3.2) it was noted that no children were allowed in the ICU where the study was conducted. When undertaking the document review (see appendix 3.1) there was no evidence that an assessment of family dynamics was made, for example, if there is no child minder in the family and no family member is visiting, or if there are problems of transport or any of the families' experiences which constitute barriers to visiting their loved ones.

Some participants indicated that no routine provisions were made for children's visits, but that should they arrive, it would depend on the discretion of the person in charge as reflected in this excerpt: *"…depends on which sister is in\charge, as whoever it is may allow the children just to look in for two minutes and they will not be allowed to stay…."* (Participant 4), and this was discouraged by others as indicated in this quote, *"…..imagine controlling…… imagine if you have a lot of children flocking into the ICU, they must not be allowed."* (Participant: 5).

On review of the nursing care plan, (see appendix 3.1), ICU nurses made interim entries post-visiting times to indicate whether or not the patient was visited by the family, as a benefit to the patient psychological care, rather than the family.

2.2.2 CATEGORY B: The extent of formal educational preparation of the ICU nurses, to empower them to provide psychosocial support to families.

Three themes emerged from this category of data as follows hereunder:

➢ **Themes 1…** *should do more (lessons on family support) ….things are changing now….*

➢ **Theme 2.…they (lecturers) do accompany us (ICU learners) to the ICU, but not during visiting hours…**

➢ **Theme 3.…** *in basic* **(education and training)** *there was psychosocial support to families of patients but I think it ended there.*

➢ *Themes 1… should do more (lessons on family support) ….things are changing now….*

Participants recalled that lecturers did not focus on the family of ICU patients as indicated in this excerpt: *"...not on family care, but it is based on what we are doing here in the ICU as an intensive care unit, on the monitors that we are using, and the ventilation, and the various types of diagnosis and conditions* (disease) *of the patients..."* (Participant 6) *"We didn't have any formal training in caring for patients' families...nor a lot of support in providing psychological support to the patients.…"* (Participant 3) *"….All of them* (ICU nurses) *are not educationally prepared…..*" (Participant: 5).

Other participants were in agreement that lessons on psychosocial support to the family are absent from formal education and training, thus they were unable to implement psychosocial support to the families of critically ill patients as indicated in this quote: *"...if you are not taught you will not deliver it the way it was supposed to be delivered; we need to be taught how to give that psychosocial support and how to cope ..."* (Participant 4).

The lack of lessons on psychosocial support was verified by a lecturer as noted in these quotes: *"...we want to finish the conditions* (disease) *and actually neglect the psychosocial aspect..."* and *"...we are aware of the family and the attention to the psychosocial aspects, but as far as the curriculum is concerned, it does not actually cover it..."*

On document review (see appendix 3.1) it was revealed that the curriculum did cover general objectives on the psychosocial support to clients, family and community, but there were no lessons annotated in the register as psychosocial support to families of critically ill patients. Tests and examinations did not include questions on the provision of psychosocial support to families of ICU patients', but the evaluation of one educational institution did include aspects of the family in the comprehensive assessment at the patient's bedside. The Objective Simulated Clinical Examination (OSCE) that was conducted included: history-taking from the mother whose child had overdosed, however no psychosocial support was directed to the mother. At another station – the mother was empowered regarding the condition of her child with congenital heart defects, and yet again, the component on psychosocial support to the mother was mainly omitted. Admittedly, the understanding of the child's condition by the mother equates to the information needs according to Jamerson et al.'s (1996) model, the second phase of family experience in ICU.

➢ **Theme 2….they (lecturers) do accompany us (ICU learners) to the ICU but not during visiting hours…**

Most of the participants indicated that the formal ICU educational preparation and training is extensive, and that the lecturers conducted clinical accompaniment, but did not pay attention to family psychosocial support, because the family would not be present at the time of the clinical accompaniment, as noted in these excerpts:

"...it is not easy ..., .they do accompany us, but not during visiting time." (Participant 2); *"... they* (lecturers) *come to the unit, it is in the morning and they see the nurse who teaches them procedures and how to use technology, but they never get education on how to support families, no they don't ..."* (Participant 4). The lecturers confirmed this (clinical accompaniment during visiting time) as noted in these quotes: *"...as lecturers, we are actually neglecting this, though sometimes we come doing clinical accompaniment they* (family) *are not there, but we don't really focus on the relatives much in training participants in the clinical area ..."* and *"... we come, but we are more task-oriented and tend to forget the relatives..."*.

Through observation (see appendix 3.2) this practice was confirmed. The lecturers from one educational institution were in the ICU during visiting time, but they concentrated on evaluating ICU learner competencies related to tasks and procedures. Lecturers left the patients' bedsides when visitors arrived, taking the learners out of this interactive situation with the family.

➢ *Theme 3…. in basic* **(education and training)** *there was psychosocial support to families of patients but I think it ended there.*

The participants indicated that most post-registration qualifications do not cater for the educational support of ICU nurses to provide psychosocial support to families of critically ill patients as noted in this quote, *"…I have done other diploma courses and I cannot remember anyone focusing on the psychosocial support of the family ..."* (Participant 4).

ICU nurses do not find themselves to be confident in providing psychosocial support to families of ICU patients after formal training as indicated in this quote: *"...this ICU we are almost all formally trained so we should be very well versed with this aspect on how to provide this psychosocial support to the families of the ICU patients, yet we* are *not..."* (Participant 4)

Another participant indicated that she lacked the knowledge on this phenomenon, that is, the practice of providing psychosocial support to families of ICU patients, as noted in this excerpt: *"I thought you only inform the family when ……. the prognosis is poor, we hardly do it when we see that the prognosis is good..."* (Participant 1)

Some of the participants were ignorant about this phenomenon and stated that they (ICU nurse) gained from participating in this study as indicated in this excerpt: '...*it has actually opened my eyes....I see that the families are actually completely left out in giving care ...."* (Participant 6)

4.2.2.3 CATEGORY C: The extent of informal educational preparation of the ICU nurses to empower them to provide psychosocial support to families.

The following themes emerged from this category of data:

> **Theme 1…** *we are very busy and have no time to read, if it (policies) is not read to us then we (ICU nurses) don't know...*

> **Theme 2:..** *... teaching program we need to put in these topics on psychosocial support to the families. No topics on ….*

> **Theme3...** *...We have no time for the relatives and they wait for … to speak with them. Nurses need direction … to know exactly what is expected of them.*

> **Theme 1…** *we are very busy and have no time to read, if it (policies) is not read to us then we (ICU nurses) don't know...*

Relating to policies regarding support to families, ICU nurses appeared to shift that responsibility to other role-players, such as domain managers. ICU nurses expect policies to be read at unit meetings, if not, they will not know about the policies. They justified their attitude in terms of the lack of time as indicated in this excerpt: *"...we don't have time for reading policies "We don't get the time to read..."* (Participant: 5).

But on the other hand, the domain manager indicated that ICU nurses should know policies that guide their practice as indicated in this quote: *"...going after them reminding them of the procedures and policies and sometimes you have to remind one individual more than three times of the same policy or procedure..."* (Participant: Manager). One participant indicated that there were no policies, but that guidelines existed to support them in their work as noted in this excerpt: *"…not really policies, maybe like basic guidelines ….but policies we don't have."* (Participant: 3).

Indeed, no such policy was found. However, the visitation policy was found. It stated that only two visitors are allowed at any given time. There were no guidelines on how to communicate or behave with the families. During observation, (see appendix 3.2) it was noted that only basic information was given to the family members via phone, for example, information as to whether the patient's operation has been completed and whether or not s/he was in the ICU. On observation, family members were not allowed out of visiting hours. During visiting times when procedures were performed family members were asked to leave. The researcher found no policies relating to this behaviour. Therefore it is evident that the ICU nurses did 'things' without some form of direction.

➢ **Theme 2:.. .... *teaching programme we need to include those topics such as psychosocial support to the families. No topics on* ….**

Participants reported that family support was a neglected area in the unit's structured in-service plan as indicated in this excerpt: *"…yes the truth is it* (family psychosocial care) *is being neglected, instead more on procedures…"* (Participant: 3).

On enquiry, the trained ICU nurses reported that they too have failed to plot themselves as presenters of topic pertaining to family psychosocial support, on the unit's in-service plan as noted in this quote: *"…. No, no…. not on family, we don't include the family." (Respondent laughs)* (Participant: 6). This was also appropriately indicated by another participant in this quote: *"…look at the topics it is all academically oriented. We never think of this psychosocial support to the families of the ICU patients because we do not see it as important; we concentrate on conditions* (disease) …" *(*Participant 4).

On review of the unit's structured in-service programme, (see appendix 3.1), there were no topics covering family support or any form of psychosocial support. The programme was disease-orientated, moreover, the presenters were predominantly from other health professions within the multidisciplinary team, e.g. doctors or dieticians as noted during participant observations.

> **Theme3... ...*We have no time for the relatives and they wait for doctors or nurses to speak with them. Nurses need direction … to know exactly what is expected of them*.**

The ICU environment is highly charged with emotions that could be overwhelming for all role-players within the multi-disciplinary team, thus, when they encounter each other, this may result in unpleasantness as indicated in this excerpt: "*... young ones (nurses coming out of formal ICU training) need to be taught the correct way of talking to adults* (Participant 2). Some ICU nurses are emotionally immature as indicated in this excerpt: "*.....some individuals will not sit down with family members and explain; they just answer in passing, and continue to do whatever*" (Participant 7).

Some participants started reflecting on negative incidents with families members. For example, one participant recalled an encounter with a family complaining about a noisy ICU as indicated in the following quote: "*.…it was not rude. We* (ICU nurses) *were communicating from a distance with each other, the family misunderstood, complaining about the noise in the ICU. We understand they* (family) *are stressed, thus they behave in this way, but they shouldn't. We* (ICU nurses) *are also stressed; they* (families) *……mustn't come here and be rude to us.*" (Participant5).

Nevertheless ICU nurses have indicated that, while they do try, things may not be done as expected due to other factors that interfere with their work as indicated in this excerpt: *"... no proper education, we need this education on how to deal with it"* (psychosocial support of families of ICU patients) *"... rushing all the time ... we don't give time to family, and, added to this, we are short-staffed thus we cannot go and sit down with the family, but we do try although not enough, and I think we don't do it the way it is supposed to be."* (Participant4).

During the document review (see appendix 3.1) it was observed that a document pinned to the notice-board outlined the procedure guidelines for families to deal with challenging complaints, yet there was no reference to any procedure guidelines to follow to praise ICU nurses when they communicated pleasantly, or should they excel in providing psychosocial support to families of ICU patients.

➢ **Theme4: …*it (informal education on family support) should be on-going really.***

The participants felt that they still needed educational support even though they had completed formal training, as noted in this quote: *"it* (psychosocial support to families of ICU patients) *is lacking. In fact ...even doctors, senior staff, all need to be taught how to provide psychological support to the family"* (Participant 5).

However, participants think that the managers perceive a person coming out of ICU training as a finite product with no need for supervision and support, as noted in the excerpts hereunder: *"... we just take it for granted that a person coming from training has received education and also knows how to give psychosocial support"* (Participant 5)

Most participants reported that there is a lack of support from managers, the responsibility of continuing education is left to the individuals as noted in these quotes: *"……don't think much support is provided ……especially to nursing staff ….."* (Participant1).

"…you go on your own time …" *"Yes, own money too."* (Participant 3); *"I can say in a nutshell, really, not much support is given to the nurses for them to be able to…"* (Participant4).

Under observation, the researcher noted that the formally trained ICU nurses worked with very little, or no supervision, but they indicated that they lacked confidence as finite products as noted in these quotes: *"….not that much* (supervision)*….we do it alone."* (Participant:2).

"…you are trained, but if you have to implement what you have learned, now it is difficult…" (Participant: 3).

It was also noted that the ICU nurses piggy-backed on the doctors' updates for their self-development. The researcher attended the following update: It was a Cardiology in-service training that was held on the 18-19/10/2009 at one educational institution. The in-service training was organised by doctors for doctors, who invited ICU nurses. All of the speakers were doctors. This update had no topics on family psychosocial support, but some reference was made to the families in terms of demographics and history-taking.

4.2.2.4 CATEGORY D: The need for interventions to support the ICU nurses to provide psychosocial support to families of ICU patients

Three themes emerged from this category of data as follows hereunder:

➤ **Theme 1** …*doing a bit of it, but I think we should go and do more (Family psychosocial support)…*

➤ **Theme 2** …*start from the college … create this awareness because, at basic level, it is not the same because these are critically ill patients.*

➤ **Theme 3** ....*the management must be involved …. definitely we need more education and support on it…*

➤ **Theme 1** …*doing a bit of it but I think we should go and do more (Family psychosocial*

➤ *support)…*

The concept 'family psychosocial support' was not fully comprehended by ICU nurses as noted in these excerpts: "*.....I thought you only informed the family when the prognosis was poor ... we don't do it when we see that the prognosis is good."* "*I don't know, I didn't think that we (ICU nurses) should do that (providing support to all members of the family even when the patient is progressing)" (*Participant 6).

Participants never gave a thought to the patient's children at home, especially because the children were not allowed to visit. When probed about the children, the participants considered and responded as noted in this quote: *"I don't, the relatives don't come forward to ask how to provide support to the children."* (Participant1).

Participants reflected on their current practice in relation to family support, and admitted to having learned from participating in this study, using research studies as a form of discussion is essential as noted in this quote: *"…it* (the study) *actually opened my eyes and I can see that families are actually left out in giving care to the patients"* (Participant 4).

➢ **Theme 2** *…start from the college … create this awareness, because at basic level it is not the same because these are critically ill patients.*

When making enquiries from the participants about the need for interventions to support the ICU nurses to provide family psychosocial support, the responses were positive as follows:

"*…yes I could do well with some form of …training or support… on how to attend/deal with the bereaved ….becomes emotionally taxing* (without educational support*)…..*" (Participant1).

"*…..have an impact because I think if nurses are equipped as to how to provide psychosocial care to patient and the relatives…*" (Participant3). A participant who was formally trained indicated that the curriculum needs to be changed as indicated in these quotes: "*…more could be done through the ICU course maybe if a small module is included in the curriculum to inform us on the psychosocial support of the families.*" "*… they (ICU nurses) could implement….*" (Participant 4)

The lecturer facilitating the ICU programme in one of the educational settings agreed that the curriculum needed to include the psychosocial family support of ICU patients as indicated in this excerpt: "*…so when we are doing the curriculum review, these are the things we need to include; it must be emphasised.*" (Participant: lecturer). The manager in one of the study settings also agreed that this psychosocial support to families of ICU patients should be emphasised as noted in this quote: "*…in the ICU course this provision of psychosocial support to the patient's family should receive greater emphasis…*" (Participant: Manager).

➢ *Theme 3 ….the management must be involved … definitely we need more education and support on it…*

Participants identified their shortcomings in their development, for example, lack of supporting policies, lack of workshops and symposiums, and on the other hand, when they do attend workshops/symposiums, the psychosocial support to the families of ICU patients' is not covered, as noted in these quotes:

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"....not providing enough psychological care to the families because we don't have any policies in place ....we did not receive informal training..." *"....ICU stuff about physiology ......nothing about family"* (Participant: 6). The role-players in the educational development of ICU nurses indicated that ICU nurses require constant reminding through continued education as indicated in this excerpt*: "...nurses need to be supported through in-service training because as much as you have a specialty...you need to constantly be reminded by in-service education..."*(Participant: Lecturer).

To make ICU nurses committed to a teaching plan, they should be involved from the needs-assessment phase as indicated in this quote: *"... first assess the needs, there are needs that should be expressed by the staff (ICU nurses), there are needs as a supervisor, so you must ... assess them before you actually come to the programme* (in-service) *and also what I have noticed is the ... there should be participative management, the staff should be involved..."* (Participant: Manager).

One of the participants indicated that the family should be assessed to determine their needs and problems. Policies, philosophy, vision and mission need to be worked upon to give direction to providing psychosocial support to the families of ICU patients as noted in this except: *"...as I am saying this* (practice of psychosocial support to families of ICU patients) *is neglected, we need some kind of assessment strategy to ask the families about their needs and problems. Maybe that is what we should work on, as well as policies, philosophy, vision and mission..."* (Participant: 4). Management tools need to be developed (to provide or give direction) in order to provide support to the ICU nurses to practice psychosocial support to the families of ICU patients.

The categories and their emerging themes were summarised in Table 4.3 hereunder:

TABLE: 4.2 CATEGORISATION OF THEMES

CATEGORIES	A. The practice of psychosocial support to families.	B. The coverage of psychosocial support to families during formal ICU education & training	C. The coverage of informal educational support to the ICU nurses to empower them to provide psychosocial support to families.	D. Interventions to support the ICU nurses to provide psychosocial support to families.
THEMES	…..family support is not included in the unit philosophy…	… should do more (lectures on family support) ….things are changing now…"	……we are very busy no time to read, if it (policies) is not read to us, then we (ICU nurses) don't know...	… but I think we should go and do more (Family support)…
	…. we do our best and being the critical care unit …we can involve the family, but the family cannot always be there because this is an ICU...	….they (lecturers) accompany us (ICU learners) to the ICU, but the focus is on the patient; no psychosocial support to family …	... we need to put these topics on psychosocial support to the families into the teaching programme. No topics on ….	…starts from the college … create this awareness because at basic level it is not the same, because these are critically ill patients
	…..the patient comes first and the relatives are secondary, that is the truth	…. in basic (education and training) there was psychosocial support to families of patients but I think it ended there	...We have no time for the relatives and they wait for …to speak with them. Nurses need direction … to know exactly what is expected of them	…the management must be involved … definitely we need more education and support on it…
	Children under 12…not allowed…		…it (informal education on family support) should be ongoing really	

4.2.3. THE QUANTITATIVE COMPONENT OF THE STUDY

4.2.3.1 Quantitative Demographic Data

Biographic data reflects the personal information of the participants and respondents (Polit & Hungler, 2003). The sample size for the quantitative component was thirty four (34); respondents were aged between 28 and 55 years. One was male and thirty-three were female. Ten of the respondents were not formally trained under the R212, but just had ICU experience. Seven of the respondents in the quantitative data also participated in the qualitative interview as well.

- **Gender of Participants**

The study comprised 34 participants of whom one was a male (3%) and 33 (97%) were females. See Figure 4.1 Below.

Figure 4.1: Gender of Participants (n=34)

- **Age of Participants**

An equal number of respondents, 44.1% (n=15) were aged between 28 and 38 years and 39 and 49 years. Twelve percent (n=4) were aged between 49 and 55 years and no respondents older than 55 years of age were found in this study. See Figure 4.2.
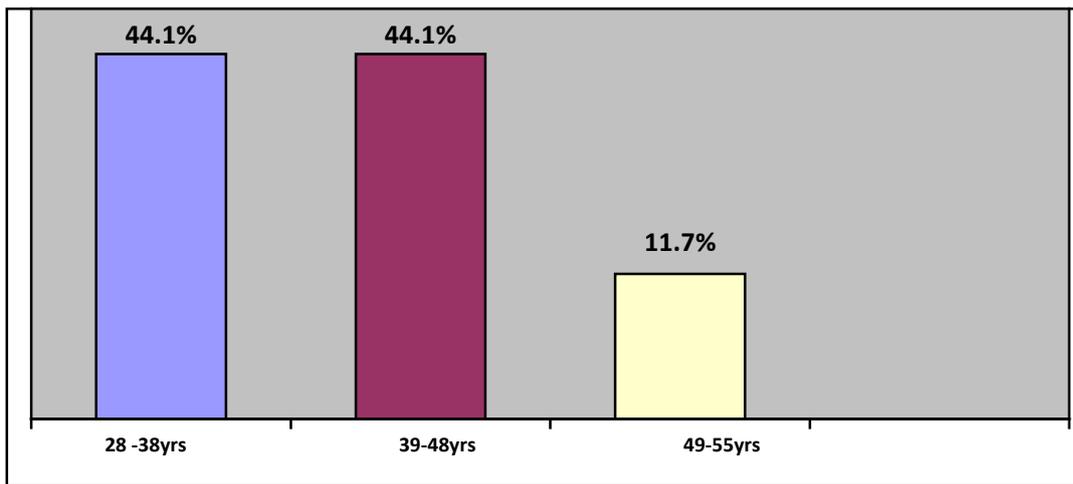
Figure 4.2: Age of Participants (n=34)

- **Work Title of Nurse Participants**

All of the participants, 100% (n=34) were working as Professional Nurses. See Table 4.2.

Table 4.3: Work Title of Participants (n=34)		
Work Title	**Frequency**	**%**
Professional Nurse	34	100%
Total	34	100%

- **Type of ICU Training of Nurse Participants**

Twenty-nine percent of the ICU nurses were not formally trained in the ICU, whereas

75.5 % (n=24) had undertaken formal training in the ICU under Regulation Number R212 of

the South African Council (1985) as amended.
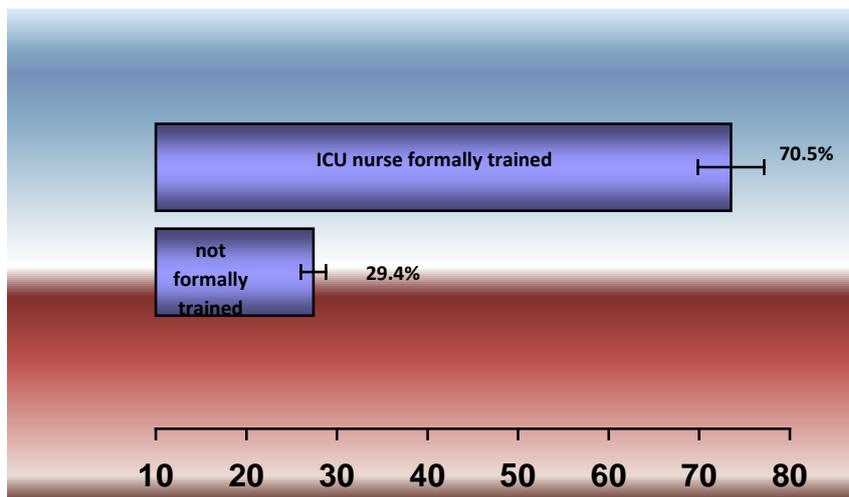
Figure 4.3: Training of Participants (n=34)

- **ICU Experience of Participants**

Twenty-seven percent (n= 9) of the participants had 2 to 5 years of ICU nursing experience, while 23% (n=8) had 6-10 years. Twenty-three percent (n= 4) had 11-15 years experience, and 9% (n=3) had 16 to 20 years experience.
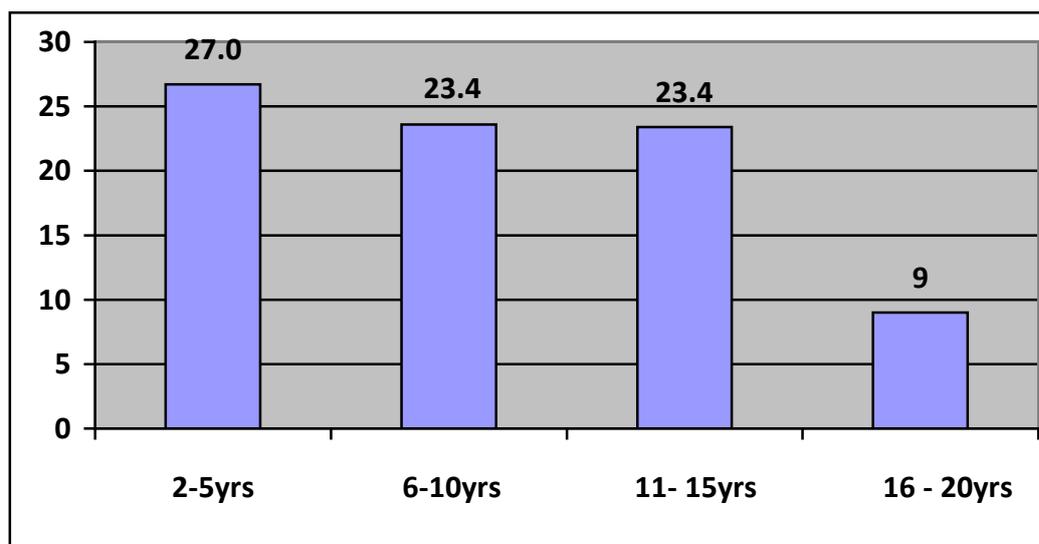
Figure 4.4: Experience of ICU nurses (n=34)

- **Nursing Educational Level**

All participants, 100% (n=34) had a diploma in Critical Care Nursing Science, while 18 % (n=6) also possessed a degree in Nursing Science.
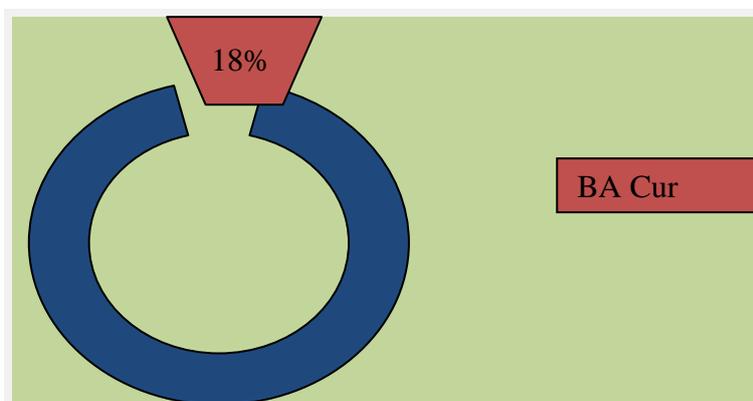
Figure 4.5: Nurses Educational Level (n=34)

4.2.4 Presentation of Findings from the Quantitative Approach of the Study

Quantitative data was analysed using frequencies tables and non-parametric tests. The study did not aim to compare the institutions, so no comparison was done. Instead, it aimed to establish the extent of informal and formal educational support to the ICU nurses to empower them to be able to provide psychosocial support to the families of ICU patients.

The quantitative data aims to answer the following questions: What is the extent of family psychosocial support in the critical care units by the critical care nurses? What is the extent of family psychosocial support coverage of formal and informal educational preparation?

A questionnaire labelled competency checklist was drawn up, based on the American College of Critical Care Nursing and the Society of Critical Care Medicines guidelines for Family Support of ICU patients. The questionnaire (Appendix 1) consisted of a total of 119 questions. It was divided into sections:

- ➢ Questions 1 to 56 represented the current practice by the ICU to render psychosocial support to the families of ICU patients.

- ➢ Questions 57 to 119 pertained to continuing education. There were 15 to 16 repeated questions with slight variations that were placed on different levels, that is, formal and informal as follows:

  - ❖ Questions 57 to 73 referred to lessons received during formal training.

  - ❖ Questions 74 to 119 referred to informal education, that were further divided as follows:

    - ➕ Questions 74 to 89 referred relevant topics that the ICU nurses received at unit level

    - ➕ Questions 90 to 104 referred to relevant topics that the ICU nurses received at hospital level.

    - ➕ Questions 105 to 119 referred to relevant topics that were presented by the ICU nurses either at hospital level and/or unit level.

Every question was ranked by a five point Likert scale: 0 = don't know, 1= disagree, 2= partially disagree, 3= partially agree, and 4= agree. Participants were asked to choose the most appropriate single statement from each question.

The results from the quantitative data are presented descriptively and through relationships of variables. The quantitative data were organised into two sections.

Descriptive Analysis – describes the current practice of the ICU nurses from their perspective. Non-parametric analysis – intends to establish whether there is a relationship between the educational preparation of the ICU nurses and the provision of psychosocial support to families by the ICU nurses.

Quantitative data was analysed using the SPSS, Version 15 and STATA 10 software, with the help of a statistician, to provide answers to the research questions.

4.2.4.1 Descriptive Analysis

The Extent of the Implementation of Family Psychosocial Support of Patients in the ICU by the ICU Nurses

Questions 1 to 56 on the questionnaire represented the current practice by the ICU to render psychosocial support to the families of ICU patients, and the responses were placed in frequency tables from Tables 4.4 to 4.11

    a) **Attitude of Nurses in Implementing Psychosocial Support to Families in the ICU**

Mitchell (2008:50) iterates that nurses' attitudes and beliefs are clearly linked to meeting the psychological needs of patients effectively, and that they have the potential to make the difference between the patients' positive and negative patterns of psychological adjustment. In the current study, the majority, 75% (n=24) of the respondents disagreed that the family is not their responsibility. On the other hand, 53% (n=17) agreed that the family is their total responsibility. This challenge may contribute to the fact the majority 77% (n=26) of the respondents view the family as a threat whilst they are working with the patient, to the extent that 44% (n=15) of the respondents do not encourage the families to participate in direct patient care. Based on the family theory that is influenced by the general systems theory, Rennick (1995:258) iterates that the families must be viewed by health care providers as the "unit facing illness." Table 4.4 reveals that 36% (n=12) of the respondents view the family as a unit facing illness. However, the majority, 85% (n-29) disagree with caring for the critically ill patient and their families as a challenge.

TABLE 4.4: Attitude of Nurses in Implementing Psychosocial Support to families of ICU patients –(n=34)						
Questions relating to the attitude of nurses in implementing psychosocial support to the families of ICU patients	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
Family is not my responsibility	75	22			3.1	100
Family is my total responsibility	13	16	3.1	16	53	100
I view family as a unit facing critical illness	27	6	3.0	36	27	100
I make every effort to encourage/assist family members to provide direct care to their loved ones.	44	6		29	21	100
I see family as a threat to me whilst working.	3	6		12	77	100
Caring for family members as well as critically ill patients is challenging.	85	9		3	3	100

b) The Inclusion of the Family within the Multidisciplinary Team

As noted from the conceptual framework for this study, the family has the potential to 'garner resources' to maintain equilibrium as a family facing critical illness, thereby contributing to the delivery of care to their loved one as part of the multidisciplinary team (Jamerson et al., 1996). Table 4.5 below indicates that the majority, 91% (n=31) of the respondents recognise the strengths and resources that family members have and may contribute to the loved one's recovery, while 79% of the respondents (n=26) agree to understanding the roles, responsibilities and relationships of families in caring for their loved one. Baggs (2004: 527) noted that to achieve better patient outcomes, collaboration is the key activity of any team. In this study, the team is a multidisciplinary health team with the inclusion of the family.

Miracle (2006:121) added that including the patient's family in their care may help to humanise the critical care environment. However, Table 4.5 reveals that 43% (n=12) of the respondents don't know, or are not sure if the family is included in their unit philosophy. This may imply that they don't know their unit philosophy. On the other hand, 54% (n=15) agree that their unit philosophy includes aspects on the care of the family.

TABLE 4.5: The Inclusion of the Family within the Multidisciplinary Team (n=34)						
Questions relating to the delivery of care when the family as a unit arrives at the ICU	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
The unit philosophy includes aspects on family	4	4	18	21	54	100
Do you have an understanding of the roles, responsibilities and relationships of families in caring for their loved one?			6	15	79	100
Do you recognise the strengths and resources that family members may contribute to the loved ones' recovery?		6	3		91	100

c) Providing Attention to the Family on Arrival/whenever

According to Jamerson et al. (1996:471) and as depicted in the conceptual framework of this study, the family is kept in the 'hovering' phase; they experience confusion, stress and uncertainty. They are frozen in this phase because they cannot control this situation. In this study, Table 4.6 reveals that the majority of the respondents, 80% (n= 27) agree that they may attend to the family members needs as soon as they settle. This is similar to the finding by Walters (1995) who claims that the nurses themselves become too engrossed in the world of technology, and are unaware of family members who have urgent needs at this stage.

However, Table 4.6 reveals that 30% (n=10) of the respondents indicated that the senior staff attend to patient and family needs simultaneously. On the other hand, 12% (n= 4) agree that the junior staff attend to family needs as soon as the patients arrive.

Table 4.6: Providing Attention to the Family on Arrival/whenever (n=34)						
Questions relating to current practice of care when the family as a unit arrives at the ICU.	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
I attend to family needs as soon as the patient arrives at the ICU.	9	9		44	38	100
Junior staff attend to family needs as soon as the patient arrives at the ICU.	27	15	6	39	12	97
Senior staff attend to patients and family needs simultaneously.	18	9	3	39	30	97
Family members' needs are attended to as soon as patients are settled in.	3	3		15	80	100
Families' needs assessments are done only when I have time available.	34	28		25	13	94

d) **Promoting Family Proximity to Loved Ones**

The proximity of family members to their loved ones means that the families need to be able to access patients and to visualise the happenings around their loved ones regularly (King-Lee & Ling-Lau, 2003; Bijttebier et al., 2001; Mendonca & Warren, 1998).

In the study by Williams (2005) proximity of family members to the patient was rated as the second most important need. In the current study, the majority, 74% (n=25) of the respondents indicated that they do whatever they can to bring the patient and family together. This finding indicates that ICU nurses control family access to patients through visitation. There is a mixed response about visitation. Table 4.7 below indicated that 38% (n=13) agree to open visitation, while on the other hand, 35 % (n=12) of the respondents agree that they restrict visitation as per schedule times as stipulated in the policy. This is in keeping with the study by Farrell, Joseph, & Schwartz-Barcott (2005) who found a lack of consistency among nurses in granting access by the family (proximity) to their loved ones, which may create disparity in the nurse-family-patient relationship.

Vint (2005) summarised that restrictions were still being imposed on children visiting loved ones, either by the well parents/carers, or by the nursing staff, for reasons not substantiated by research. Children could experience decreased understanding and feelings of abandonment and helplessness. In the current study, Table 4.7 revealed that 35% (n=12) of the respondents agree that the procedure guideline is followed for children-assisted therapy. There were no questions on what the children-assisted therapy entailed in these two educational institutions.

Through document review, (see appendix 3.1), the existence of a policy restricting children under the age of 12 years from visiting a loved one in the ICU was confirmed. Yet again, there is inconsistency in the implementation of the visitation policy.

Through the literature reviewed; child-assisted therapy was meant to include making certain the child was immunised and communicating appropriately. Vint (2005) suggested a play box/play area, and staff to facilitate children's visits, by using teddies and bandages to describe a little of what to expect to the very young, and advised having a plan of action if a child visited a family member in ICU and was not allowed.

Bergbom and Askwall (2000) indicated that it should not be the nurses who decided who should be allowed to visit because any visit could be of huge importance to the family as a unit. In maintaining this closeness, Table 4.7 indicated that 67% (n=22) of the respondents do not mind the family being around while they work with the patient. Meeting the need for proximity helps the family to remain close, and to track loved ones' progress as depicted in the conceptual framework of this study (Jamerson et al., 1996). The family is able to give support to the patient, simultaneously reducing anxiety and augmenting family resources (Leske, 2000).

Hupcey (1998) and Fox-Wasylyshyn (2006) revealed that nurses always perceive and deal with the need for comfort of families as their primary duty in the ICU environment. In the current study, 77% (n= 26) agreed that there is clear way-finding and family-friendly signage to reduce stress. In the study by Jamerson et al. (1996) the families identified the waiting-room as an important place when they had a need to get away and cry.

According to Bergbom & Askwall (2000) this provides huge support for recovering patients, as by seeing their family members near them, this shows them that their families care, protect, and love them. In this current study, Table 4.7 revealed that 97% (n=33) of the respondents agreed that the waiting-room is close to the critical care units. On observation, the family-friendly amenities proved not to be close.

Table 4:7 Promoting Family Proximity To Loved Ones (n=34)						
Questions relating to sharing the proximity to the patient with the family	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
I do whatever I can to bring patient and family together.	9			17.6	74	100
Open visitation is encouraged.	35	9		18	38	100
Visitation is restricted to scheduled times as per protocol.	38	3	3	21	35	100
Family members are allowed to be around whilst I am working with the loved one.	12	3		15	67	97.1
The procedure guideline is followed for children-assisted therapy	21	12	3	29	35	100
Way-finding and family-friendly signage to reduce stress	15		3	6	77	100
Waiting-rooms close to critical care units with inclusion of family-friendly amenities	3				97	100

e) **Promoting Family Participation in the Care of Loved Ones**

Due to the complexity of illness, patients who survive invariably need to be taken care of at home, within the family unit (Adamson, Murgo, Boyle, Kerr, Crawford, & Elliot, 2004). In the current study, Table 4.8 revealed that 42% (n=14) of the respondents agree that they recognise that family members may participate in all aspects of intervention services. However, the majority, 44% (n=15) of the respondents disagree to making every effort to encourage/assist family members to provide direct care to their loved ones, and 60% (n=18) of the respondents agree that family members are only allowed to see patients from a reasonable distance in the ICU.

Table 4:8 Promoting Family Participation in the Care of Loved Ones (n=34)						
Questions relating to sharing the proximity to the patient with family	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
I recognise that family members may participate in all aspects of intervention services.	6	9		42	42	100
I recognise that family members may participate in all aspects of intervention services including, policy development.	16	13		52	19	100
I recognise that family members may participate in all aspects of intervention services including, participation in staff instructions.	36	15	3	21	24	100
I make every effort to encourage/assist family members to provide direct care to their loved ones.	44	6		29	21	100
Family members are only allowed to see patients from a reasonable distance in the ICU.	9	3		24	12	100
Family members do not actively participate in the care of their loved ones.	50	15		24	12	100

f) Providing Family Members with Information

Jamerson et al. (1996) described 'information seeking' as the second stage of experience by family members to cope with their crisis, as depicted in the conceptual framework of this study. In this study, Table 4.9 revealed that the majority of the respondents, 74% (n=25) agreed that they provided information to the family as part of their duty. On the other hand, 32% (n=11) partially agreed that they could not give information because the protocol does not allow it.

Thirty-eight percent (n=13) of the respondents disagreed that the ICU nurses use the visiting times to interact with the family members to provide information on their loved ones' progress. Zaforteza, Gastaldo, De Pedro Sanchez-Cuenca and Lastra (2005) found that nurses spent a lot of time performing activities while the families were visiting. In the current study, Table 4.9 revealed that 65% (n=22) of the respondents agreed that the family is only contacted when the loved ones' condition is deteriorating, 42% (n=14) of the respondents disagreed that information is only given when the family request it. Forty-one percent (n=14) agreed to advocating that other health professionals, e.g. doctors give information to family members. The study by Zaforteza et al. (2005) revealed that the control of information resided with the physician.

However, 45 % (n=15) are in agreement that pre-visit education is provided to families, and 62% (n=21) agreed that consistent messages are given by health professionals to the families. According to the Institute for Family-Centred Care, USA, (2010) information must be given in an unbiased and useful manner to enable the family members to make decisions. In this study, the majority of respondents, 94% (n=32) agreed that the families are assisted in making health-related decisions. Contrarily, 44 % (n=15) of the respondents disagree that decisions on health issues concerning loved ones are made by family members (moral, religious and legal) and 62 % (n=21) disagree that family members make decisions concerning health issues.

The majority of respondents, 82% (n=28) agreed that they allow for formal spiritual counselling by chaplaincy services, while at the same time, 58% (n=14) of the respondents disagreed that families are allowed to bring their own choice of spiritual leader for support.

TABLE 4.9: Providing Family Members with Information (n=34)						
Questions relating to current practice of care when the family as a unit arrives at the ICU	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
I advocate that other health professionals, e.g. doctors give information to families' members.	15	21		24	41	100
Information is provided to families only on request.	42	6	18	12	21	
I provide information to families even if not requested because it is part of my duties.	3			24	74	
Health professionals use this time (visiting times) to interact with family members to provide information on loved ones' progress.	38	27		18	15	100
I cannot give any information, protocol does not allow it.	29	15		32	24	
I contact families only to inform them that their loved ones' conditions have deteriorated.	12	6		18	65	100
Consistent messages are received by family members from health professionals.	9	9		21	62	100
Family members make decisions concerning health issues.	62	15	3	12	9	100
Decisions on health issues concerning loved ones are made by family members (moral, religious and legal).	44	3	3	32	18	100
Family members are assisted in making these decisions.	3	3			94	100
Pre-visit education is provided to families.	33	12		9	45	100
Allow for formal spiritual counselling by chaplaincy services.	3	6	3	6	82	100
Families are allowed to bring their own choice of spiritual leader for support.	58	4		8	29	100

g) Managing Death and Dying Issues

Support to families is always needed, but even more so when the patient's prognosis does not look favourable. The majority of respondents, 82% (n=28) agreed that they are supported with policy and procedures to follow regarding debriefing family members before, during and after the death of a loved one. Table 4.10 revealed that 59% (n=19) agree that debriefing and support is provided to family members after a witnessed resuscitation.

However, only 18% (n= 6) of the respondents indicated that family members are allowed to be present during a resuscitation. Fifty-eight percent (n=20) of the respondents further iterate that debriefing occurs before, during and after the death of loved ones.

However, Table 4.10 revealed that 71% (n=24) of the respondents agreed that there is no place for palliative care in the ICU, with a mixed response, as 35% disagreed and 31% agreed that patients are transferred out to general wards for palliative care.

Table 4.10: Managing Death and Dying Issues (n=34)						
Questions relating to current practice of care when the family as a unit arrives at the ICU	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
Debriefing and support is provided to family members after a witnessed resuscitation	6	6	6	21	59	94
Family members are allowed to be present during resuscitation	32	21		29	18	100
Debriefing and support is provided to family members before, during and after the death of a loved ones	15	12		15	58	100
Policy and procedures are formulated to debrief and support family members after a witnessed resuscitation, and before, during and after death.	6			12	82	100
There is no place for palliative care in our ICU			3	27	71	100
Patients are transferred out to general wards for palliative care.	35	9	12	12	31	100
Bereavement services and follow up care is made available after the death of the patient.	36	12	9	6	36	100
Education is provided to family members about clinical manifestations of approaching death in a culturally appropriate manner	25	9	3	27	45	100

h) **Helping Family Members through Tracking**

According to Jamerson, (1996) 'tracking' is the third stage process, as depicted in the conceptual framework for this study. It involves the process of observing, analysing, and evaluating the patient's care, including the environment and health care professional attending to their loved one.

The ICU nurses are instrumental in providing families with input, thus helping them in tracking their loved one through their ordeal. Table 4.11 revealed that the majority of the respondents, 74% (n= 25) agree that family understanding of prognosis treatment and plans was assessed regularly, with 45% (n=15) of the respondents agreeing to providing pre-visit education. In contradiction of this, 100% (n=34) disagreed to allowing a family member to ask questions relevant to patient care, and 45% (n= 15) of the respondents were in disagreement that family members are educated on continued management of patients once their loved one is discharged to the general unit/home.

TABLE 4.11 Helping Family Members in Tracking				(n=34)		
Questions relating to current practice of care when the family as a unit arrives at the ICU	disagree %	partially disagree %	don't know %	partially agree %	agree %	total %
A family member is allowed to ask questions relevant to the patient's care.	100					100
Pre-visit education is provided for families.	33	12		9	45	100
Families' understanding of prognosis treatment and plans is assessed regularly.	12	3	9	3	74	100
Family members are educated on continued management of patients (caregivers) once loved ones are discharged to general units/homes.	47	18	15	21		100

i) Nurses' Knowledge Acquisition

Figure 4.6 reveals that 35% (n=12) of the respondents agreed with the statement that the knowledge they received during formal training was adequate. It is not clear that the knowledge refers to the psychosocial support required by the families of ICU patients. Twenty-nine percent (n=10) disagreed that the knowledge they possessed to meet families' needs had been acquired through self-teaching efforts alone.
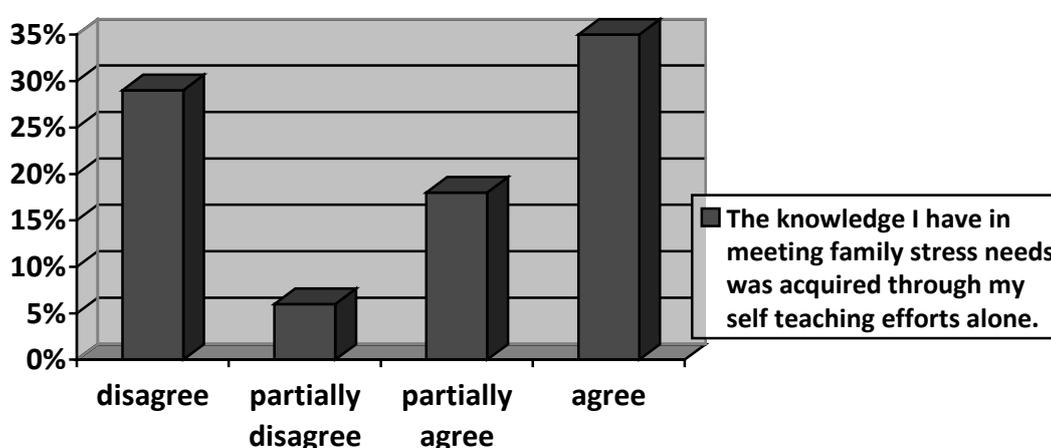
Figure 4.6: Nurses' Knowledge Acquisition

4.2.4.2 Non-Parametric Analysis

Questions 59 to 119 of the questionnaire (competency schedule) pertained to the continual educational experience of the ICU nurses. Non-parametric analysis was used to determine the best score, and to establish the relationship or an association between the variables, namely practice, formal training, informal at unit level, informal at hospital level, and informal at individual presentation level.

a) The Best Scores

The researcher attempted to describe what would be a good score with the various variables. The Likert Scale was used as follows: Agree = 5, Partially agree = 4, Partially disagree = 3, Disagree = 2, Don't know = 1.

In deciding the best score it would be appropriate to choose the option of agree and partially agree in 50% of the questions of each respondent. The researcher decided to attribute the best score to those who also choose partially disagree in 50% of the questions, thus arriving at the following conclusion. See scores below in Table 4.12.

TABLE 4.12: Acceptable Scoring (n=34)			
VARIABLE	GOOD SCORE	Cum. %	Number of questions
Practice	168	53%	49
Formal Training	62	71%	16
Informal at unit level	60	71%	16
Informal at hospital level	60	71%	15
Informal ICU presentation	61	76%	15

b) Cronbach's Alpha Reliability Scores

Cronbach's alpha is a measure of internal consistency, that is, how closely related a set of items are as a group. Cronbach's alpha is not a statistical test - it is a coefficient of reliability (or consistency). The Cronbach's alpha score was calculated for the variables: attitude, practice, formal education, informal education at unit level, informal education at hospital level, informal education at individual level (lessons presented either at unit or hospital level).

To establish a relationship or an association between the variables, the researcher had to determine the Cronbach's Alpha Reliability score for the various variables, as reflected in Table 4.13. The variable 'attitude' produced a very poor score (scores close to 1 show more reliability) and thus was not used to determine relationship with the other variables.

TABLE4.13– CRONBACH'S SCORE		
VARIABLE	Number of item per scale	Cronbach's Alpha Scores
Attitude	6	0.24
Practice	49	0.81
Formal education	15	0.98
Informal education – unit level	16	0.91
Informal education- hospital level	15	0.96
Informal education – individual presentations	15	0.93

c) Spearman's rank correlation coefficient

Spearman's rank correlation coefficient or Spearman's rho, denoted by the Greek letter ρ (rho) or as r_s, is a non-parametric measure of statistical dependence between two variables. It assesses how well the relationship between two variables can be described using a monotonic function. In this study, the educational support that the ICU nurses received should appropriately influence practice (dependent variable). Thus the researcher used the variable 'practice' to show whether there is an association with the current practice from the ICU nurses' perspective to the educational support they received formally and informally. A perfect Spearman correlation occurs when each variable is a perfect monotone function of the other. Simple scatter-plots were used to visualise this correlation:

- **Practice versus Formal Education**

Figure 4.7: Spearman rank - Practice versus formal education. There should be a correlation between what is actually practiced and the lessons received during the formal educational experience, but there is no linear correlation that is displayed in the scatter-plot in Figure 4.7.
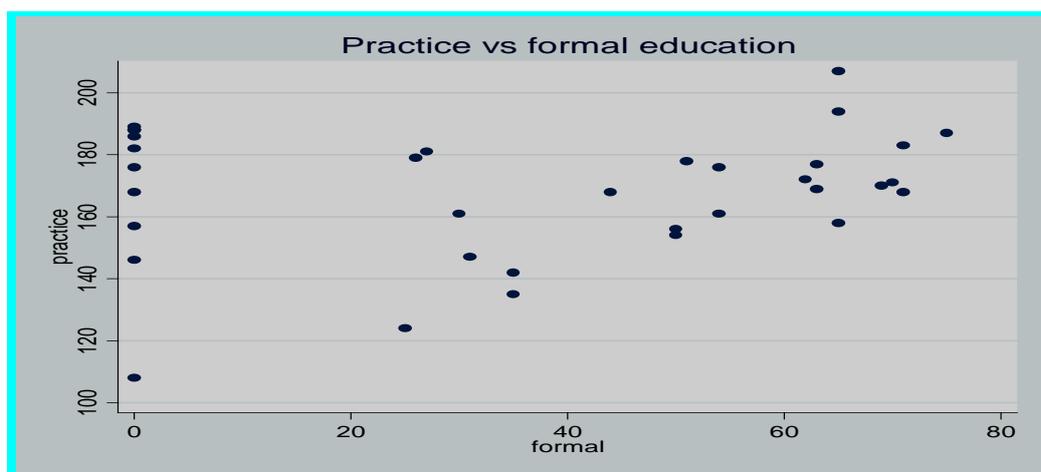
Figure 4.7: A weak correlation exists between practice and formal education (ρ) **0.1023 (n=34)**

- **Practice versus Informal Education**

Informal educational experienced by ICU nurses was described as lessons received at unit level (in ICU), at hospital level (lessons organised by the organisation), and at individual level (lessons that were presented by ICU nurses at any of these levels).

  o **Practice Versus Informal Education (Hospital Level)**

Figure 4.8: Spearman rank - practice versus informal education at hospital level indicated that practice is not influenced by the educational experience (lessons received by ICU nurses at hospital level).
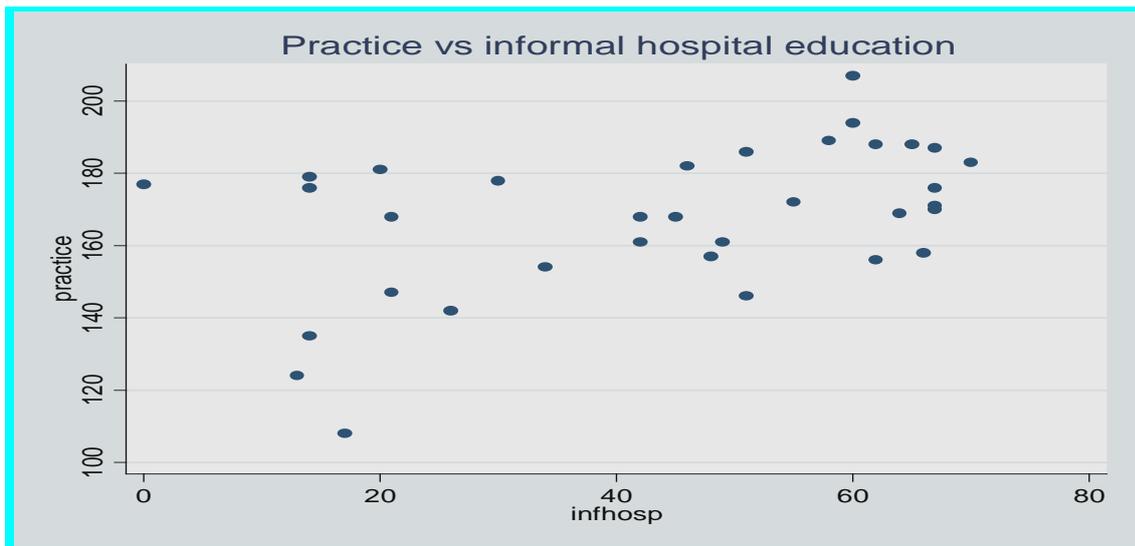
FIGURE4.8: depicts a weak correlation for practice vs. informal training at hospital level =

(ρ)   **0.3826 (n=34).**

o   **Practice Versus Informal Education (Unit Level)**

Figure 4.9: Spearman rank - practice versus informal education at unit level indicates that a slight relationship exists, suggesting that the lessons received at unit level do influence what is practiced in providing psychosocial support by ICU nurses to families of critically ill patients.
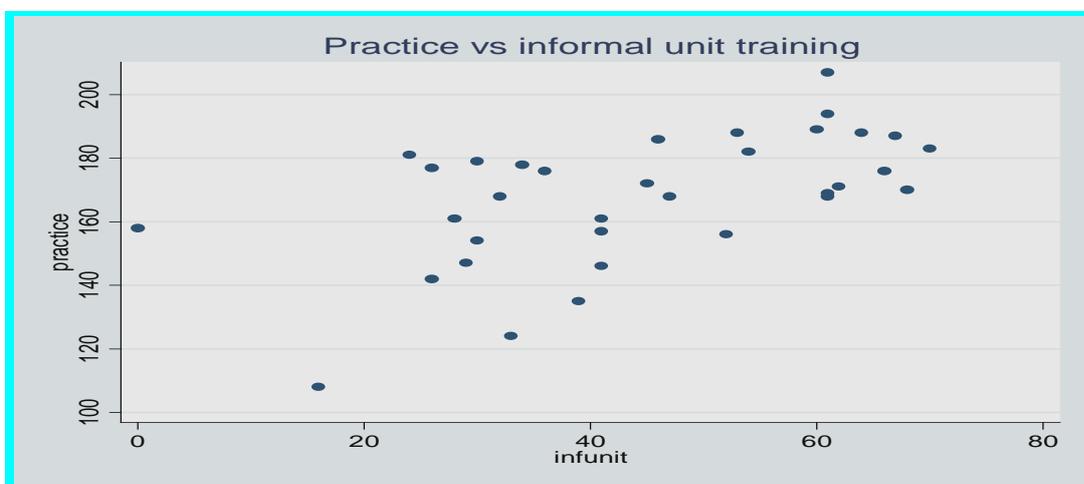
FIGURE 4.9: displays a not so noticeable linear correlation coefficient for practice versus

informal training at unit level – (ρ) **0.3826 (n=34).**

o **Practice Versus Informal Education (Lessons Presented by ICU Nurses at Unit/Hospital Level)**

Figure 4.10: spearman rank - practice versus informal education by means of lesson presented by ICU nurses at unit or hospital level indicates that a correlation exists, that is, that lessons that the nurses delivered either at unit or hospital level, do influence practice.
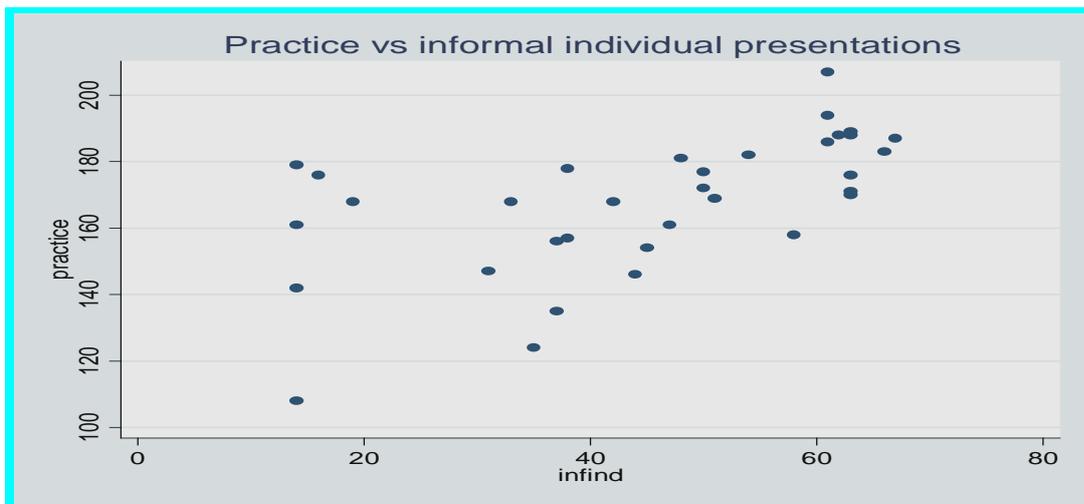
FIGURE 4.10: reflects a more defined linear correlation existed for practice verses informal training at the individual presentation level – (ρ) **0.6369(n=34).**

d) **Mann-Whitney-Wilcoxon (MWW)**

The Mann-Whitney *U* test (also called the Mann-Whitney-Wilcoxon (MWW), the Wilcoxon rank-sum test, or the Wilcoxon-Mann-Whitney test) is a non-parametric test for assessing whether two independent samples of observations have equally large values. It is one of the best-known non-parametric significance tests. In this study, question number 73 asked the respondents to indicate if their formal training was adequate or not. Thus the observations from both groups are independent of each other, that is, respondents may agree or disagree. The responses are ordinal (the researcher can see which of any two observations is greater). See percentages in Figure 4.11 below.
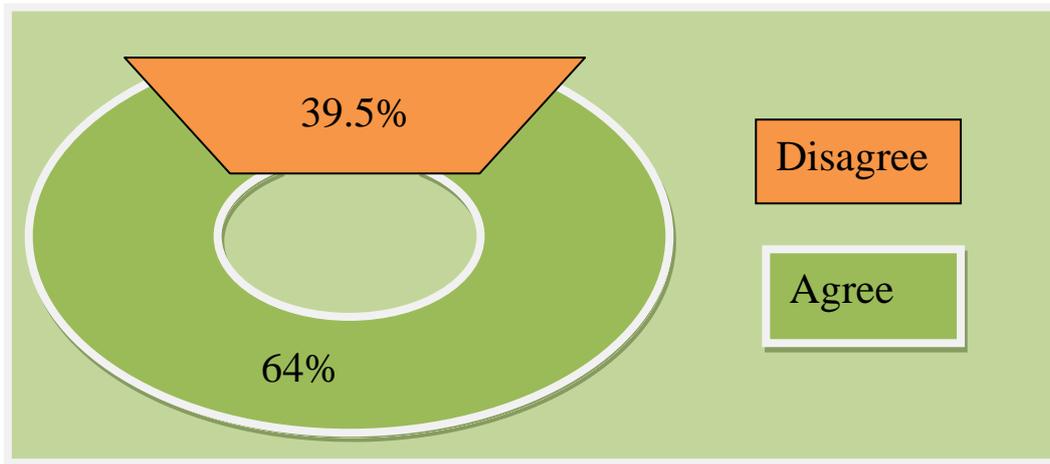
Figure 4.11: Adequacy of formal education (n=24)

There was a significant difference, as those who agreed indicated a raised value of 64 % compared to those who did not agree at 39.5%. The greater value is attributed to those who agreed which one would have hoped would be displayed.

4.3 CONCLUSION

This chapter has given a detailed account of the findings according to the different approaches namely: qualitative and quantitative data. The following chapter (Chapter 5) will present a refectory discussion of the integrated findings of the different approaches in the context of the conceptual framework.

CHAPTER 5: INTERPRETATION, DISCUSSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

In this chapter, the findings of the study are discussed in the context of the conceptual framework. Conclusions, recommendations and limitations are also outlined, based on the findings of the study. The conceptual framework of the study includes attempts by critical care nurses to maintain an equilibrium and closeness between families of critically ill patients and their loved ones by accompanying these families through Jamerson et al.'s (1996) phases of experience of, or adaptation to critical illness, such as 'hovering' (confusion), 'information seeking' (need to know), 'tracking' (keeping tabs) and 'garnering of resources'. To achieve and maintain equilibrium, the ICU nurse requires continual educational preparation (which is a lifelong process) for the growth and development necessary to deliver holistic care within a therapeutic environment.

5.2 INTERPRETATION AND DISCUSSION OF FINDINGS

5.2.1 Hovering

According to Jamerson et al. (1996: 472) in the 'hovering' phase, the families of critical care are overwhelmed with feelings of shock, confusion, stress, separation, guilt, uncertainty about life changes and they appear to be vulnerable. During the 'hovering' phase, the family wait to see the patient in the ICU and to know the diagnosis and prognosis (Jamerson et al., 1966). In subsequent qualitative studies, Agard and Harder (2007); Kutash and Northrop (2007); Engström, & Söderberg, (2004) & Hughes et al. (2004), researchers discovered that these feelings that the families experienced emerged as themes.

Furthermore, Rennick (1995:258) in the general systems theory maintains that families must be viewed by health care providers as the "unit facing illness". Miracle (2006) and Henneman and Cardin (2002) indicated that, as a rule, families are usually secondary to the patients and do not find integration into the ICU easy. Miracle (2006) stated that the family have a vital role in the care of the patient (member of the family). The physiologic patient care demands the highest priority for critical care nurses. This has been supported by Verhaeghe et al., (2005) in a systematic review of many studies emerged the theme; the patient takes precedence. This implied that the ICU nurses' energy and attention is directed towards the caring for the patient.

Indeed, in the current study, participants perceived the patients as their primary responsibility and not necessarily the family, inviting them at stipulated times to the loved one's bedside as visitors, because they were too busy with the patient to be able to attend to a family outside the visiting time. The current study also revealed that there was no direction in terms of vision and philosophy, as 43% (n=12) of the respondents did not know if family support was included in their unit philosophy, while others said, when interviewed, that it focuses on patient care only, as indicated in the quote, *"…caters only for patient care."* When conducting the document review it was evident that the philosophy did not include family support. Thus ICU nurse are not directed towards providing psychosocial support to the families of ICU patients. Mckiernan and McCarthy (2010) recommend that a philosophy of nursing care that focuses on family-centred care be developed through consultation with nursing staff.

To enable the family to cope under such challenging circumstances, critical care nurses need to orientate the families about the ICU environment and routines, anticipate the need for information, assess families' previous experiences with the ICU, and provide appropriate support (Plakas et al., 2009; Jamerson et al. 1996).

The family experience a variety of emotions as they cannot gain access to the ICU, until information is given about their loved so that appropriate actions are taken (Jamerson et al. 1996). In a study by Quinn et al. (1996a) and Quinn et al. (1996b) nurses identified themselves as the group most suitable to meet the support needs of the families of critically ill patients. Critical care nurses must have a positive outlook and attitude towards family support. Burr (1998) and Holden et al. (2000) indicated that other activities related to patient care take precedence over the assessment and care of families of patients in the ICU in the initial hours after admission to the ICU.

The current study found that 80% (n= 27) of the respondents agreed that they may attend to the family members as soon as they settle, with mixed responses as to who attends to the patient and family among junior and senior staff. Participants projected that they were very busy and had no time to invest in family psychosocial support. They concentrated on the patient, as indicated in the following excerpts: "…*it depends on how busy we are….*"; "…*our work is not routine…we do emergencies most of the time…*"

Critical care nurses themselves need support, both psychologically, socially, culturally and educationally to be able to support families (Candela & Bowles, 2008; Hoye and Severinsson, 2008; Mian et al. 2007; Farnell & Dawson, 2006; Williams, 2005; Flowers, 2004; Neabel et al., 2000). In the current study, the participants also indicated that they needed support to provide family support. O'Malley et al., (1991) stated that nursing education programs need to be designed to prepare critical care nurses to cope and thrive in the workplace.

5.2.2 Information seeking

During this phase, the family actively engages in seeking data on their loved one. Successful coping in this phase allows the family to move out of the 'hovering' phase. Limited access to information will keep this family in the 'hovering' phase. The information includes what has been done, what needs to be done, patient's progress and updates on any changes that occur to the patient. Somehow, the information needs become focused in this phase (Jamerson et al., 1996). In agreement with this, studies by King-Lee & Ling-Lau (2003); Bijttebier et al. (2001) and Mendonca & Warren (1998) revealed that the families of ICU patients have a tremendous desire to receive accurate information and knowledge about progress, and to be informed about any changes in the condition of their loved ones timeously.

In the current study, ICU nurses did acknowledge the need for family members to be around as indicated by this quote, "…*most of our patients are unconscious so we relate and communicate with the relatives so they form the bigger part of our care.*" However, ICU nurses found their business to be an obstacle to appropriate communication as noted in this quote: "*…when we are busy we do not have time to talk to relatives.…*"; "*…our work is not routine…we do emergencies most of the time…*".

In the quantitative data, the majority of the respondents (74%) agreed that they provided information to the families as part of their duty. However, 41% of the participants maintained that it is the doctors who should give the information, with reasons given for this such as that it is protocol not to take the responsibility for information giving. Zaforteza et al.'s (2005) study revealed that the control of information resided with the physician in most institutions. This was confirmed by participants in the current study who stated that giving information is the doctor's responsibility as noted in this quote, " *It's the doctors, because they normally explain to the patients and their relatives about the operation*"; "*…most of the times the doctor is present explaining the condition of the patient and the prognosis…*".

However, in the study by Mckiernan & McCarthy (2010) it was found that nurses were generally identified by the families of critically ill patients as being able to give understandable information in contrast to doctors. Similar findings in the current study indicated that participants reinforced the doctor's information in understandable terms as noted in this quote, *"…as nurses we just reinforce what the doctor said"*; *"…to support, to explain more if the relatives have further questions to ask, because you know doctors sometime use these medical terms which the relatives don't understand especially the black patients…"*.

As to the time appropriate for information giving, 65% of the participants advocated that families be given information only when the condition of the loved one is deteriorating. Furthermore, 42% of the participants indicated that they would give the information if the family requested it, while 15% stated that they used the visiting time to provide information on the loved one's progress. The current study further indicates that 82% of the participants support the policy and procedure for the debriefing of family members before, during and after death which included resuscitation. A study by Walker (2008:354) concluded that accident and emergency staff perceive both positive and negative effects of the family presence during adult resuscitation, and further indicated that there are more risks than benefits. However, Walker (2008:354) states that the opinion of accident and emergency staff could be modified in favour of family-witnessed resuscitation through educational initiatives.

To meet the information needs of families, studies by Fox-Wasylyshyn (2006) and Hupcey (1998) revealed that the need for comfort must first be met. In a study by Jamerson et al., (1996) families identified the waiting-room as a very important place where the family could get away and cry in comfort. In the current study, 97% of the participants agreed that there were waiting-rooms with family-friendly amenities close to the critical care units.

Many studies such as Mckiernan & McCarthy (2010); Quinn et al. (1996a) and Quinn et al. (1996b) identified communication and interpersonal skills as being vital to meet the support needs of families, especially their information needs. Zafortez et al., (2005) found that nurses spent a lot of time performing activities while the families were visiting. In the current study this could contribute to nurses not adopting proper interpersonal skills when imparting information as noted in this excerpt: *"…..some individuals will not sit down with (family members) and explain, they just answer in passing and continue to do whatever……"*

Results from a previous study (Hughes, Bryan & Robbins, 2005) show that ICU nurses were at times blamed by families for not giving enough information, and this made the nurses stressed and aggressive. Doctors were not always available to meet the families' needs for information, thus the families place pressure on the ICU nurses, nurses become emotional and lose their tempers. This is supported by Heyland et al., (2002); Bjttebier et al.(2001) and Molter (1979) who found that truthful and accurate information has been consistently discovered to be amongst the needs which are least met. Mckiernan & McCarthy's (2010) study indicated that clinical knowledge and experience influenced the quality of information given, and that the staff members giving the information need to make sure that the information given is understood. The information given must also be understood, for example, a patient is not unconscious, but has been sedated.

Good communication has been documented as the primary need for family members of critically ill patients (Molter, 1979). However, a study by Hughes et al., (2005) revealed that communication remains poorly performed. In the current study a participant indicated that education is required on how to communicate with families' of ICU patients' as noted in this quote: *"… we need a bit of education so that we can we can be well equipped and be able to talk to families the right way."* (Participant: 4).

For the young and inexperienced ICU nurses, communication skills need to be reinforced informally in the ICU environment as noted in this quote: *"... young ones (nurses coming out of ICU training) need to be taught the correct way of talking to adults...."* Previous studies such as those of Simpson (1997); Kirchhoff (1993) and O'Malley et al., (1991) show that lack of time, knowledge deficit, and staff shortages pose a problematic area for nurses, despite the fact that nurses perceive the giving of information as their responsibility, as reported in the current study.

Simpson (1997); Kirchhoff (1993) and O'Malley et al., (1991) showed that due to ineffective communication skills, nurses tend not to meet the need for information. Pochard et al., (2001) claimed that failure to provide consistent and satisfactory information to family members has been the underlying cause of depression, mistrust and anxiety. Managers may also do harm in the manner in which they delivered the information to the families of ICU patients.

During the document review, (see appendix 3.1), it was observed a document that was pinned on the notice-board that outlined the procedure for handling challenging complaints experienced by the family members of ICU patients. This form of negative communication can delineate the efforts of ICU nurses to partner with family members, as one participant recalled this incident and the following emerged: *"....it was not rude. We (ICU nurses) were communicating from a distant with each other, the family misunderstood, complaining about the noise in ICU. We understand they (family) are stressed thus behave in this way, but they shouldn't. We (ICU nurses) are also stressed; they (families) ......mustn't come here and be rude to us".*

5.2.3 Tracking

During the 'tracking' phase, the families observe, analyse and evaluate the patients' care including the environment and the performance of the health care professionals. Of importance in this phase is the demonstration by nurses of competence in high-tech nursing care, organisational abilities, confidence, anticipation of and responsiveness to physical and emotional needs, privacy, respect, dignity, kindness, communication and interpersonal skills (Jamerson et al., 1996). In the study by Agard and Harder (2007) the family members spoke about the significance of being with their loved one at all times. At the bedside they would seek information and proximity, hoping that in some way they could be of help to their loved one, and to make certain that everything was done in the best possible way.

Mitchell & Chaboyer's (2010) study found that some families' members were willing to partake in the care of the loved one so that they felt useful and able to help their loved ones, not just standing back, but being part of the situation. To meet the needs of families during the 'tracking' phase, Jamerson et al. (1996: 470) also suggest that a consistent health care professional be assigned to the patient, and that knowledge and skill be maintained through in-service training.

Williams (2005) found that the need for proximity to the patient by family members was ranked second on the priority list. Family members need answers to the following questions, "What is going on? Is everything going to be okay? Can those entrusted with the care of the loved one provide the care required, and are they competent enough to do so? Is the environment conducive to recovery?" The proximity of the family members to the patient has been identified as a family need by many research studies, amongst others, Mckiernan & McCarthy (2010); Williams (2005); Bergbom and Askwall, 2000 and is described by Plakas et al., (2008) as vigilant attendance.

Proximity means gaining access to their loved ones, and in doing so, instils a feeling of reassurance while at the same time family members are able to see what is happening around their loved ones.

In the current study, the majority, 91% (n=31) of the respondents recognised the strengths and resources that family members may contribute to the loved one's recovery, while 79% (n=26) agreed to understanding the roles, responsibilities and relationships of families in caring for their loved ones. The studies by Mitchell and Chaboyer (2010) and Agard and Harder (2007) showed that family members indicated that they enjoyed participating in their loved ones' care because it made them feel useful, able to connect with their loved ones and the nurses, and not just seem to be standing in the background. The studies further provided insight into the benefits of offering family members the opportunity of providing some care to their loved ones at times the nurses might not normally consider appropriate or of benefit.

However, the majority of the participants (77%) viewed the family as a threat, to the extent that 44% of them would not let families participate in the care of their loved ones, even though 67% of the participants did not mind the family being around while they worked with the patient. Although 42% (n=14) agreed that they did recognise that family members could participate in all aspects of interventions, 60% (n=18) of the participants agreed that family members were only allowed to see patients from a reasonable distance in the ICU, and as indicated in this excerpt: *"…what can they do, they standby and watch"*.

 To meet the proximity need, the literature advocates allowing families to participate actively in direct patient care; joining ward rounds, engaging in family meetings and flexible visitation, including children's visitation (Agard and Harder, 2007; Johansson et al., 2005; Verhaeghe et al., 2005; Vint, 2005; Jamerson et al., 1996).

There were also mixed responses about open visitation, as 35% disagreed with open visitation, while on the other hand, 38% agreed; participants indicated that open visitation would not work as noted in this excerpt: *"...relatives would wait outside for hours without seeing patients...; ...it disrupts the routine...."*. An open visiting hour policy is encouraged as an intervention that may help both the critically ill patients and the patients' families (Knutsson, Otterberg and Bergbom, 2004). Restricted visitation was supported by 35% who supplied 'protocol' as a reason for this support and disagreed with by 38% of the participants.

Vint, 2005 stated that it is vital to attend to children's needs as potential visitors to the adult ICU. In the current study, while 35% of participants agreed that they followed the procedure guidelines for children-assisted therapy, the qualitative data in contrast indicated that no children under 12 years were allowed in the ICU.

During the document review, (see appendix 3.1), the guidelines for children-assisted therapy were not found, and there were clear sign-boards indicating restrictions regarding the presence of children. A similar finding was recorded by Knutsson, Otterberg and Bergbom (2004) who indicated that many hospitals in North America still restricted visiting times and placed restrictions on children's visits. Yet Vint (2005) supports children visiting the critically ill family member because this is a positive intervention to help children cope with feelings of guilt, separation, abandonment and helplessness.

In South Africa there are many households run by children below the age of 12 years. This implies that those children may never connect with their loved one or that the critically ill patient may never have visitors. Vint (2005) considers the continued practice of restricted children's visiting unethical, because it is unsupported by research and harmful to the well-being of the child and the family unit.

5.2.4 Garnering of resources

This is the final phase of the experience by families in ICU. It involves the acquisition of what families perceived as needs for themselves or their family members, for example, physical needs such as rest, nutrition, diversionary activities and personal space or privacy. The psychosocial needs include support from other family members (Halligan, 2006) or families of former patients (Sacco, Stapleton & Ingersoll, 2009), friends, health care workers (Stayt, 2007) and other ICU patient's family members (Halligan, 2006). Access to the loved one as in flexible visitation and the ability to network and collaborate with family members regarding treatment and discharge plans are other factors that would assist during this phase (Halligan, 2006; Jamerson et al., 1996). This phase extends to resources such as waiting-rooms with family-friendly amenities such as tea, water, nutrition, and even a play area for children (Halligan, 2006; Vint, 2005; Jamerson et al., 1996).

The current study revealed that 97% of the participants agreed that the ICU had waiting-rooms close to the ICU. Seventy-seven percent agreed that way-finding and family-friendly signage reduced stress. Eighty-two percent of the participants agreed that they allowed formal spiritual counselling by chaplaincy services. Forty-five percent of the participants indicated that education is provided to family members about clinical manifestations of approaching death in a culturally appropriate manner. Thirty-six percent agreed that they provided bereavement services and that follow-up care was made available after the death of the patient. On the other hand participants contradicted themselves as revealed in this excerpt: *"...nurses become immune to the environment* (ICU) *....cannot see the psychosocial needs of the family because they see patients dying all the time.... everything is a rush, nurses talk to relatives without sitting them down ....comfort room here, all families cannot be accommodated"* (Participant 4). However, the majority of participants (71%) indicated that there was no place for palliative care in the ICU.

5.2.5 Continuing Education and Preparation of the ICU Nurse

It is evident that the ICU nurses themselves need support both psychologically, socially, culturally and educationally to be able to support families (Institute of Family Care, 2008; Jamerson et al., 1996). Chaboyer, Dunn, Theobald, Aitken and Perrott (2001) concluded that the learners provided a unique and in-depth understanding of curricula issues from their perspective in relation to post-graduation critical care nursing education in Australia. This study provides insight about the need for the ongoing educational preparation of the ICU nurses in relation to them providing psychosocial support to the families of critically ill patients, and looks at their experience from the ICU nurses' perspective.

5.2.5.1 Formal education

O'Malley et al., (1991) stated that nursing education programs need to be designed to prepare critical care nurses to cope and thrive in the workplace. Hardcastle (2008) claimed that a synergistic relationship exists between education and practice experience. The same relationship was determined in the current study, but the Spearman's rank correlation coefficient indicated a weak relationship between practice and the coverage of informal education at unit and hospital level. A slightly stronger relationship was displayed between the variable practice and informal education at individual level. This finding could be attributed to the questionnaire labelled as 'competency checklist'. The respondents might have marked items as 'favourable' as they perceived themselves to appear competent in doing so. However, in the qualitative data, the inadequacy of formal education to support ICU nurses in providing psychosocial care to the families of critically ill patients emerged in the current study, as noted in these quotes:

1.…*should do more (lectures on family support) ….things are changing now… "*. This is similar to the findings in previous studies by Hardcastle (2008); Engström, & Söderberg (2006) and Hupcey (1999) which indicated that critical care nurses are required to apply advanced knowledge and technical skills to complex and ever-changing practice situations. During document review, (see appendix 3.1), the register indicated that lectures were held regarding communication and professional practice.

However, the following quotes emerged: "*… young ones* (nurses coming out of ICU training) *need to be taught the correct way of talking to adults"; "…yet are given lectures on professional practice…..they do not practice this in the clinical situation"*.

2.…*some* (formally trained ICU nurses) *still lack* (knowledge), *you have to ask if you* (ICU nurses) b*een formally ICU trained. …"it* (support) *is lacking. In fact …even doctors, senior staff, all need to be taught how to provide psychological support to the family*". In addition, the document review (see appendix 3.1), showed that no test or exam papers contained questions on family psychosocial support in the ICU. This is similar to the findings by Quinn (1996) which showed that some nurses who hold a post-basic qualification did not reflect accurate knowledge of the importance of families' needs. The conceptual framework of this study depicts that the educational support of the ICU nurses will equip them with the skills and the knowledge required for rendering psychosocial support to patients and their families. The ICU nurses may also adopt strategies that will allow them to become socialised to the critical care therapeutic professional environment (Farnell & Dawson, 2006).

ICU learners are working around real life situations, and thus need to be encouraged to integrate knowledge from different subject areas to comprehend the whole. This concurs with the view of Lane et al., (2005) that professional growth occurs through a combination of educational strategies that build theories (systems, family and crisis) and knowledge development. Huggins (2004) claimed that learning also occurs from observing others in action, debating that this cannot be taught in the classroom, but that a certain amount of knowledge needs to be learned so that the skill can be performed competently. This author further iterates that formal education and training provide a small portion of what is learned in the clinical area. In the current study, there were lessons which helped ICU nurses to provide psychosocial support to families such as communication, ethical dilemma and ethics grouped under a subject called Nursing Dynamics.

However, during participative observations, (see appendix 3.2), the lecturers from one educational institution were in the ICU during visiting time, but concentrated on evaluating ICU learner competencies related to tasks and procedures. Lecturers left the patients' bedsides with the learners when visitors arrived, taking the learners out of this interactive situation with the family. This was confirmed by this excerpt: "*.they (lecturers) do accompany us (ICU learners) to the ICU but not during visiting hours…*".

During the interviews, a participant reflected upon the training and education received, and claimed that more could have been done to focus on the care of the family as noted in this quote: "*.....you* (lecturers, the researcher being a lecturer) *can do more...*" In this study, the participants further indicated that lecturers did not focus on the psychosocial support of the family in the ICU care as indicated in these excerpts:

"…not on family care, but it is based on what we are doing here in the ICU as an intensive care unit, on the monitors that we are using, and the ventilation, and the various types of diagnosis and conditions of the patients…"; "We didn't have any formal training in caring for patients' families….lot of support in providing psychological support to the patients….".

In the quantitative data there was a weak correlation for practice and formal education in this study. However, the Mann-Whitney U test indicated a significant difference between those who agreed that their formal education was adequate, and those who disagreed. The greater value was attributed to those who agreed.

However, Hardcastle (2008) concluded that educators, clinicians and learners are urged to reflect on what is the right education, and to question whether existing educational programmes actually relate to the clinical practice experience, and the individual and collective learning needs of the nurses involved.

5.2.5.2 Informal education

Candela & Bowles (2008) claimed that, on completion of a formal education programme, employers should not expect an end product, however, ironically, managers are always telling nursing programs that their graduates are not nearly enough of a finished product. Similar findings emerged in the current study, as one respondent (a manager) perceived a person coming out of ICU training as a finite product, with no need for continued supervision and support. The formally trained ICU nurses work with very little, or no supervision, as noted during participant observations, and they voiced their lack of confidence as a final product, indicating that they needed to be supported educationally to provide psychosocial support to the families of ICU patients. In this study, most participants reported that there was a lack of support from the managers.

Participants claimed that the responsibility of continuing education is left to the individuals. The products of formal ICU training had gaps identified in their competency skills to provide psychosocial support to the families of critically ill patients.

In the qualitative data, participants reported that family support as a topic was a neglected area in the unit's structured in-service plan. The formally trained ICU nurses reported that they too had failed to plot themselves as presenters of family support on the unit in-service plan. During participant observation (see appendix 3.2) there appeared to be no in-service training at hospital level or at unit level that covered topics on communication, interpersonal skills or family support care. During the document review (see appendix 3.1), of the yearly in-service plan of the ICU, it became evident that these topics had been excluded.

A study by Mckiernan & McCarthy (2010) indicated that clinical knowledge and experience influenced the quality of information given, and that staff giving the information should make sure that the information given is understood. The information given must be understood, for example, a patient is not unconscious, but sedated. Mckiernan & McCarthy (2010) found furthermore that family members made the link between having information on the loved one's condition and the family member's situation. Understanding the prognosis and outcome helped family members to cope with their experience, because receiving this information that the family required was also regarded as a source of reassurance.

Mian et al., (2007) states that one educational program alone does not change practice. Ongoing strategies for practice are essential for reinforcement. This is evident in this study, as participants claimed that they were ignorant of policies because these policies had not been read to them and they were too busy. However, reading policies is part of self-development, enabling professionals to cope in their working environment.

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Ääri, Taira, and Helena (2008) indicated that self-development is also part of professional competence, and refers to the ability of ICU nurses to develop themselves, to empower themselves at work, and to develop evidence-based nursing. In the current study a participant indicated that through participating in this study, an awareness was developed with regard to the psychosocial support of family members in the ICU as noted in this quote: : *"...it (the study) actually opened my eyes and I can see that families are actually left out in giving care to the patients"*.

Hardcastle (2008) claimed that a synergistic relationship exists between education and practice experience which begs exploration. The same occurred in this study, however, the Spearman's rank correlation coefficient indicated a weak relationship between practice and coverage of informal education at unit (Spearman's rho 0.5238 & Prob>[t] 0.001) and hospital level (Spearman's rho 0.3836 & Prob>[t] 0.0255). A slightly stronger relationship between the variable practice and informal education at individual level (Spearman's rho 0.6369 & Prob>[t] 0.0001) was displayed. In conclusion, the continual educational support, whether formal or informal is inadequate, as reflected in this quote: *"...yes the truth is it (family psychosocial care) is being neglected, instead more on procedures...*

5.2.6 Therapeutic Critical Care Environment

As depicted in the conceptual framework, the ICU environment could be dehumanising due to the high technology that is used. The complexity of care required by patients in this environment often blinds the ICU nurses to the patient and his/her family's perspective, while the ICU presents as a scary, intimidating and stress-provoking environment. As discussed above, the ICU nurses need to be educationally supported to deliver a balanced, holistic approach that incorporates the family as a unit facing critical illness.

The family requires to be accompanied through the phases with appropriate interventions to meet the needs of patient and family. The current study found that a gap exists in the educational preparation of the ICU nurses to provide psychosocial support to the families of critically ill patients.

In the last decade, technology has advanced so much that it has impacted on the ICU environment which includes advanced monitoring capabilities at the bedside, the method of communication required, and to open the ICU to families, rather than visitors. These factors require change to a healing environment with all significant role players working together to support the family as a unit facing crisis, thereby achieving equilibrium within the family. Shirey (2008) explains the Professional Practice Model (PPM) which describes how a professional practice therapeutic environment is created. This framework guides and aligns clinical practice, education and administration. The PPM has five subsystems: professional values, professional relationships, a care delivery model (family-centred care) management or governance, and professional recognition and rewards. (In this study it may mean: The non-trained ICU nurses are eventually rewarded to undertake formal training.

5.3 CONCLUSIONS

The qualitative and quantitative data analysis revealed that the families of critically ill patients are not integrated into the ICU as a unit facing critical illness. Instead, they are viewed as visitors who come into the ICU at stipulated times, who cannot contribute or participate in their loved ones' care. This deprives families of the proximity that many authors advocate (Mckiernan & McCarthy, 2010; Williams, 2005; Bergbom and Askwall, 2000 and as described by Plakas, et al., 2008). This creates an imbalance in the delivery of care by the ICU nurses. Jamerson et al., (1996) has described the four phases in a critical illness trajectory that the family experiences from 'hovering' to 'garnering resources'

The literature has indicated that the ICU nurses are best placed to accompany the families through these phases (Jamerson, et al., 1996) to enable these families to cope.

In this study, the continued educational preparation is inadequate for ICU nurses to provide psychosocial support to the families of critically ill patients. This inadequacy includes the lack of clinical accompaniment to provide psychosocial support to families of ICU patients, for example, a lack of direction in terms of the philosophy of the units, their visions and missions including policies that guide family psychosocial support.

ICU nurses were left on their own for professional development on family support, while a lack of related topics (communication, interpersonal skills and family support) was experienced in the educational development unit plan, at all levels. This lack of educational support is reflected in the practice of ICU nurses in providing psychosocial support to the families of ICU patients, thus failing to create a therapeutic environment.

There is a need for strategies to assist ICU nurses to cope with family needs during their journey through Jamerson, et al.'s (1996) phases. These strategies could be curricular innovations which include family support, communication, ethics, and professional practice, as an inclusion of such topics in in-service education plans of units; role-modeling by senior, experienced staff, including the use of checklists to ensure that such issues as family support are not excluded in the holistic care of ICU patients. These will be discussed in detail under recommendations.

5.4 RECOMMENDATIONS

The findings in this study showed that the ICU nurses' have a need for continuing educational support in order to be able to provide psychosocial support to the families of critically ill patients. The following recommendations are made to nursing practice, nursing education, nursing management and nursing research.

5.4.1 Recommendations for Nursing Practice

-The admission of a loved one to the ICU exposes the family members to a sudden emergent situation without warning that contributes to the psychosocial stress for the family as a whole. This creates a need for family needs assessment on admission, during the interim stay, and on discharge, to ensure that a systematic plan of practice is implemented by all ICU nurses.

This was also supported by Mckiernan & McCarthy (2010); Hughes, Bryan and Robbins (2005) and Jamerson et al., (1996) who showed that nurses' recognition of the families' experience may facilitate nurses creating a therapeutic environment to include the families, thus creating healthy relationships. The researcher, in an attempt to answer the last objective of this study, has developed a tool (practice checklist) that could be used for this purpose. This has also been recommended by Mckiernan & McCarthy (2010) as the development of documentation will allow for uniformity in the assessment process for all nursing staff. Exactly what the family needs, where and how these needs are met is never documented, as supported by Rushton, and Williams (2002).

-It is within the ICU environment of extreme urgency and uncertainty that treatment decisions are required to be made by family members. Thus health professionals need the family to be actively involved in the decision-making process related to treatment. ICU nurses need to allow the family to be more supportive of their loved ones, as this would lessen the disruption for the family as a system, and less anxiety would be communicated to the patient by family members. This concept is supported by Michaelene et al., (2003); Van Horn et al., (2002); Appleyard (2000); Neabel et al., (2000); Jamerson et al., (1996); O'Malley et al., (1991) and Wooley (1990). Nurses should avoid labelling family members as visitors; encouraging them to get closer to the patient instead of looking on from a distance.

-Although ICU nurses accepted giving information as part of their responsibility they did not exercise this, instead they relied on doctors to meet this need. In this study, nurses were not present when doctors provided information to family members. ICU nurses need to be present when the patient is given information by the doctors, so that they can reinforce that information and assess the family's understanding of it. Family members need information on their loved ones' condition, progress, treatment, procedures and equipment to help and support them to make appropriate decisions.

This could be provided in the form of information booklet/brochures, allowing family members to be present at the bedside rounds, support groups and family meetings. To save health professionals' time and to prevent conflict within the family unit, families should be encouraged to identify a family spokesperson who would be responsible for receiving and relaying information within the family.

In the study by Ball and McElligot (2003) who concluded that critical care needs resources, especially nurses, to deliver a quality service as required by the public. The families of the critically ill patients valued the attributes of patient-centredness and vigilance, and at the same time appreciated the emotional support offered by the nurses. In addition, the current study revealed that the ICU nurses were faced with major challenges, that is, to balance care between the patients and their families, at the same time preventing burn-out. Therefore, nurses need to be supported through continuing education (formally and informally) to be able to implement the above recommendations.

5.4.2 Recommendations for Nursing Education and Management

The description of the experiences of ICU nurses in implementing psychosocial support of families of ICU patients and their lack of continual educational support to optimize this support has been highlighted. Managers and lecturers have acknowledged this as participants in the qualitative component of this study.

-It is suggested that a flexible visitation policy be formulated which allows the family to visit their loved ones according to their convenience, for example, amongst other issues, according to transport availability. Children's visitation should be allowed, taking into account the immunisation records, etc. ICU nurses could be supported to formulate their visitation policies as part of their professional development.

This has been supported by Vandijck, Labeau, Geerinckx, Puydt, Bolders, Claes and Blot (2009) who reported that approximately three-quarters of the ICUs that participated in their study adapted their visiting hours to individual cases, and that the children's visits were permitted in the majority (91.2%) of Belgian ICUs. This is also recommended by Mckiernan & McCarthy (2010) who indicated that the development of flexible visiting policies will take into account the needs of all concerned parties.

-The health care industry is evolving, thus posing challenges to the ICU nurses and at times they may become overwhelmed. Nurse Managers need to take cognisance of this fact and formulate policies/guidelines to support the ICU nurses in their practice of psychosocial support to the families of critically ill patients. In this study, ICU nurses do have autonomy when interacting with families, but they were inconsistent in the way they delivered care to the families of critically ill patients, as this was dependent on emotional maturity, knowledge acquisition, staff availability and protocols that were obstructive. Policies/guidelines or checklists are required for educational support to the ICU nurses to ensure uniformity when delivering family psychosocial support.

-In this study nurses voiced the opinion that the ICU environment is very stressful due to the complexity of care which patients require, and because the family members have a need for proximity to the patient which should be met. Managers need to unfreeze posts and employ more nurses, or create new posts, for example, those of family consultants, to interact with family members as required. When more nurses are deployed to these areas, then ICU nurses who have been formally trained could assume mentorships, as increasing education at the bedside will provide experience so that nurses can develop competence and confidence.

Fumis (2008); Candela & Bowles (2008); Mian et al. (2007); Farnell & Dawson (2006) & Williams (2005) also emphasise that continuing educational support will equip ICU nurses with the knowledge and skills to provide family-patient-nurse-centred delivery of care, and to demonstrate appropriate behaviours to provide psychosocial support to the families of critically ill patients.

- The current study showed that the continuing nursing educating programme lacks certain aspects, namely, creating a mindset which views the family as a unit facing illness; including the family as part of the multidisciplinary team; attending to families as soon as they arrive in the ICU; promoting family proximity and participation; communicating with families; accompaniment of families through the ICU experience; and managing death and dying issues. Nursing education programs need to be designed by educators with input from clinical managers. All players need to work together to provide a service that values caring. Lecturers should ensure that curricula are developed which demonstrate valuing of professional caring, rather than the "care of" approach to nursing as supported by Beeby (2000). Knowledge acquisition gives the power to cope and thrive in the workplace. Critical care nursing educators need to be developed so that they are able to facilitate the learning of nurses to acquire the specific knowledge and skills which will equip them in this dynamic environment.

Agard (2007) and Halligan (2006) also recommend that ICU nurses develop educational programs that acknowledge the complexity of providing psychosocial support to the families of patients in the ICU. Thus preventing ICU learners from becoming embedded in practice, acquiring beliefs and practices promoted by other health professionals, e.g. the medical model of care which focuses on solving identified problems through various specialists. Families are not part of the problem, and are excluded, but are given information on a need-to-know basis. In addition, the critical care nurses' daily practice of reporting and documenting data by organ systems individually, imparts no meaning to the data in the context of the patients' and families' goals. This view misses the holistic concept of patients and their families who have desires and feelings (Rushton, Williams & Sabatienr, 2002).

-Nurse managers need to take note that family care demands expertise and theoretical knowledge, but that basic nursing training programmes do not support the educational needs of nurses to care for families and to be developed professionally, thus anxiety levels rise when they are placed in the ICU (Hardcastle, 2008; Farnell & Dawson, 2006; Medina, 2005 and Little, 2000). Managers should not expect an end product when ICU nurses return to the ICU on completion of a formal educational programme, and should avoid telling educators that their graduates are not nearly enough of a finished product, as supported by Candela & Bowles (2008).

Managers need to find ways of working together to promote opportunities for caring attitudes through continuing educators' programmes, encouraging nurses to present papers on psychosocial support of the family and the contemporary delivery of care. Professional growth occurs through a combination of educational strategies which build theories (systems, family and crisis) and knowledge development should enhance the application of critical thinking skills in the clinical setting (Lane et al., 2005).

5.4.3 Recommendations for Nursing Research

-Within this study the ICU nurses from these two educational institutions voiced their opinion of the lack of educational support received by the ICU nurses' to provide psychosocial support to the families of critically ill patients. Replication of the study in other educational institutions and provinces will provide evidence which will determine the need for additions or changes to the ICU curricula, to inform regulations made by SANC.

- The ICUs need to be developed into therapeutic caring environments, to deliver humanising care within a highly technological environment. Providing support to ICU nurses is the key to achieving practice skills, thus demonstrating appropriate behaviours in providing psychosocial support to the families of critically ill patients. This would be the form of care delivery which would create a therapeutic professional practice environment that maintains equilibrium in the ICU and within the family unit, as depicted in the conceptual framework of this study (Shirey, 2008; Jamerson et al., 1996). Blanchard and Christine (2008) state that the ICU nurses' needs to reflect on how multidimensional the family is, how the family expresses interconnectedness to their loved ones, and to integrate this aspect into the care of the patient. The study revealed that families were not just visitors, or to be regarded as separate from the patient, but should be included in patient care. Supporting the family to achieve participation in care requires the nurses to develop an understanding of the family (Blanchard and Christine, 2008).

Thus, a therapeutic environment is created where the patients and their families find security and maintain homeostasis in a situation, as depicted in the conceptual framework of this study (Jamerson et al., 1996). The Professional Practice Therapeutic Model (PPTM) needs to be developed within the South African situation, encompassing family care as the contemporary delivery of care in ICUs. Although family-centred care sounds beneficial in theory, little evidence is available of ways to operationalise this model of care.

-A needs assessment is not synonymous with satisfaction, because unmet needs do not always translate into dissatisfaction, while meeting those needs does not guarantee satisfaction.

Further research needs to be conducted within the South African situation to determine family members' satisfaction/dissatisfaction in relation to needs met/unmet as supported by Heyland et al., (2002).

In the current study one of the research setting is a referral facility indicating that the family member are not nearby, thus no account is taken of family members who do not come or cannot come to the ICU for whatever reason. A gap is thus identified.

A practice checklist has been developed using the nominal group technique and literature (Nelson & Plost, 2009; Mian et al., 2007; Henneman, 2002) to ensure that holistic nurse-patient-family-centred care is provided, which could also assist in continued educational support to the ICU nurses to help document the assessment needs of families on arrival in the ICU and during subsequent interactions. Mckiernan & McCarthy (2010) also recommend the development of documentation which allows uniformity in the assessment process of the family. Research could be conducted to test this checklist to ensure evidence-based practice, and to determine the applicability of the checklist in the context that it is meant for.

5.5 LIMITATIONS OF THE STUDY

This study was conducted using the English language which poses a limitation. The researcher was English-speaking and conversations between nurses and family members were frequently in Zulu. This led to some information being missed.

The researcher's limited research experience poses a limitation to the study, as this is the first research project that she has conducted independently.

In the study, the questionnaire for the survey was developed using the guidelines from the Institute of Family Care in the USA. The questionnaire was labeled as a 'competency skill checklist' and may have contributed to the ICU nurses completing this questionnaire in the manner in which they would prefer to be viewed, for example, as competent ICU nurses.

The purposive sampling selected predominately female participants with only one male, thus this was not totally representative of the population of nurses, although at the time of study, only one male nurse was allocated to the ICU.

Due to non-continuous participation observations, the event which one was waiting for might not occur in the two week participation period utilised by the researcher, for example, no workshop on family care might be held, etc.

The mixed method model requires more effort and expertise to adequately study a phenomenon with two separate methods, in a single study. The researcher may have experienced difficulty in comparing the results of two analyses using data of different forms.

In addition, the researcher may be unclear as to how to resolve discrepancies which may arise in comparing the results, although procedures are emerging in the literature, such as conducting additional data collection to resolve discrepancy, revisiting the original data base, gaining new insights from the disparity of the data, or developing a new project that addresses the discrepancy (Creswell & Clark, 2007, as cited in Creswell, 2009). In the current study the research used various methods of data collection to overcome discrepancies.

5.6 CONCLUSION

The study investigated the continual educational support of ICU nurses in two educational institutions, to provide psychosocial support to the families of critically ill patients in ICUs in KZN. The quantitative and qualitative approaches were triangulated to provide a more holistic understanding and it was found that the educational support of ICU nurses to provide psychosocial support to the families of critically ill patients was questionable. There were aspects which ICU nurses raised as concerns, and which indicated that they learned something through participation in the study. Recommendations have been made in an attempt to improve nursing practice, nursing education, management and research. A practice checklist was developed as an intervention to help ICU nurses in their practice of providing psychosocial support to the families of ICU patients, so that documented evidence could be made available. It is hoped that efforts may be made to address the issues highlighted to provide continual educational support for the ICU nurses so that they, in turn may provide psychosocial support to the families of ICU patients.

6: DEFINITION, PURPOSE AND BENEFITS OF CHECKLIST, PROCESS OF DEVELOPMENT, OPINION-SEEKING (NOMINAL-GROUP TECHNIQUE) THE PRACTICE CHECKLIST

6.1 INTRODUCTION

Based on the findings of the study, the researcher reflected on the most feasible way of ensuring support to the ICU nurses to empower them to be able to give psychosocial support to the families of patients in the ICU. A possibility would be curriculum change. The participants, among others, would not benefit from this curricular change as they had already passed their ICU post-registration course, and thus this lack in the curriculum would be irreversible for them. Curriculum change could assist current and future ICU learners undertaking the post-registration qualification in Critical Care Nursing under R212 of the South African Council (1997). A checklist was opted for because a large quantity of knowledge could be condensed, reducing the areas of omission and so improving the standard of care in the ICU. The researcher hopes that the checklist will eventually become part of the care bundle supporting the ICU nurses to enable them to provide psychosocial support to the families of patients in the ICU. In addition, the checklist may also be used by the multidisciplinary team throughout the trajectory of professional development, including supporting assessors and clinical facilitators involved in teaching the post-registration qualification.

6.2 DEFINITION AND THE USE OF THE CHECKLIST

A checklist is defined as an organised tool which outlines the criteria of consideration for a particular process. As a cognitive aid, the checklist will be used to guide the ICU nurse to provide psychosocial support to the families of critically ill patients. The checklist as a guide will be used by ICU nurses to recall information which is of use in providing psychosocial support to the families of ICU patients (Hales, Terblanche, Fowler and Sibbald, 2008).

6.3 THE PURPOSE OF THE CHECKLIST

Hales, et al. (2008) maintain that when formulating checklists using evidence-based criteria and expert judgment, healthcare providers might be more comfortable in the knowledge that they are providing a proven best standard of patient care. This will assist the user not to forget important criteria, and can enhance the objectivity of the assessment, while at the same time achieving standardisation of the process.

The current study concluded that ICU nurses require continuous educational support to provide psychosocial support to the families of patients in the ICU. The checklist will, in itself, become a teaching and learning tool for all staff of the multidisciplinary team, and can achieve documented evidence of family accompaniment in the trajectory of their loved one's illness. In this study, the checklist identifies aspects of intervention implemented to meet the psychosocial support of the family members of critically ill patients. It is a cognitive aid that supports the ICU nurses in recalling aspects of psychosocial support which the family requires during their turmoil, and ICU nurses then document their interventions.

6.4 THE BENEFITS OF A CHECKLIST

Wolff, Taylor and McCabe (2004) concluded that the use of checklists and memory-aids in clinical pathways has been shown to improve the quality of medical care, and has shown significant improvements in compliance with key best practices and when used as a support resource and an error management tool. For example, there are checklists for initiating mechanical ventilation, for inducing anaesthesia, and in patients admitted for acute myocardial infarction or stroke, etc. The literature reveals that checklists are important tools in ensuring: the standard of quality care, the prediction of successful weaning-off from mechanical ventilation, adherence to evidence-based practice, and improvement of patient safety in the clinical areas.

However, there are concerns that checklists may contribute to adverse events such as imposing burdens on health care professionals, delays in treatment due to lengthy checklists or errors of omission, and overburdening the health care professionals. There is no published data to support these concerns, instead, the checklist condenses large quantities of knowledge, decreases the frequencies of errors of omission, creates reliable and reproducible evaluation, and improves the quality standards and best practices (Wolf et al., 2004).

6.5 PROCESS OF DEVELOPMENT

The literature suggests that a checklist be formulated using evidence-based criteria (Hales et al., 2007). This author further advocates that the checklists be run past expert judgment and opinion. Once the checklist has been proven to be useful in improving patient and process outcomes, it may be standardised as a procedure, and used across the organisation (Hales et al., 2007).

Winters, Gurses, Lehmann, Sexton, Rampersadh and Pronovost (2009) suggest several principles to follow to develop a checklist namely:

- Design checklists based on the health professionals' needs and the realities of their work by doing ethnographic studies of the clinical work and the involvement of the potential users.

- List the most critical items at the beginning of the checklist whenever possible.

- Subdivide the long checklist into small meaningful sections, and create one checklist for the moment and time.

- Pay close attention to usability, including the time it takes to complete the checklist, considering potential negative effects on health professionals' work and patient safety and feedback from potential users.

- Perform rigorous pilot-testing and validation of the checklist before full-scale implementation.

- Include potential users, content experts and human factor usability experts on the design team.

- Re-evaluate and update checklists periodically, based on new literature and organisational experience.

Campbell, Braspenning, Hutchinson and Marshall (2003) recommend expert opinion in the form of consensus development conferences, nominal group technique, the RAND appropriation method, the Delphi method and the iterated consensus rating procedure. The researcher opted for the nominal group technique.

6.5.1 Opinion Seeking

The Nominal-Group Technique (NGT) is so called because NGT alternates between 'nominal' and 'interacting' modes. The 'nominal' mode allows individual perspectives on the problem to be shared. The NGT provided a more structured way of collecting and organising the thoughts of ICU nurses on the practice of providing psychosocial support to the families of ICU patients. This involved the creation of original ideas. Participants were encouraged to share opinions, exchange facts and challenge their views, in contrast to other methods, where two to three individuals monopolise the opinion-giving. According to Tuffrey-Wijne, Benal, Butler, Hollins and Curfs (2007) this allows all group members to contribute equally, producing a large pool of items and is thus easy to implement. The nominal group technique can be valuable for facilitating a group to prioritise their ideas, concerns or input to arrive at a final decision through consensus building.

There were nine participants in the nominal group, and the group was divided into three, with each group consisting of three members. Consent was obtained from the members.

They were then presented with the literature (Nelson & Plost , 2009; Mian, et al., 2007 and Henneman & Cardin, 2002) for perusal to obtain a sense of the subject matter which consists of providing psychosocial support to the families of critically ill patients. They were then asked to extract evidence from experience to decide on the contents of the checklist.

The teams were requested to identify evidence in their practice guidelines. They were also asked to seek the opinion of those who would eventually use the checklist, thus obtaining input from a broader source. Once the list of potential interventions had been compiled, the team considered those with the strongest impact and lowest barriers to use in clinical practice. The culling process was initiated so that each intervention was translated into an explicit and concise and unambiguous behaviour, to make the checklist logical and functional (Winters, et al., 2009). See Figure 6.1 for final checklist.

Authors such as Winters et al. (2009) and Hales et al. (2007) suggest that, on completion, the developed checklist be tested. However, this study is for academic purposes, and is limited by time and financial constraints which prevented the researcher from proceeding to test the checklist. Therefore the researcher recommends that further research be considered to test this checklist.

6.6 RECORDING PSYCHOSOCIAL SUPPORT

Jost, (1995), indicated that documentation of psychosocial support to families will enable the nurses' to determine whether a conversation with the patient's family was a therapeutic intervention through reviewing the outcome, intervention and initial assessment. Jost, (1995) further stated that charting psychosocial care is less clear than documenting physical care, the patient assessment and monitoring.

Thus the checklist hereunder provides a format to follow in recording the psychosocial support to families of ICU patients. This documentation also allows the members of the multidisciplinary team to understand that providing the psychosocial support to families' of ICU patients' are essential to holistic care to the family as a unit, thus creating a therapeutic environment (a standard of best practice).

6.7. THE PRACTICE CHECKLIST FOR ICU FAMILY PSYCHOSOCIAL SUPPORT ASSESSMENT

TABLE 6.1 An Intervention Checklist		
ICU FAMILY PSYCOSOCIAL SUPPORT ASSESSMENT CHECKLIST	**DATE**	
PRACTICE STATEMENT: *Family inclusion within the Multidisciplinary Team to create a Professional Practice Therapeutic Environment*		
INTERVENTIONS	**√**	*SIGN*
ON ADMISSION		
1. Introduce self and staff to the family. Determine the relationship of each family member present to patient.		
2. Establish whether family member(s) has/have had previous experience of a family member being admitted to an ICU.		
3. Orientate family to the ICU setting with regards to monitors, equipment and general routine.		
4. Provide family with information pamphlet.		
5. Write down the unit contact no. and inform that it is okay to call and enquire about the loved one's wellbeing.		
6. Detemine who is the designated family contact person – Obtain name _____and Phone No._____ .		
7.Explain to the family on observing posted safety and infection control measures such as use of D-germ , aprons and ensuring cot sides up when leaving loved one's bedside		
8. Instruct family on visitation, and advise that, at times, they may be asked to leave the ICU in certain circumstances e.g. handing over, emergencies or when procedures are performed. Make special visitation rules for children, if allowed.		
9 Inform family members of waiting-room and amenities.		
10 Orientate family members to signage.		
11. Ask family whether they have questions/concerns before walking away, and answer these to your best ability.		
12. Assist family at the bedside.		

DURING THE INTERIM FOLLOW UP VISITS		
1. Introduce yourself and find out the relationship of the member(s) to patient.		
2. Offer a brief update on their loved one's condition, accurate info, e.g. not unconscious, but sedated and reasons for sedation.		
3. Enquire about the family members' condition. (How are the family doing?)		
4. Assess desirability to participate in patient care activities. YES/NO		
5. Enable the family members to have positive interaction with loved ones such as holding the hand, talking to the patient even if patient appears unable to hear.		
6. Ask if member would like to speak to doctor or other team members and arrange for meeting accordingly.		
7. Meet family members as arranged to discuss progress and treatment plans.		
8. Refer families to the experts' available, e.g. counselling professionals. Include these details in information pamphlets.		
9. Allow for special visitation by spiritual leaders as desired by the family.		
10. Make courtesy call to family to provide information such as if the loved one is transferred out of the ICU, has gone to OT, or his/her condition has changed for the worse.		
ON TRANSFER / DISCHARGE		
1. Inform family of pending transfer/discharge.		
2. Give family transfer/discharge advice.		
3. Explain medication to family including follow-up visits.		
HANDED OVER TO: FROM:		

6.8 CONCLUSION

The study identified gaps in the educational preparation of the ICU nurses in providing psychosocial support to the families of critically ill patients. The researcher opted for a checklist that would benefit the entire multidisciplinary team, rather than overloading the critical care curriculum, which consists of one year of academic study. There are many benefits of a checklist, which fulfil various functions namely, serving to conduct error management, teaching, and as an orientation tool. To develop a checklist, the researcher opted to use expert opinion, such as the nominal interactive group technique. A checklist was finally formulated, to capture the moments with the families of ICU patients through documentation. (See Table 6.1).

7. REFERENCES

Ääri, R.L., Taria, S., and Helena, L.K. (2008). Competence in intensive and critical care nursing: A literature review. *Intensive and Critical Care Nursing,* Vol. 24 (2): 78 – 89.

Adamson, H., Murgo, M., Boyle, M., Kerr, S., Crawford, M. & Elliott, D. (2004). Memories of intensive care and experiences of survivors of a critical illness: An interview study. *Intensive Critical Care Nursing,* Vol. 20 (5): 257-263.

Agard, A.S., Harder, I. (2007). Relatives' experience in intensive care - Finding a place in a world of uncertainty. *Intensive and Critical Care Nursing,* Vol. 23: 170-177.

Alamddine, M., Dainty, K.N., Deber, R. and Sibbald, W.J.B.(2009): The intensive care unit work environment: Current challenges and recommendations for the future. *Journal of Critical Care,* Vol. 24(2): 243-248.

Appleyard, M. E., Cavaghan, S. R., Gonazalez, M., Ananian, C., Tyrell, R. & Carroll, D.L. (2000). Nurse-coached interventions for the families of patients in critical care units. *Critical Care Nurses*, Vol. 20: 40-48.

Azoulay, E., Pochard, F., Chevret, S., Lemaire, F., Mokhtari, M., Le Gall, J., Dhainaut, J. & Schlemmer, B. (2001). Meeting the needs of the intensive care unit patient's families. *American Journal of Respiratory and Critical Care Medicine,* Vol. 163: 135-139.

Azoulay, E., Pochard, F., Chevret, S., Lemaire, F., Mokhtari, M., Le Gall, J., Dhainaut, J. & Schlemmer, B. (2005). Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *American Journal of Respiratory and Critical Care Medicine,* Vol. 171: 987-994.

Baggs, J.G., Norton, S.A., Schmitt, H.M. and Sellers, R. C. (2004). The dying patient in the ICU: Role of the interdisciplinary team. *Critical Care Clinics,* 20: 525-540.

Blanchard, D. and Alavi, C. (2008). Asymmetry in the intensive care unit: redressing imbalance and meeting the needs of family. *British Association of Critical Care Nurses, Nursing in Critical Care,* Vol. 13(5): 225 -231.

Bailey J. J., Sabbagh, M., Loiselle, C. G., Boileau, J., & McVey, L. (2010). Supporting families in the ICU: A descriptive correlational study of informational support, anxiety, and satisfaction with care. *Intensive and Critical Care Nursing,* Vol. 26 (2): 114-122

Ball, C., and McElligot, M. (2003). Realising the potential of critical care nurses: An exploratory study of the factors that affect and comprise the nursing contribution to the recovery of critically ill patients. *Intensive and Critical Car Nursing,*Vol. 19 (4): 226-238.

Barclay, L. & Lie, D. (2007). New guidelines issued for family support in patient-centered ICU. *Critical Care Medicine,* Vol. 35: 605-622.

Beeby, J.P. (2000). Intensive Care Nurses' experiences of caring. *Intensive Critical Care Nursing,* Vol . 16: 151-163.

Bergbom, I. & Askwall, A. (2000).The nearest and dearest: A lifeline for ICU patients. *Intensive Critical Care Nursing,* Vol. 16 (6): 384 – 395.

Bersten, A.D. & Soni, N. (2003). *Oh's Intensive Care manual.* 5th ed. London: Elsevier Science.

Berwick, D. M. & Kotagal, M. (2004). Restricted visiting hours in ICUs': Time to change. *Journal of the American Medical Association,* Vol. 292(6): 736-737.

Brink, H. (2006). Fundamentals of research methodology for health care professionals. Capetown: Juta and Company LTD.

Bijttebier, P., Vanoost, S., Delva, D., Ferdinand P., Frans, E. (2001) Needs of relatives of critical care patients: perceptions of relatives, physicians and nurses. *Intensive Care Medicine,* 27(1): 160 -165.

Bucher, L. & Milander, S. (1999) *Critical Care Nursing*. Philadelphia: W.B. Saunders Company.

Burns, N. & Grove, S.K. (2001). *The practice of nursing research conduct, critique and utilization.* 4th ed. Philadephia: W.B. Saunders.

Burns, N. & Grove, S. K. (2005). *The practice of nursing research conduct, critique and utilization.* 5th ed. St. Louise: W.B. Saunders.

Burr, G. (1998). The family and critical care nursing: a brief review of the literature. *Australian Critical Care*, Vol. 10: 124 – 127.

Campbell, M., Braspenning, J., Hutchinson, A., and Marshall, M.N. (2003). Improving the quality of health care: Research indicators in primary care method used in developing and applying tools. *BMJ,* Vol. 326.

Candela, L., and Bowles, C. (2008). Recent graduate perceptions of educational preparation. *Nursing Education Perspective,* Vol 29 (5): 266 – 271.

Chaboyer, W., Dunn, V. S., Theobald, K., Aitken, and Perott, J. (2001). Critical care education: An examination of student perspective. *Nursing Education Today,* 21: 526-533.

Chien, W. T., Chiu, Y. L., Lai-Wah, L. & Wan-Yim, I.P. (2006). Effects of a needs-based education programme for family carers with a relative in an intensive care unit: A quasi-experimental study. *International Journal of Nursing Studies*, Vol.3 (1):39-50.

Chui, Y-Y.W. & Chan, W-C.S. (2007). Families and cares. Stress and coping of Hong Kong Chinese family members during a critical illness. *Journal of Clinical Nursing,* Vol. 16, 372 – 381.

Corey, G. (2009). *Theory and practice of counseling and psychotherapy.* 8th ed. USA: Thomson Brooks/ Cole.

Covington, L.W. (2001). Cultural competence for critical care nursing practice. *Critical Care Nursing Clinics of North America,* Vol 13: 521-530.

Creswell, J., Fetters, M. and Iyankova, N. (2004).Designing a mixed methods study in primary care. *Annals of Family Medicine,* Vol. 2 (1): 7 – 12.

Creswell, J.W. (2007). *Qualitative inquiry & research design choosing among five approaches.* 2nd ed. Thousand Oaks, California, USA: Sage Publications.

Creswell, J. W. (2009). *Research design qualitative, quantitative and mixed methods approaches.* 3rd ed. Thousand Oaks, California USA: Sage Pubications.

Drenkard, K.N. (2008). Integrating human caring science into a professional nursing practice model. *Critical Care, Nursing Clinics of North America,* Vol. 20 (4): 403 -414.

Eldredge, D. (2004). Helping at the bedside: Spouses' preferences for helping critically ill patients. *Research Nurs Health*, Vol. 27 (5): 307-321.

El-Masri, M.M., & Fox-Wasylyshyn, S.M. (2007). Nurses' roles with families: Perceptions of ICU nurses. *Intensive and Critical Care Nursing,* Vol 23(1): 43-50.

Engström, A., & Söderberg, S. (2004). The experience of partners of critically ill persons in an intensive care unit. *Intensive and Critical Care Nursing* 20, 299-308.

Farrell, M., Joseph, D., & Schwartz-Barcott, D. (2005). Visiting hours in the ICU: finding the balance among patient, visitor and staff needs. *Nursing Forum,* Vol 40 (1): 18-28.

Farnell, S. & Dawson, D. (2006). 'It's not like the ward'. Experiences of nurses new to critical care: A qualitative study. *International Journal of Nursing Studies,* Vol. 43,(3): 319-331.

Flowers, D.L. (2004). Culturally competent nursing care. A challenge for the 21st century. *Critical Care Nurse*, Vol.24(4): 48 -52.

Fox-Wasylyshyn, S.M; Maher, M. and Susan, M. (2006). Nurses' roles with families perceptions of ICU nurses. *Intensive and Critical Care Nursing,* 23: 43-50.

Fumis, R.R.L., Nishimoto, I.N. & Deheinelin, D.D. (2008). Families' interactions with physicians in the intensive care unit: The impact on family's satisfaction. *Journal of Critical Care,* 23, 281-286.

Fouchë, N. A. (2006). Editorial: What a critical care nursing curriculum does not teach us. *SAJCC,* Vol.22 (2):45.

Gilmer. M. J. (2002). Pediatric palliative care: a family-centered model for critical care. *Critical Care Nurse Clinics of North America.* Vol. 14(2): 207-214.

Gonazalez, C. E., Carroll, D. L., Elliott, J. S., Fitzgerald P. A., Vallent, H. J. (2004). Visiting preference of patients in the intensive care medical unit and in a complex care medical unit. *American Journal Crit Care,*Vol. 13 (3): 194 – 147.

Gough, J., Johnson, L., Waldron, S., Tyler, P. and Donath, S. (2009). Clinical communication: Innovative education for graduate nurses in paediatrics. *Nursing Education in Practice.*,Vol. 9 (3): 209-214.

Guilianelli, S., Kelly, R., Skelskey, J., Gonzalez, V., Sharp, T., Turley, T. & James, A. (2005). Critical care nurse manager's perspective: The critical care family assistance program. *Chest*, Vol. 128: 118-123.

Hales, B., Terblanche, M., Flower, R., and Sibbald, W. (2008). Development of medical checklists for improved quality of patient care. International Journal for Quality in Health Care. Vol. 20 (1): 22-30.

Halligan, P. (2006). Caring for patients of Islamic denomination: critical care nurses' experiences in Saudi Arabia. *Journal of Clinical Nursing,* 15, 1565 – 1573.

Hardcastle, J.E. (2008). Back to bedside: Graduate level education in critical care. *Nurse Education in Practice,* Vol, 8(1): 46-53, [online] Available at http:// www.sciencedirect.com/science [Accessed 9 April 2009].

Hatrick, G., Lindsey, A.E. and Hills, M. (1994). Family nursing assessment: Meeting the challenge of health promotion. *Journal of Advanced Nursing,* 20: 85-91.

Hewitt, J. (2002). Psycho-affective disorder in intensive care units: a review. *Journal of Clinical Nursing*, Vol. 11: 575- 584.

Henneman, E. A. & Cardin, S. (2002). Family-centered critical care: A practical approach to making it happen. *Critical Care Nurses*, Vol.22 (6):12-19.

Henning, E.,Van Rensburg, W. and Smit, B. (2004). *Finding your way in qualitative research.* Pretoria. Van Schaik Publishers.

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Heyland, D.K., Rocker, G.M., Dodek, P.M., Kutsogiannis, D.J., Konopad, E., Cook, J.D., Peters, S., Tranmer, J.E., and O'Callaghan, C.J. (2002). Family satisfaction with care in the intensive care unit: Results of a multiple center study. *Critical Care Medicine,* Vol.30 (7) 1413-1418.

Holden J., Harris, L. and Johnson, M. (2002) Families, nurses and intensive care patients: A review of literature. *Journal of Clinical Nursing*, Vol. 11(2): 140-148.

Holmboe, E. S., Rodak, W., Mills, G., McFarlane, M.J., Schultz, J. H. (2006). Outcomes-based evaluation in resident education: Creating systems and structured portfolios. *The American Journal of Medicine*,Vol. 119(8): 708-714.

Houser, J., (2008). Nursing Research. Reading, using and Creating Evidence. USA. Jones and Bartlett Publishers.

Hoye, S., and Severinsson, E. (2008). Intensive care nurses' encounters with multicultural families in Norway: An exploratory study. *Intensive and Critical Care Nursing,* Vol. 24 (6). 338-348.

Hoye, S. and Severinsson, E. (2010). Multicultural family members' experiences with nurses and the intensive care context: A hermeneutic study. *Intensive and Critical Care Nursing,* Vol. 26 (1): 24 -32.

Hughes, F., Bryan, K. & Robbins, I. (2005). Relatives' experiences of critical care. *Nursing in Critical Care*, 10: 23-30.

Huggins, K.,(2004). Lifelong learning - the key to competence in the intensive care unit? *Intensive and Critical Care Nursing,* Vol. 20 (1) :38-44.

Hupcey, H. J. (1999). Looking out for the patient and ourselves - the process of family integration into the ICU. *Journal of Clinical Nursing,* Vol. 8: 253-262.

Hymovich, C. (1979). Incorporating the family into care. *Journal of New York Nursing Association,* 5.5-9.

Hynes, P., Conlon, P., O'Neill, J., Lapinsky, S. (2008). Partners in critical care. *Spring, Canadian Association of Critical Care Nurses,* Vol. 9 (1).

Institute for Family Centered Care. (2008). *Institute for Family Centered Care*.[online] Available at:http:/www.familycenteredcare.org/faq.html]. Published 2005, updated June 25, 2008. [Accessed 2009].

Jamerson, P.A., Scheibmeir, M., Bott, M., Crighton, F., Hinton R.H., Cobb, A.K. (1996). The experience of families with a relative in the intensive care unit. *Heart and Lung,* Vol.25 (6) 467-474.

Johansson, I., Fridlund, B. & Hildingh, C. (2005). What is supportive when an adult next-of-kin is in critical care? *Nursing in Critical Care,* Vol. 5(6): 289-297.

Jost, K. E. (1995). Psychosocial Care: Document It. *American Journal of Nursing.* Pg: 46 – 48.

King Lee, L.Y. & Ling Lau, Y. (2003). Immediate needs of adult family members of adult intensive care patients in Hong Kong. *Journal of Clinical Medicine,* Vol. 12(4): 490-500.

Kirchhoff, K., Pugh E., Calame, R. & Reynolds, N. (1993). Nurses' beliefs and attitudes towards visiting in adult critical care settings. *American Journal of Critical Care,* 2(3): 238-245.

Knutsson, M. E. S., Otterberg, C. L., Bergbom, I.L. (2004). Visits of children to patients being cared for in adult ICUs: Policies, guidelines and recommendations. *Intensive and Critical Care Nursing,* 20 (5): 264-274.

Kutash, M., & Northrop, L. (2007). Family members' experiences of intensive care unit waiting room. *Journal of Advanced Nursing,* 60(4): 384 – 388.

Lane P., O'Brien, U. & Gooney, M.A. (2005). The progression of holism into postgraduate curricula in critical care nursing. *Dimensions of Critical Care Nursing,* Vol. 24 (3) 131-138.

Lave, J., Wenger, E., In: Huggins, K.,(2004). Lifelong learning - the key to competence in the intensive care unit? *Intensive and Critical Care Nursing,* Vol. 20 (1) :38-44.

Leske, J. S. (2002). Intervention to decrease family anxiety. *Critical Care Nurse,* Vol. 22(6); 61-65.

Little, C.V. (2000). Technological competence as a fundamental structure of learning in critical care nursing: a phenomenological study. *Journal of Clinical Nursing*, 9 (3) 391-400.

McAdam, J.L., Shoshana, A., & Puntillo, K.A. (2008). Unrecognised contributions of families in the intensive care unit. *Intensive Care Medicine,* Vol. 34: 1097-1101.

McAdam, J.L., Puntillo, K. (2009). Symptoms experienced by family members of patients in Intensive Care Units. *American Journal of Critical Care,* Vol. 18(3). .

Maxwell, K.E., Stuenkel, D. and Saylor, C. (2007) Needs of family members of critically ill patients. Comparison of nurse and family perceptions. *Heart and Lung,* Vol. 36(5): 367-376.

McKiernan, M. & McCarthy, G. (2010). Family members' lived experience in the intensive care unit: A phemenological study. *Intensive and Critical Care Nursing*, Vol. 26 (5): 254-261.

Medina, J. (2005). A natural synergy in creating a patient focused care environment: The critical care family assistance program and critical care nursing. *Chest Journal*, Vol. 128:99-102.

Mendonca, D. and Warren, N.A. (1998). Perceived and unmet needs of critical care family members. *Critical Care Nursing Quarterly*, Vol. 21: 58-67.

Mian, P., Warchal, S., Whitney S., Fitsmaurice, J. & Tancrdei, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' attitudes and behaviours towards family presence during resuscitation. *Critical Care Nurse*, Vol 27 (1): 52-61

Michaelene, P., Mirr-Jansen, B.C. Nola A. Schmitt, I., (2003) Family focused interventions. Critical Care Nurse Clinics North America. Vol 15: 347 – 354.

Michel, M. (2009). Positive effects of a nursing intervention on family-centered care in adult critical care. *Americal Journal of Critical Care,* Vol. 18: 543-552.

Miracle, V.A. (2006). Strategies to meet the needs of families of critically ill patients. *Dimensions Critical Care Nursing,* 25(3):121-125.

Mirr-Jansen, M.P. & Schmitt, N.A. (2003). Family-focused interventions. *Critical Care Nursing Clinics of North America,*15: 347-354.

Mitchell, M.L. (2008). Attitudes and beliefs about family presence in critical care. *Australian Critical Care,* Vol 21: 48-50.

Mitchell, M. L. & Chaboyer, W. (2010). Family centred care - A way to connect patients, families and nurses in critical care: A qualitative study using telephone interviews. *Intensive and Critical Care Nursing,* Vol. 26 (3): 154-160.

Molter, N.C. (2003). Creating a healing environment for critical care. *Critical Care Nursing North America,* 15: 295-304.

Molter, N. & Leske, J. S. (1883). Critical Care Family Needs Inventory. Copyrighted form available from authors.

Molter, N. (1979).Needs of relatives of critically ill patients: A descriptive study. *Heart & Lung,* 8 (2) 332–339.

Mouton, E.B.J. & Prozesky, P.V.B. (2007). *The practice of social research.7th impression.* SA: Oxford University Press.

Neabel, B., Bourbonnais, F.F. & Dunning J. (2000). Family assessment tools: A review of the literature from 1978-1997. *Heart and Lung,* Vol. 29(3) 196-208.

Nelson, D.P. and Plost, G. (2009). Registered nurses as family care specialists in the Intensive Care Unit. *Critical Care Nurse,* Vol. 29(3): 46-52.

Neuman, W.L. (2000). Social research methods – Qualitative and quantitative approaches. 4th ed. London: Allyn & Bacon.

O'Malley P., Favaloro, R., Anderson, B., Anderson, M.L., Siewe, S., Benson-Landau, M., Deane, D., Feeney, J., Gmeiner, J., Keefer, N., Mains, J. & Riddle, K. (1991). Critical care nurse perception of family needs. *Heart & Lung,* Vol. 20. (2) 189-201.

Oberley, K. & Hughes, D. K. (2001). Doctors' and nurses' perception of ethical problems in end-of-life decisions. *Journal of Advanced Nursing,* Vol. 33(6): 707-715.

Olsen, D.K., Dysik, E. and Hansen, S.B. (2009): The meaning of family members' presence during intensive care stay: A qualitative study. *Intensive and Critical Care Nursing,* Vol 25 (4): 190 -198.

Palazzo, M. O. (2001). Teaching in Crisis. Patient and family Education in Critical Care. *Critical Care Nursing of North America.* Vol.13 (1): 83 – 92.

Peel, N. (2003). The role of the critical care nurse in the delivery of bad news. *British Journal of Nursing,* Vol.12 (16) 966-971.

Plakas, S., Cant, B. and Taket, A. (2009). The experiences of families of critically ill patients in Greece: A social constructionist grounded theory study. *Intensive and Critical Care Nursing,* Vol. 25(1):10-20.

Pochard, F., Azoulay, E., Chevret, S., Lemaire, F., Hubert, P., Canoui, P., Grassin, M., Zittoun, R., le Gall, J.R., Dhainaut, J.F. & Schlemmer, B. (2001). Symptoms of anxiety and depression in family members of intensive care unit patients: Ethical hypothesis regarding decision making capacity. *Critical Care Medicine,* Vol.29(10): 1893-1897.

Plowright, C.I. (1998). Intensive therapy unit nurses' beliefs about and attitudes towards visiting in three district general hospitals. *Intensive and Critical Nursing*, Vol. 14 (6): 262-270.

Polit, D.F. & Beck, C.T.(2004). *Nursing research: Principles and methods.* 7th ed. Philadelphia: J. B. Lippincott. Williams and Wilkins Company.

Polit, D. F. & Hungler, B.P. (1997). *Nursing research: Principles and methods*. Philadelphia: Lippincott.

Ponte, P.R. & Peterson, K. (2008). A patient-and family-centered care model paves the way for a culture of quality and safety. *Critical Care Nursing Clinics of North America,* Vol. 20 (4): 451- 464.

Price, A.M. (2004). Intensive care nurses 'experiences of assessing and dealing with patients psychological needs. *Nursing in Critical Care,* Vol. 9 (3): 134-142.

Pryzby, B.J. (2005). Effects of nurse caring behaviours on family stress responses in critical care. *Intensive and Critical Care Nursing,* Vol. 21 (1): 16-23.

Quinn S., Redmond K., Begley, C. (1996a). The needs of relatives visiting adult critical care units as perceived by relatives and nurses. Part 1. *Intensive Critical Care Nurse,* Vol. 12 (4): 239-245.

Quinn S., Redmond K., Begley, C. (1996b). The needs of relatives visiting adult critical care units as perceived by relatives and nurses. Part 2. *Intensive Critical Care Nurse,* Vol. 12 (3): 168-172.

Rennick, J. E. (1995). The changing profile of acute childhood illness: a need for the development of family nursing knowledge. *Journal of Advanced Nursing,* Vol. 22: 258-266.

Rice,V. (2001). The critical care consortium: Maximizing continuing education dollars. *Critical Care Nurse Clinics North America,* Vol. 13(1): 25-31.

Rushton, C.H., Williams, M.A. & Sabatier K.H. (2002). The integration of palliative care and critical care: one vision, one voice. *Critical Care Nurse Clinics North America,* Vol.14: 133-140.

Sacco, T.L.,Stapleton, M. F. and Ingersoll, G. L. (2009). Support groups facilitated by families of former patients: creating family-inclusive critical care units. *Critical Care Nurse* Vol,29(3) 36-45.

Shirey, M.R. (2008). Innovative practice models for acute and critical care. *Critical Care Nursing Clinics of North America,* Vol. 20 (4): 368-374.

Simpson, S.H. (1997). Reconnecting: the experiences of nurses caring for hopelessly ill patients in intensive care. *Intensive and Critical Care Nursing* Vol. 13: 189 – 192.

South African Nursing Council (S.A.N.C.) (1997). *Regulations relating to the approval in critical nursing science leading to registration of an additional qualification.* Government Notice R212 of January 1997, as amended by No. R.74, in terms of the Nursing Act 50, 1978. Pretoria: Government Printers.

S.A.N.C.(1997*). Regulations relating to the approval and the minimum requirements for the education and training of a nurse (general, psychiatric and community) and a midwife leading to registration.* Regulation R.425, as amended by No R .1312 of 19 June 1987, and No R. 2078 of 25 September 1987 and No R.753 of 22 April 1988, in terms of the Nursing Act 50 of 1978. Pretoria: Government Printers.

Stayt, L.C. (2007). Nurses'experience of caring for families with relatives in intensive care units. *Journal of Advanced Nursing,* Vol 57(6): 623-30.

Takman, C.A.S. & Severinsson, E. (2004). The needs of significant others within intensive care. The perspective of Swedish nurses and physicians. *Intensive and Critical Care Nursing,* Vol. 20, (1): 22-31.

Tashakkori,A., & Teddie, C.(1998). *Mixed methodology: Combining qualitative and quantitative approaches.* Applied Social Research Methods Series. Vol. 46. Thousand Oaks, California, USA**:** Sage Publications.

Tuffrey-Wijne, I., Benal, J., Butler, G., Hollins, S. and Curfs, L. (2007). Using Nominal Group Technique to investigate the views of people with intellectual diabilities on end-of-life care provision. *Journal of Advanced Nursing,*Vol. 58(1): 80-89.

Twibell, R.S. (1998). Family coping during critical illness. *Dimensons Critical Care Nursing,* Vol. 17 (2): 100-112.

Van Horn, E., Fleury, J., Moore, S. (2002). Family interventions during the trajectory of recovery from a cardiac event: An integrative literature review. *Heart and lung,* Vol. 31(3) : 186-192.

Vandijck, D.M., Labeau, S. O., Geerinckx, C. E., Puydt, E. D., Bolders, A.C., Claes, B. and Blot, S. I.(2009) An evaluation of family-centered care services and organization of visiting policies in Belgian intensive care units: A multicenter survey. *Heart & Lung,* 06:1-10.

Verhaeghe, S., Defloor, T., Van Suuren, F., Duijnstee, M. & Grypdonck, M. (2005). The needs and experiences of family members of adults patients in an intensive care unit: A review of the literature. *Journal of Clinical Nursing*, Vol, 14: 501-509.

Vint, P.E. (2005). An exploration of the support available to children who may wish to visit a critiacally adult in ITU. *Intensive and Critical Care Nursing*, Vol. 21 (3): 149-159.

Walker, W. (2008). Accident and emergency staff opinion on the effects of family presence during adult resuscitation: Critical literature review. *Journal of Advanced Nursing,* 61(4): 348-362.

Walters, A. J. (1995). Technology and the life world of critical care nursing. *Journal of Advanced Nursing,* Vol. 22: 338-346.

Wasser, T., Pasquale, M. A., Matchett, S.C., Bryan, Y. & Pasquale, M. (2001). Establishing the reliability and validity of the critical care family dissatisfaction survey. *Critical Care Medicine,* Vol 29 (1): 192-196.

Wigens, L., Westwood, S. (2000). Issues surrounding educational preparation for intensive care nursing in the 21st century. *Intensive and Critical Care Nursing,* 16: 221-227.

Williams, C.M.A. (2005). The identification of family members' contribution to patients 'care in the intensive care unit: a naturalistic inquiry. *Nursing in Critical Care*, Vol. 10 (1): 6-14.

Winters, B.D., Gurses, A.P., Lehmann, H., Sexton, B.J., Rampersadh, C.J. and Pronovost, P.J. (2009). Clinical review: Checklists - translating evidence into practice. *Critical Care Nurse,* Vol. 13 (6): 1-9.

Wolff, A.M., Taylor, S.A. and McCabe, J.F. (2004): Using checklist and reminders in clinical pathways to improve hospital inpatient care. *Med. Journal*, August 181: 1428-1431.

Wooley, N. (1990). Crisis theory: A paradigm of effective intervention with families of critically ill people. *Journal of Advanced Nursing,* Vol. 15: 1402-1408.

Yang, S. (2005). A mixed methods study on the needs of Korean families in the intensive care unit. *Australian Journal of Advanced Nursing,* Vol.25(4): 79-85.

Zaforteza, C., Gastaldo, D., dePedro, J.E., Sanchez-Guenca, P. & Lastro, P, (2005). The process of giving information to family of critically ill patients: A field of tension. *International Journal of Nursing Studies,* Vol. 42(2): 135-145.

Zarubi, K.L., Reiley, P. & McCarter, B. (2008). Putting patients and families at the center of care. *The Journal of Nursing Administration,* Vol. 38 (6): 275-281.

COMPETENCIES	disagree	partially disagree	Don't know	agree	Partially agree
APPENDIX 1 – Questionnaire for the Quantitative Data					
COMPETENCIES CHECKLIST FOR FAMILY PSYCHOSOCIAL SUPPORT ADAPTED FROM THE AMERICAN COLLEGE OF CRITICAL CARE MEDICINE GUIDELINES					
1. The unit philosophy includes aspects on family philosophy.					
2. You understand the roles, responsibilities and relationships of families in caring for their loved one?					
3. You recognize the strengths and resources that family members may contribute to the loved ones recovery.					
4. I attend to family needs as soon as the patient arrives to ICU.					
5. Junior staff attends to family needs as soon as patient arrives to ICU.					
6. Senior staff attends to patients and family needs simultaneously.					
7. Family members' needs are attended to as soon as patient is settled in.					
8. Families' needs assessment is done only when I have time available.					
9. I do what ever to bring patient and family together.					
10. Family is not my responsibility.					
11. Family is part of my responsibility.					
12. Family is my total responsibility.					
13. I view the family as a unit facing critical illness.					
14. I recognize that family members may participate in all aspects of interventions services including:					
15. Policy development					
16. Participation in staff instructions					
17. I make an effort to encourage/assist family members to provide direct care to their love one.					
18. Family members only allowed see patients from a reasonable distance in ICU.					
19. Family members do not actively participate in the care of their loved one.					
20. Families only allowed if their loved one requests that they should be around.					
21. Family members make decision concerning health issues.					
22. A family members are allowed being present on rounds.					
23. A family members are allowed being present during resuscitation.					
24. Family meetings held on regular basis with health professionals.					
25. A family member is allowed to ask questions relevant to the patient's care.					

26. Decision on health issues concerning loved ones is made by family members (moral, religious and legal).					
27. Family members assisted to make these decisions.					
28. Policy and procedures for the conduct of these family meetings.					
29. I advocate that other health professionals eg doctors to give information to families members.					
30. Information is provided to families only on request					
31. I provide information to families even if not requested because it is part of my duties.					
32. I cannot give any information protocol does not allow it.					
33. I contact families only to inform them that their loved ones condition - deteriorates.					
34. Pre-visit education is provided to families.					
35. Open flexible visitations encouraged.					
36. Visitation is restricted to scheduled times as per protocol					
37. Health professional use this time (visiting times) to interact with family members to provide information on loved ones' progress.					
38. I see families as a threat to me whilst working.					
39. Family members allowed to be around whilst I am working with loved one					
40. Caring for family members as well as critically ill patient is challenging					
41. If yes to No. 23, Do you inform members on what you are doing and why.					
42. Allow for formal spiritual counseling by chaplaincy service.					
43. Families are allowed to bring their own choice of spiritual leader for support.					
44. Way – finding and family friendly signage to reduce stress in the					
45. Waiting rooms are close to critical care units with inclusion of family friendly amenities					
46. Debriefing and support is provided to family members after a witnessed resuscitation.					
47. Debriefing and support is provided to family members after before, during and after death of a loved one.					
48. You assess family members understanding of prognosis and treatment plan regularly.					
49. Policy and procedures formulated to debrief and support family member after a witnessed resuscitation, before during and after death.					
50. There is no place for palliative care in our ICU.					
51. Patients are transferred out to general wards for palliative care.					
52. Bereavement services and follow up care are made available after the death of the patient.					

53. Education is provided to family members about clinical manifestations of approaching death in culturally appropriate manner						
54. Family members are educated on continued management of patients (caregivers) once loved one is discharged to general unit/home.						
55. Procedure guidelines followed for children – assisted therapy e.g. play area						
56. Consistent messages are received by family members from health professionals						

EDUCATION

57. The knowledge I have in meeting family stress needs was acquired through my self teaching efforts alone						
A. Experience during ICU formal Training **I received lessons on:**						
58. Family dynamics and its impact on the family as a unit.						
59. How to conduct family assessment needs.						
60. Cultural diversity and its impact on care delivery.						
61. Communication skills						
62. Crisis interventions that assist me in caring for family members						
63. Allowing family presence in ICU –during resuscitation						
64. Debriefing family members during crisis.						
65. Palliative care						
66. Creating a therapeutic environment						
67. Including the family as part of the multidisciplinary team of the ICU						
68. How to provide psychosocial support to family members.						
69. Providing care in balance with cultural norms of patient and family.						
70. Accompaniment of family members of ICU patients through their experience to a state of equilibrium						
71. Researched information on family experiences in ICU						
72. Policy and Procedures education on the above						
73. My education during formal training was adequate for me to provide psychosocial support to families of ICU patients						
B. Experience during ICU informal Training at unit level - in-service, workshops or structure teaching plan **I received lessons on:**						
74. Family dynamics and its impact on the family as a unit.						
75. How to conduct family assessment needs.						
76. Cultural diversity and its impact on care delivery.						
77. Communication skills						
78. Crisis interventions that assist me in caring for family members						
79. allowing family presence in ICU –during resuscitation						
80. Debriefing family members during crisis.						
81. Palliative care						
82. Creating a therapeutic environment						
83. How to provide psychosocial support to family members.						
84. Including the family as part of the multidisciplinary team of the ICU						

85. Providing care in balance with cultural norms of patient and family.					
86. Accompaniment of family members of ICU patients through their experience to a state of equilibrium					
87. Researched information on family experiences in ICU					
88. Recommendations from researched information have been implemented by me.					
89. Policy and Procedures in place for independent learning on the above.					
C. Experience during ICU informal Training at Hospital level – in-service, workshops or structure teaching plan **I received lessons on:**					
90. Family dynamics and its impact on the family as a unit.					
91. How to conduct family assessment needs in ICU.					
92. Cultural diversity and its impact on care delivery.					
93. Communication skills					
94. Crisis interventions that assist me in caring for family members					
95. Allowing family presence in ICU –during resuscitation					
96. Debriefing family members during crisis.					
97. Palliative care					
98. Creating a therapeutic environment					
99. How to provide psychosocial support to family members.					
100. Including the family as part of the multidisciplinary team of the ICU					
101. Providing care in balance with cultural norms of patient and family.					
102. Policy and Procedures education on the above					
103. Accompaniment of family members of ICU patients through their experience to a state of equilibrium					
104. Researched information on family experiences in ICU					
D. As part of my teaching function **I delivered lessons on:**					
105. Family dynamics and its impact on the family as a unit.					
106. How to conduct family assessment needs in ICU.					
107. Cultural diversity and its impact on care delivery.					
108. Communication skills					
109. Crisis interventions that assist me in caring for family members					
110. Allowing family presence in ICU –during resuscitation					
111. Debriefing family members during crisis.					
112. Palliative care					
113. Creating a therapeutic environment					
114. Including the family as part of the multidisciplinary team of the ICU					
115. How to provide psychosocial support to family members.					
116. Providing care in balance with cultural norms of patient and family.					
117. Policy and Procedures education on the above					
118. Accompaniment of family members of ICU patients through their experience to a state of equilibrium					
119. Researched information on family experiences in ICU					

INTERVIEW NO_____

SECTION A: DEMOGRAPHIC DATA

1. Gender   Male   ☐

                                             Female   ☐

2. What is your age in years at your previous birthday?   ☐

3. Your Academic Qualifications – Please mark all relevant qualifications

Masters degree   ☐

Honors degree   ☐

Basic B degree   ☐

Ba Cur degree   ☐

Diploma in Critical Care Nursing Science   ☐

Diploma in Nursing Administration   ☐

Diploma in Community Nursing   ☐

Diploma in Midwifery   ☐

R425 Diploma   ☐

4. Indicate the number of years and months of experience you have working

in the critical care units.   ☐

INTERVIEW GUIDE - APPENDIX 2.1

ICU Nurses Working Hands On

Objective I

To establish the extent of family psychosocial support in the critical care units by the critical care nurses.

Question I
1. What is your current practice of psychosocial support to families of ICU patients?
2. Do families participate in patient care and how?
3. Is there provision for children and sibling visiting?

Objective II

To determine the formal educational preparation of critical care nurses to provide family psychosocial support in the ICU.

Question II
4. Did your formal education and training prepare you to provide psychosocial support to families of ICU patients?
5. Do you think there was any additional learning beyond your basic training on this aspect, if so please elaborate?

Objective III

To determine the managerial support that critical care nurses receive to provide family psychosocial support in the ICU.

Questions III
6. Is there provision available to support you in your practice of ICU to provide psychosocial support?

Objective IV

In consensus with the experts, develop intervention(s) which support the critical care nurse enabling him/her to provide psychosocial support to the families of patients in the ICU.

Question IV

7. What recommendations/ interventions would you make to support the ICU nurses to provide psychosocial support to families?

APPENDIX 2.2

INTERVIEW GUIDE – MANAGER OF THE ICUs

1. Do you think ICU nurses needed support to provide psychosocial support to families of critically ill patients?

2. If so what provision is made to support the ICU nurses to empower them to provide psychosocial support to critically patients?

3. Do you think more could be done? If so what? Where? And How?

APPENDIX 2.3

INTERVIEW GUIDE – LECTURER OF THE ICU PROGRAMME CURRENTLY CONDUCTED.

1. Do you think psychosocial support to families of critically ill patients is important?

2. If so what provision has your curriculum made to cover this component in the ICUs?

3. Do you think more could be done? If so what? Where? And How?

APPENDIX 3:- CHECKLISTS

 APPENDIX 3.2: DOCUMENT REVIEW

RECORD - NAME	ACCESSIBILITY	COMPILED BY	EDUCATIONAL SUPPORT TO ICU NURSES TO RENDER PSYCHOSOCIAL SUPPORT
1. Directive to provision of psychosocial support to families of ICU patients, for example, Unit Philosophy,	√	NURSES	nil
2. Policies and Protocols on family psychosocial support	Not found		
3.Communication tools to families: - Sinage	√	Managers	Negative communication, what families should not do?
- Notice Boards	√	Managers	Grievance Procedures outlined
- information booklets	√ (In one hospital)	Managers	
4.Practice of Psychosocial support - Self reports – nursing care plans including	√	ICU Nurses	Nil
5. Structured teaching plan-	√	ICU nurses	Nil
6. Suggestion box and directives to the use of suggestion box.	√	ICU nurses	Underutilized by families
7. Registers, Clinical accompaniment records, Assignment on family care, Test papers,	√	Lecturers	Nil
8. Curriculum	√	Lecturers	Broad – family is included with patient and community
9.SANC directives & Regulations	√	SANC	General not specific to ICU
10. In- Service	√	ICU nurses	Nil
11. Allocation of ICU nurses as presenters in in-service programmes	Nil	Nil	Nil

(Henneman & Cardin, 2002: 15)

APPENDIX 3.2: PARTICIPANT OBSERVATIONS																								
DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Family psychosocial support inclusion
Patient focused care	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
Interaction between staff & family																								
- Information sharing					√				√			√		√			√							By doctor
- Calling family											√			√										
- Participation in care																								
Visiting times	√	√			√		√		√	√		√		√		√			√		√		√	
- Family just standing by / distance																								
- Children present at bedside																								
- Outside the unit		√										√								√				
- Family seeking to speak with someone	√										√						√				√			
Waiting room usage - by doctor						√						√				√			√			√		
- ICU nurses				√										√										
Clinical accompaniment									√												√			Nil- during visiting time the lecturer left.
Clinical Assessment					√												√							No aspect on providing psychosocial to family noted

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Family psychosocial support inclusion
Classroom teaching																√	√							No aspect on providing psychosocial support to families
In –service - Unit level										√				√										Nil
- Hospital													√					√						No aspect on the provision of psychosocial care of families
- ICU nurses presented																								

APPENDIX 4: INFORMATION DOCUMENT

TOPIC: Investigation of educational preparation of ICU nurses in providing psychosocial support to families of critically ill patients in two educational institutions in KZN

I am Thazaya Khan (Rajes), a masters' learner registered for research by masters, at the University of KwaZulu Natal in Durban, South Africa. In fulfillment of the masters program, I am required to complete a research study. I am interested in *investigation of educational preparation of ICU nurses in providing psychosocial support to families of critically ill patients in two educational institutions in KZN*. The population consists of nurses working ICU of the two hospitals in KZN, the unit and organizational managers of the ICUs, and facilitators and learners of these institutions.

The health industry is evolving to keep up with international standards and the expectation of consumers. In creating a therapeutic professional practice environment the delivery of care as a subsystem need to be articulated by ICU nurses. This needs to be holistic thus requiring the professional – family – patient relationship. Caring for families as a unit facing critical illness is the responsibility of all health professionals. The ICU nurses is with the patients 24/7 thus being most visible. Therefore ICU nurses, assume the role of maintaining this relationship and link family members with loved one and other role players within the ICU. They accompany the family members through their experience, providing psychosocial support, including being aware of the family members unique challenges, stressors and needs, helping them cope in their own way as they endure uncertainty with the quality of life/survival of their critically ill member. To meet this challenge is the ICU nurse must be supported educationally (formally and informally). Against this background the researcher wishes to conduct a study to better understand this educational preparation of ICU nurses.

The purpose of this study is to explore the educational and training support (formal and informal) that the critical care nurse receives to provide psychosocial support to family members of patients in ICU in KZN.

I am therefore writing to ask you to participate in this study. The interview will last for 45-60 minutes and will be tape recorded for transcription. Should you require any clarification do not hesitate to contact me or my supervisor on the contact details below.

Your participation will be highly appreciated.

Thank you,

Thazaya Khan (Rajes)

Researcher's Contact Details

Howard College Campus

School of Nursing

5th Floor, Desmond Clarence Building

4041 Durban South Africa

+27 (0)836 597 693

Email: Rajes.Moodley@kznhealth.gov.za

Supervisor's Contact Details

Howard College Campus

School of Nursing

5th Floor, Desmond Clarence Building

4041 Durban South Africa

+27 (031) 260 7209

Email: bhengu2@kzn.ac.za

APPENDIX 5: CONSENT DOCUMENT

STUDY TITLE: **Investigation of educational preparation of ICU nurses in providing psychosocial support to families of critically ill patients in two educational institutions in KZN**

ETHICAL CLEARANCE NUMER: HSS/0473/09M

You may have attended presentations or heard about the above study. With regards to the same, you are being asked to participate in the study. The researcher is interested in knowing what is presently happening in ICU with regards to providing family psychosocial support of patients in ICU and from your perspective the educational preparation of the ICU nurses receives formally and informally, in this regard. During this study you will be interviewed and the interview will be tape recorded for transcription.

There is no individual benefits but the researcher hopes that the information from this study may identify opportunities for improvement the educational preparation of ICU nurses to providing psychosocial support to family members of critically ill patients in ICU. Your participation is voluntary and there will be no penalties involved if you choose not to participate in the study.

You may contact the investigator by email at Rajes.Moodley@kznhealth.gov.za, or by phone cell no. +27 (0) 836 597 693, (031) 360 3637 any time if you have any queries regarding the study.

You may contact the UKZN Ethics Committee, Faculty of health Science, P/ Bag X 54001, Durban, 4000 at +27 (031) 2607209 if you have any questions about your rights as a research participants.

If you agree to participate you will append you signature as evidence of your acceptance and be given a copy of the document.

The researcher study including the above information has been explained verbally to me. I agree to the interviewed.

_____   _____

Signature of Participant   Date

_____   _____

Signature of Researcher   Date

APPENDIX 6: ETHICAL CLEARANCE – ETHICS COMMITTEE,

UNIVERSITY OF KWAZULU-NATAL

UNIVERSITY OF KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

20 JULY 2009

MS. T MOODLEY (204523336)
SCHOOL OF NURSING

Dear Ms. Moodley

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0473/09M

I wish to confirm that ethical clearance has been approved for the following project:

"Investigation of Education Preparation of ICU Nurses in providing psychosocial support to families or Critically Ill Patients in Two Educational Institution in KZN"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully
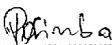
MS. PHUMELELE XIMBA
ADMINISTRATOR
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Prof. RB Bhengu)
cc. Mr. S Reddy

Founding Campuses: ▪ Edgewood ▪ Howard College ▪ Medical School ▪ Pietermaritzburg ▪ Westville

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APPENDIX 7A: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY- EDUCATIONAL INSTITUTION A

135 Road 729

Chatsworth

4093

Prof B. Bhengu
Head of School UKZN

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparedness of the Critical Care Nurse to Enhance Psychosocial Support of Families of Critically Ill Patients in Two educational institutions in K.Z.N.

I request your permission to access and interview Lecturers and learners as part of the data collection process. Permission for voluntary participation will be requested from participants, and their rights to informed consent, confidentiality and anonymity will be ensured.

I hope my application will receive your favorable considerations as information obtained will be of relevance to your institution, nursing practice and future research.

Ethical clearance approved. No. HSS/0473/09M

Yours truly,

Thazaya Khan (Rajes)

E-mail: RajesMoodley@kznhealth.gov.za

Cell: 0836597693

APPENDIX 7B: LETTER GRANTING PERMISSION TO CONDUCT THE STUDY: EDUCATIONAL INSTITUTION A

UNIVERSITY OF KWAZULU-NATAL

13th August 2009

Mrs T Moodley
135 Road 729
Chatsworth
4093

Dear Mrs Moodley

Permission to conduct research at the School of Nursing University of KwaZulu-Natal

With reference to your request, regarding permission to conduct research at the School of Nursing, University of KwaZulu-Natal, please note that this matter was discussed our staff meeting.

Permission was hereby granted for you to conduct your research.

We look forward to working with you, and wish you all the luck in your study.

Thank you

Sincerely

Professor N G Mtshali
Deputy Head
School of Nursing

School of Nursing, Howard College Campus

Postal Address: Durban4041, South Africa

Telephone: +27 (0)31 260 2499   Facsimile: +27 (0)31 260 1543   **Email:**   **Website:** www.ukzn.ac.za

Founding Campuses: Edgewood   Howard College   Medical School   Pietermaritzburg   Westville

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APPENDIX 8A: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY- DOH(KZN)

The University of Kwa –Zulu Natal
Department of Nursing Science
DURBAN
4001

August 4, 2009

Mrs. G. E. Khumalo
The Department of Health
Province of Kwa – Zulu Natal
Private Bag 95051
3200

To Whom It May Concern:

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AT TWO PROVINICAL HOSPITALS IN THE KZN PROVINCE: August – December 2009

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparation of the Critical Care Nurse to provide Psychosocial Support to Families of Critically Ill Patients in two educational institutions in K.Z.N.

I request your permission to access and interview critical care nurses, operational managers lecturers and learners as part of the data collection process at: King Edward VIII Campus and Inkosi Albert Luthuli Central Hospital (IALCH).

I hope my application will receive your favorable consideration, because the information obtained will be of relevance to the Province of KZN.

Yours truly,

Ms Thazaya Khan

To Whom It May Concern:

I have changed my name through persal from Ms T. Moodley to Ms Thazaya Khan.

HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 109 Natalia Building, 330 Langalibalela Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 - 3953189
Fax.: 033 – 394 0782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM094/09
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

02 September 2009

Dear Ms Moodley

Subject: Approval of a Research Proposal

1. The research proposal titled 'Investigation of educational preparation of ICU nurses in providing psychological support to families of critically ill patients in two educational institutions in KZN' was reviewed by the KwaZulu-Natal Department of Health.

    The proposal is hereby approved for research to be undertaken at Inkosi Albert Luthuli Central and King Edward VIII Hospitals.

2. You are requested to undertake the following:
    a. Make the necessary arrangement with identified facility before commencing with your research project.
    b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 9A: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY- NCN(KZN)

The University of Kwa –Zulu Natal
Department of Nursing Science
DURBAN
4001

August 4, 2009

Dr L. Nkonzo-Mthembu
Natal College of Nursing
Province of Kwa – Zulu Natal
Private Bag X9089
3200

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AT KING EDWARD VIII CAMPUS - KZN PROVINCE: August – December 2009

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparation of the Critical Care Nurse to provide Psychosocial Support to Families of Critically Ill Patients in two educational institutions in K.Z.N.

I request your permission to access and interview critical care nurses, operational managers lecturers and learners as part of the data collection process at: King Edward VIII Campus and Inkosi Albert Luthuli Central Hospital (IALCH).

I hope my application will receive your favorable consideration, because the information obtained will be of relevance to the Province of KZN.

Yours truly,

Ms Thazaya Khan

To Whom It May Concern:

I have changed my name through persal from Ms T. Moodley to Ms Thazaya Khan

APPENDIX 9B: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY- NCN –KEH CAMPUS (KZN)

The University of Kwa –Zulu Natal
Department of Nursing Science
DURBAN
4001
August 4, 2009

Mrs B. Hlatswayo
King Edward VIII Campus
Natal College of Nursing
Province of Kwa – Zulu Natal

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AT KING EDWARD VIII CAMPUS - KZN PROVINCE: August – December 2009

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparation of the Critical Care Nurse to provide Psychosocial Support to Families of Critically Ill Patients in two educational institutions in K.Z.N.

I request your permission to access and interview critical care nurses, operational managers lecturers and learners as part of the data collection process at: King Edward VIII Campus and Inkosi Albert Luthuli Central Hospital (IALCH).

I hope my application will receive your favorable consideration, because the information obtained will be of relevance to the Province of KZN.

Yours truly,

Ms Thazaya Khan (Rajes)

To Whom It May Concern:

I have changed my name through persal from Ms T. Moodley to Ms Thazaya Khan

APPENDIX 9C: LETTER GRANTING PERMISSION TO CONDUCT THE STUDY: EDUCATIONAL INSTITUTION

HEALTH
KwaZulu-Natal

KWAZULU-NATAL COLLEGE OF NURSING
Prdag X9089, Pietermaritzburg 3200
Tel: (033) 264 7806, Fax: (033) 394 7295
e-mail: sulama.mtembu@kznhealth.gov.za
www.kznhealth.gov.za

Enquires: Mrs. S. Maharaj
Telephone: 033 – 264 7806
Date: 27 August 2009

Principal Investigator.
Ms. T. Moodley (204523396);
School of Nursing
University of KwaZulu-Natal

Dear Sir/Madam

RE: PERMISSION TO CONDUCT RESEARCH AT KING EDWARD VIII CAMPUS

I have pleasure in informing you that permission has been granted to you by the Principal of the KwaZulu-Natal College of Nursing to conduct research on:

"Investigation of Education Preparation of ICU Nurses in providing psychosocial support to families or Critically ill Patients in Two Education in KZN"

Please note the following:

1)   Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

2)   This Research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health

3)   Please ensure this office is informed before you commence your research.

4)   The KwaZulu-Natal College (King Edward VIII Campus) will not provide any resources for this research.

5)   You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thanking You.
Sincerely

Dr. L. Nkonzo Mtembu
Principal KwaZulu-Natal College of Nursing

APPENDIX 10A: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY: INSTITUTION B

The University of Kwa –Zulu Natal
Department of Nursing Science
DURBAN
4001

August 4, 2009

Mrs Zola
King Edward VIII Hospital

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH AT KING EDWARD VIII CAMPUS - KZN PROVINCE: August – December 2009

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparation of the Critical Care Nurse to provide Psychosocial Support to Families of Critically Ill Patients in two educational institutions in K.Z.N.

I request your permission to access and interview lecturers and learners as part of the data collection process at: King Edward VIII Campus.

I hope my application will receive your favorable consideration, because the information obtained will be of relevance to the Province of KZN.

Yours truly,

Ms Thazaya Khan (Rajes)

To Whom It May Concern:

I have changed my name through persal from Ms T. Moodley to Ms Thazaya Khan.

APPENDIX 10B: LETTER GRANTING PERMISSION TO CONDUCT THE STUDY:

INSTITUTION B

KING EDWARD VIII HOSPITAL
Private Bag X02, **CONGELLA** 4013
Corner of François & Sydney Road
Tel.:031-3603853, Fax: 031-2061457
Email.:rejoice.khuzwayo@.kznhealth.gov.za
www.kznhealth.gov.za

HEALTH
KwaZulu-Natal

Enq.:Miss. R.Khuzwayo
Ref.: KE 2/7/1/ **26/09)**
Research Programming

9 September 2009

Ms. T. Moodley/Thazaya/Rajes
Faculty of Health Sciences
School of Nursing
UNIVERSITY OF KWAZULU-NATAL

Dear Ms. Moodley

Request to conduct research at King Edward VIII Hospital

**Protocol:- Investigation of Educational Preparation of ICU in Providing
Psychosocial Support to Families of Critically ill Patients in two
Educational Institution in KZN**

Your request to conduct research at King Edward VIII Hospital has been approved.

Please ensure the following:-

- That King Edward VIII Hospital receives full acknowledgment in the study on all publications and reports and also kindly present a copy of the publication or report on completion.

- Before commencement:
  * Discuss your research project with our relevant Directorate Managers
 * Sign an indemnity form at Room8, CEO's Complex, Admin. Block.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

| SUPPORTED / ~~NOT SUPPORTED~~ |
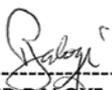
DR. OSB BALOYI
MEDICAL MANAGER

10/09/2009
DATE
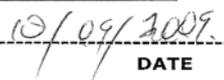
| APPROVED/ NOT APPROVED |
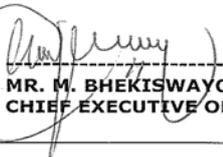
MR. M. BHEKISWAYO
CHIEF EXECUTIVE OFFICER

15/09/09
DATE

uMnyango Wezempilo . Departement van Gesondheid

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APPENDIX 11A: LETTER REQUESTING FOR PERMISSION TO CONDUCT THE STUDY: INSTITUTION A

The University of Kwa –Zulu Natal
Department of Nursing Science
DURBAN
4001

The Chief Executive Officier
Mrs Zondi
Inkosi Albert Luthuli Central Hospital
P. B. Box

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY: AUGUST – DEC. 2009

I am a registered learner at the University of KZN Durban. As a requirement to the fulfillment of a Research Master in Nursing Science I need to complete a research study entitled:

An Investigation into the Educational Preparation of the Critical Care Nurse to provide Psychosocial Support to Families of Critically Ill Patients in two educational institutions in K.Z.N.

 I request your permission to access and interview critical care nurses, operational managers and learners as part of the data collection process. Permission for voluntary participation will be requested from participants, and their rights to informed consent, confidentiality and anonymity will be ensured.

I hope my application will receive your favorable considerations as information obtained will be of relevance to your institution, nursing practice and future research.

Yours truly,

T. Khan (Rajes)

E-mail: RajesMoodley@kznhealth.gov.za
Cell: 0836597693
Work: 031 3603637/3104

30/12 '10 THU 20:37 FAX 27 31 4010191   SPARKPORT CHATSWORTH   ☒003

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

INKOSI ALBERT LUTHULI CENTRAL HOSPITAL

OFFICE OF THE MEDICAL MANAGER
800 Bellair Road, Mayville, 4058
Private Bag X03 Mayville, 4058
Tel : 021 240 1042 Fax. 031 240 1030
Email: Palish:amoz@ialch.co.za

28 August 2009

Ms T.Moodley
Dept of Nursing and Quality
IALCH

Dear Ms T.Moodley

Re: Ref No: Investigation of Education Preparation of ICU Nurses in providing Psychosocial support to families of critically Ill Patients in two Education Institution in KZN.?

As per the policy of the Provincial Health Research Committee (PHRC), you are hereby granted permission to conduct the above mentioned research once all relevant documentation has been submitted to PHRC inclusive of Full Ethical Approval.

Kindly note the following.

1. The research should adhere to all policies, procedures, protocols and guidelines of the KwaZulu-Natal Department of Health.
2. Research will only commence once the PHRC has granted approval to the researcher.
3. The researcher must ensure that the Medical Manager is informed before the commencement of the research by means of the approval letter by the chairperson of the PHRC.
4. The Medical Manager expects to be provided feedback on the findings of the research
5. Kindly submit your research to:

   The Secretariat
   Health Research & Knowledge Management
   330 Langalibalele Street, Pietermaritzburg, 3200
   Private Bag X9501, Pietermaritzburg , 3201
   Tel: 033395-3123, Fax 033394-3782

Yours faithfully

Dr M E L Joshua
Medical Manager

Umnyango Wezempilo   ☻   Departement van Gesondheid

APPENDIX 12: PROOFREADING LETTER FROM THE EDITOR

7 Woodlands Road
Glenwood
DURBAN
4001

30 December 2010

Reg No. 2006/156780/23

To whom it may concern

EDITING OF RESEARCH DISSERTATION OF THAZAYA KHAN (RAJES) BY CATHERINE EBERLE

I hereby confirm that I was employed to edit the above document. I have an MA (Eng) from University of Natal, and am frequently employed by students to provide this function.

I have edited her text and initiated changes with regard to spelling, punctuation, language, grammar and syntax. I have not edited content as I am not a subject expert. I have provided an Error Report which makes suggestions for changes, remedies for layout issued, clarification, etc. and provides examples of errors which I cannot rectify, but which need to be addressed prior to the document being deemed correct.

The student has indicated that she will make the necessary corrections and adjustments as deemed appropriate.

I trust that her document will then prove acceptable in terms of language and presentation.

Yours sincerely

CATHERINE P. EBERLE (MA)

APPENDIX 13: TRANCRIBED INTERVIEWS

APPENDIX 13.1: A TRANCRIBED INTERVIEW WITH AN ICU NURSE THAT IS HANDS ON

Objective I

To establish the extent of family psychosocial support in the critical care units by the critical care nurses.

1. ***Researcher: What is your current practice of psychosocial support to families of ICU patients?***

Participant: We do give psycho social support but not as how we supposed to do it, yes, but most of the time we have very ill patients critically ill patient and relatives ask about the patient or the doctors want to say to relatives that there is very little they can do or they want to withdraw treatment that is when we call in the relatives. The patients we are dealing with here are very sick, critically ill, and we have sudden deaths and, and we have the severely injured patients, all that is traumatic to the nurses. So I just think that the nurse would discover that they spend more time concentrating on the patients and forget to give psychosocial support to the families of the critically patients because the patients are so demanding. So in the end it likes, you want to do the best for the patients and there is just very little time for the family.

We sit here in the comfort room and the doctor explains everything but the nurses also there to explain further or maybe to translate or just be there as a witness because you got a counseling book where we do record the whole session because we don't want latter on the relatives to say we never told them of prognosis or about the condition of the patient. So we do counseling but as I am telling you, not the way we love it to be done. There is very little counseling as I say if there is a problem like, if maybe the patient is very sick or they need to change treatment or they need to withdraw, that is the time we call in the relatives, and we sit down, and talk to the relatives about what is happening. I just like to encourage that it is done often because we tend to forget about it because we are so busy and we do forget about this psychosocial support to the families yet it is very important that it is dealt with because you discover that most of our problems is that the patient is very sick and not able to talk and this comes from the relatives so if they are not given this psychosocial support the families become more stressed they come up with problems and give you more problems as well. But then nurses also become immune to the environment to they so used to it that they cannot see the psychosocial needs of the family because they see patients dying all the time and sorry to say this but some don't have any feeling for relatives, we have no time all the time we are too busy everything is a rush and there are times that the nurses talk to relatives without sitting them down, they speak at the patients bedside and even whilst standing. Like this comfort room is here but the families all cannot be accommodated. During visiting time they sit outside on the benches waiting to take turns to visit their relative. But this comfort room we accommodate one family at a time to talk about the relatives. But generally I notice we not compliant with is talking to the relatives, some do it some don't. Nurses tend to forget about the family**. (*Researcher Probes: Is it included in the policies, philosophy, vision and mission?)***
Participant: No, no, no, policies, philosophy, vision and mission no, there is nothing like that I haven't seen it, no I don't want to lie, no, I have not seen that, no. We do not read these policies because we are always busy and they are not read to us so we don't know if they are there. Maybe that is what we should work on to guide and to give us direction. The family is ignored because there is no compulsory direction from anyone that this should be done, no policy or any document that we fill in to say that this is done or not. So if we are audited and this is not done we will not be seen as if we are non-compliant with regards to providing support to families, we will still get a good percent if we do not provide this care to families, because no document to say that this must be done as it is compulsory, no I have not seen any document.

2. *Researcher: Do families participate in patient care?*

Participant: All right to some extent. If there is a patient that is critically ill and is not doing well and everything is done and you not going anywhere , before we do anything the doctors usually say phone the relatives so that they want to know how the patient was before they go so sick so they want all that information so the patient was active doing gardening, doing his own things etc then we reconsider and maybe if we try harder but if the patient was already bedridden at home so you can see the prognosis is poor so we involve them to some extent them in such cases we want to capped treatment then we explain and tell them what our plans that we done this this and we not going to switch off anything that we going to continue and we not going to jump if anything happens because we reached our maximum we call them and explain so we do involve them. We do our best and being the critical care unit I think we doing our best although we can involve the family but the family cannot be there because this is an ICU so they cannot be always here. *(Researcher probes): do families participate in information sharing, in actual nursing care.* *Participant:* No, no not in ICU, they are not involved in any care not any physical care, no. What we do most of the time I see that we are compliant with is telling the relatives that we are very much of infection control so when you come to ICU the first thing you do before going to your relatives is to wash your hands to make sure that whatever you came in wash out because your relative is very sick and you don't want to bring in more infection and also when you go out we don't want you take germs out to your children at home so wash your hands again that's what we are very compliant with. But we are not compliant in engaging the families in providing physical nursing care to the relative, no never. They just standby or sit if benches available. The family is not here all the time they only come visiting time and maybe that time we are busy and we can't talk to each and everyone of them and engage them in doing any nursing care for the relatives. We are worried that the ET tube or lines may be pulled out. But we need to talk to families to get more information. It really depends on the individual nurses some are very interested in asking everything about the family for example is the patient married if you the wife does he have children or where does he work , in the end I will know the social history and everything and I will eventually know if there is a problem, but because we all are not equipped with this skill others don't bother to ask, by right if you engage the families some information gained could help in the management for example there was this patient that was so restless and anxious that no one could say why until he extubated himself and said " *where is my ARVs please phone my family , I was told never to miss a day, you put this tube how am I going to take it.*" This is because we did know about this patient and he was determine to take out the tube to tell us about this, therefore it is a must that we engage with the family to discover all this vital information. We would have said to bring this medication we can still give it. Some nurses do this and others just not interested to engage the family to verbalize their concerns and fears. At times we do get certain people coming in here and tell us what to do you know and relatives not being co-operative with us so people are different, you find other losing their temper. Laughs out aloud, people are not the same you know if you talk to a person like that I have seen some. But it comes from the relatives. Yes I know they are stressed, that why they behave this way but they shouldn't because we are also stressed we are looking for so many patient looking after so many patient and we are tired, so we must work hand in hand they must meet us half way they mustn't come here and be rude to us. That why the nurses do not ask them to do anything for the relatives. We are responsible for the patient not the family. That's why some nurses just work for the day, they just to what supposed to be done for the patients, and that it.

3. _Researcher: Is there provision for children and sibling visiting?_

Participant: The children 12 years and below are not allowed to visit in the ICU and I think the hospital as a whole because of the infection. The infectious diseases are there and also in ICU again we just feel very traumatic for a young child to come and see someone who is basically eh dead, when you look at them the mother father or sister looks dead because of the way it is. The patient is ventilated and got all those tubes and invasive lines coming in and out so I don't think it is a place which is conducive for children so we indicate that children not allowed in ICU. But sometimes it depends on the sister they do allow for them to see and go out, but generally we all don't want to see the children in the ICU, because it is highly infectious, but children are not allowed. Even if they come in at the gates they are not allowed maybe they come in as patients, but they are definitely not allowed, if they ask it depends on the which sister in-charge who may allow the children just to look for 2 minutes and they out not allowed to stay for the duration of the visiting time to stay in ICU. But if the family speak about it there are exceptions if the family explain there situation the sister would allow just to see, but we don't encourage children visiting.

Objective II

To determine the formal educational preparation of critical care nurses to provide family psychosocial support in the ICU.

4. _Researcher: Did your formal education and training prepare you to provide psychosocial support to families of ICU patients?_

Participant: The problem is we are never taught, because when it comes to ICU I can't remember exactly but we are never taught to do psychosocial but I think education would help the nurses, we can know how to handle. We are working here they have stress because of the type of patients we nurse. So now giving psychosocial support to the families we need a bit of education so that we can we can be well equipped and be able to talk to families the right way, because sometimes you if you are not taught you will not deliver it the way it was supposed to be delivered, we need to be taught how to give that psychosocial support and how to cope with what is happening the stresses and all that. So I think education is needed at all levels. All the patients that here in ICU are here because they might live or die , it is 50/50,.so they are here because they are very sick so what I think the each and every family needs that psychosocial support from the nurses. So for the nurses to be able to deliver this psychosocial support they need to be given that education of which I don't think we get it when doing the ICU training, the way it is done so these are the things we don't go into detail about. (Researcher Probes): Is it catered for in terms of the content? Practical exposure? Clinical accompaniment? Participant: I don't think I heard anyone mention the psychosocial support of the family of the patient but the psychosocial support to the patient they mentioned. The educational support of the ICU nurses is really needed so that the families are provided with this support. It must start from the college when they start the course. It also depends on the staff as well according to our ICU those that are working for a long time you can see that they are more stable and thus able to give some psychosocial support to the families better because they have been in the situation for a long time and they have nursed these patients even before going on the courses and they able to provide support better than the new ICU nurses who just come for one or two months and go for the ICU course. It is different because the ICU patients are very sick and families that just come in and we have to give psychosocial support and nurses are not well equipped like they supposed to be. Thus my suggestion be that nurses going for the courses also experience the ICU environment at least for a year as well before going for formal training so that they know about this environment. Psychosocial support of the family is not in the curriculum or maybe not taught the way it should be, because here in this ICU we are almost all formally trained so we should be very well versed on this aspect on how to provide this psychosocial support to the families of the ICU patients, yet not, because this psychosocial support of the family is not administered it was never there in the curriculum or it was never done properly.

(*Researcher Probes*: *during training were you exposed or clinically accompanied by the academic staff*). *Participant:* It just comes down to the fact that this is not covered in the course whilst I was training because everything is more about the patient and academically it more the, the conditions and whatever but not the family. The teachers when they come to the unit, it is in the morning and they see the nurse and teach them procedures and how to use technology never get education on how to support families no they don't, during visiting time there are no lecturers here or they take the students away from the bedside during visiting times. The procedure tools used in training, they never cover anything on psychosocial support, no never nothing pertaining to psychosocial support of the family. The tools instruct you to do something for example the intubation is just the procedure which it is focused on just on the patient the drugs used. No tool covers the provision of providing psychosocial support. This is where the problem is no emphasis is placed on caring for the family psychologically; it must be part of the curriculum.

5. **_Researcher: Do you think there was any additional learning beyond your basic training on this aspect_**_?_

_Participant__:_ Yes in basic there was psychosocial support to families of patients but I think it ended there. I have done other diploma courses I cannot remember anyone focusing on the psychosocial support of the critically ill, but there was little bit on the psychosocial support of the family in education, but that it. We tend to forget about this aspect but taught about the patient who we should focus because that is our core responsibility. So I think if we are taught to talk to relatives properly, the proper way and adequately then the problems would be less so if there is any congresses conferences somebody needs to go and give the feedback to others. But there too there is very little attention on providing psychosocial support to the families. The staff needs to academically grow to improve on whatever we have and we need not only concentrate on the ICU aspect but the psychosocial support to the families. This is definitely an area that we neglect yet is an area that is very important.

Objective III

To determine the managerial support critical care nurses receive to provide family psychosocial support in the ICU.

6. **_Researcher: Is there provision available to support you in your practice of ICU to provide psychosocial support?_**

Participant: No the ICU nurses are not supported on this area yet I think it is important that they the nurses get support so that they are able to provide that psychosocial support to the families of the critically ill patients. Lot can be done but it is about money. The management must be involved but as individual we need to try to do more but definitely we need more education and support on it. We do neglect this aspect and concentrate on the patient, because we are very busy and the patients are critically ill. We have no time for the relatives and they wait for maybe a nurse or doctor to speak with them. Nurses need direction they need to know exactly what they expected of them. The only thing we was provided is this comfort room, we call families in here to deliver bad news or if doctor wants to talk about treatment. I can say in a nutshell really not much support is given to the nurses for them to be able to. There is no proper education we need this education on how to deal with it and nurses are rushing all the time they don't give time to family and added to this we are short staffed thus we cannot go and sit down with the family but we do try but not enough and we I think we don't do it the way it supposed to be done, we all do it differently but through education we can do it the way it supposed to be delivered. But as it now we have no direction like when to inform the relatives especially knowing that anything could happen.

Because the relative come in they see all this lines and go home and nobody tell you much and maybe the next time your relative is not there. There is nothing that guides the nurses to provide psychosocial support. **(*Researcher probes*): *Do in-service training, mentoring or the your individual professional development plan cater for this)?* Participant:** No it is a problem because we don't see this as an important we are very busy with the patient and all is about the patient. Even in the morning teaching this is not covered maybe we should come up with something and implementing it. We need something that we can use. Our teaching programe we need to put in these topics on psychosocial support to the families. If you have a look at the topic it it all academically orientated we never think of this psychosocial support to the families of the ICU patient because we do not see it as important we concentrate on conditions eg acute renal failure its management, ARDS it management, psychosocial support is not on our list, or even from the management level not a single in-service that included the support to nurses to provide this psychosocial support. Even at this in-service level we forget to present this as a topic or it is not done because we don't see it as important because we focus on the patient all the time and we just speak to relatives if they want to know something and even then we tend to refer them to the doctors, because nurses fail to do the psychosocial support to the family, and they prefer to let the doctors do it. But I think that the educational support is very necessary. It is lacking, yes it is lacking. In fact it is everybody even the doctors, senior staff all need to learn how to provide psychosocial support to the family.

Objective IV

In consensus with the experts, develop intervention(s) which support the critical care nurse enabling him/her to provide psychosocial support to the families of patients in the ICU.

7. <u>**Researcher: What recommendations/ interventions would you make to support the ICU nurses to provide psychosocial support to families?**</u>

Participant: The management should do team building, nurses come to this ICU just work and go home so that is stressful for ICU nurses but financial constraints may be a issue but team building would work and it is ideal to teach nurses away from the ICU environment and where they learn how to deal with such things thus this team building is important. Secondly I would also do in service and need to call in an outside speaker to come in and give the education on psychosocial support of the families of ICU patients, just to make them understand that that this environment you feel that you may not be coping, nurses themselves need to learn about exercises and diet together with how to give this psychosocial support to the families. I also think that the management should be aware that the ICU is different from the other departments because of the type of patients we have, thus their support is also very important for the ICU nurses. So maybe in ICU programmes can be arranged to like in-service training / calling in a counselor, motivation speaker. It is also about the psychosocial support to the nurses themselves so that they are able to deliver to the patients and the patient's family. Managers do talk to the nurses in the morning as we take reports about many things but not much on the psychosocial support to families. There must be someone coming to check we giving support to the relatives and how we can do it better. More could be done through the ICU course maybe if there could be a small module to be included in the curriculum just to talk about the psychosocial support of the families. I think the suggestion would be a change in the curriculum to include this aspect so that when the nurses come to the ICU they could implement to see if it is working. Thus this should start from the college it must be introduced properly to create this awareness because at basic level it is not the same because these are critically ill patients. As I am saying this is neglected we need some kind of assessment strategy to ask the families about their needs and problems. Maybe that what we should work on as well are policies, philosophy, vision and mission which we should all read. We need to be taught how to give that psychosocial support and how to cope with whatever is happening especially the stresses and all that. So I think education is needed at all levels.

APPENDIX 13.2: A TRANCRIBED INTERVIEW WITH THE ICU LECTURER
(aimed at triangulation)

Objective II
To determine the formal educational preparation of critical care nurses to provide family psychosocial support in the ICU.

1. *Researcher: Do you think psychosocial support to families of critically ill patients is important?*

Participant: Definitely, yes it is very important since we nursing a patient that is critically ill, and it is not only the patient, also attend to the family members, who are concerned about their progress and prognosis of their loved one. So this actually makes them to feel comfortable to look at the patient per se. So treating the patient holistically you might be able to identify some root causes which might be eh, eh, contributing to the patient's diseases and would be able to treat the patient (computer music goes on, participant excuses and switch it off) effectively. So and also as patient the relatives are looking forward and remember these patients you might find that the patient as never been admitted before, never been sick and now she finds himself in such a place, an unusual place the relatives so we need to orientate the relatives as far as the ventilator is concerned, all these lines you know many lines you know and the way they are complicating because sometimes you may find you know it not even easy to ask questions but we are able to we are there in order to identify any complications and allay any anxiety because they are looking forward to the family member. So you know as a patient also if you are there admitted there are lots of problems and you know we need to actually as I said you actually get the report that might be contributing to the disease and you know to make the patient and allay that anxiety and make the patient more comfortable, and I think it is very, very important to actually attending to the psychosocial aspect of the patient. (*Researcher probes*): *and the family.* *Participant*: the family is also important, as I have said you know they never been orientated about the ICU and also about the prognosis and the condition of the patient something you not going to reveal but I mean as they will be aware you need to explain to them now and again because they want to know the progress of the patient and also as far as you might find that person that patient is a breadwinner at the home you find that the family members are actually worried because they don't the outcome of everything so now you are now made to actually assist them as far as their sick leave, doctors notes which they could actually submit that to the place of employment so that the patient could get the pay and actually the patient family do not suffer .

2. *Researcher: If so what provision has your curriculum made to cover this component in the ICUs?*

Participant: Our curriculum does not really cover this aspect because our curriculum is content based. Now if you look at that we are more want to finish the condition and actually neglecting the psychosocial aspect. As lecturers you aware that each time you doing the condition you have to explain because of our experience because we have actually worked in ICU and we are aware about the family the attention to the psychosocial aspect but as far as the curriculum is concerned it does not actually cover it but I mean as lectures we know that we as lecturer be aware of it. (*Researcher probes*): *do you think that the students are missing out on this component.* *Participant*: Yes they are definitely but I mean as far as the curriculum *is* concerned as I am saying it mean as lecturers we always you know we definitely do make them aware because the relatives and the significant others are not even aware of the environment so there is fear they are being overwhelmed by the whole environment, so we actually you know do tell our learners that they also need to attend to the relatives and the significant others of this and to be aware because they are also worried because I mean not much you going to say to the patient as much as you explaining what you doing to the patient but the people that are more concerned is the relatives

because they are conscious, aware and they know exactly and they are we need to emphasize with them because they are actually feeling so it is only that you talking to the patient as you are doing but now the relatives we must never forget about them because what can I say the experience will always leave that first impression so it is important to actually attend to the relative.

3. *Researcher: Do you think more could be done? If so what? Where? And How?*

Participant: Ya there is a lot as we are saying we are not educating it is not included in the curriculum, so when we doing the curriculum review these are the things we need to included, it must be emphasized.*(Researcher probes: clinical accompaniment)* **Participant:** Clinical accompaniment hmm I am sure in that case also because when we come we are more on the task orientated and tend to forget the relatives because we tell ourselves that we come to see patients, students and not the relatives, which I think is also as lectures we are actually neglecting this though sometimes we come doing clinical accompaniment they are not there but we don't really focus in the clinically area much on the relatives. **(*Researcher probes: do you think clinical accompaniment be done during visiting times*). *Participant*:** not really because at the end you know there is going to be some you know eh eh I mean if it happens that is co- incidental you come then it means you also as a lecturer need to attend to the but because of clashing of time you won't be able to attend to the learner because you have to cover a lot of aspects. **(*Researcher probes: the assessment tools do the cover psychosocial support to the relatives*) Participan*t:*** The assessment tools they do cover the psychosocial aspect that's why I am saying the curriculum but the tools they are revamped and they actually included the psychosocial because we actually as I have said most of the patients is an underlying cause so that underlying cause we need to actually remove to eradicate to actually to make the patients what the disease as I have said some actually contribute to the patients illness. As I have said that as we are teaching the lessons it is important not to focus on the disease itself but to include the general things applying the psychosocial aspect and what impact does it have that is the social aspect and to the disease itself because as I have said it is important to look at that because we actually removing the cause the root cause. The death and dying. This is what we actually neglect. I mean as nurse we tend to deny when the patient I mean as much as the patient can see now thing are not going right what if I am not going to make we say no, no don't worry you going to be better you going to be better. So you know we never really be honest and say look as much as the life of the patient is not in our hands but we need to the critically ill patient, so anything the condition could change and anything could happen so we need to actually prepare the patient but we seem to be neglecting it actually depends sometimes on what type of nurse you are, because you may find that you are touching that aspect now and again, you always say lets pray, pray for the patient but you. Some ICU nurses are not really equipped with this skill. It depends whether or what type of person you are and play that role of spiritual care if you are also a Christian if you not you tend to neglect it and think other people going to do it . I remember when we were student nurses the spiritual care was very important because you actually to, to the extent of calling the hospital priest and they would come and actually bless the patient. But these days not sure if the still doing it we do ask the students the say there is a chaplain to be honest I don't think the actually go to that extent like we used to before. Also the ICU nurses now are more task orientated, they look at finishing a task and actually neglect these important aspect that need to actually look at the patient sometimes they feel it is a waste some ICU don't allow more people. The teaching plans in the units should include this aspect. Everybody should be aware because that how we promote the communication, communicating with patient, with the relatives. This interaction with the relative which actually makes them to gain the trust and to do whatever you can help. Nurses need to be support through in service because as much as you have the specialty, you feel you done it you need to constantly you know be reminded as an in service education whether it is ICU or not ICU patients as I have said the first impression you give to patients is important.

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APPENDIX 13.3: A TRANCRIBED INTERVIEW WITH THE ICU MANAGER (aimed at triangulation)

Objective III

To determine the managerial support critical care nurses receive to provide family psychosocial support in the ICU.

1. ___Researcher : Do you think psychosocial support to families of critically ill patients is important?___

Participant: It is very important, the support to family as they are undergoing stress, they not sure if the patient going to make it or not. As much as the patient needs the support the families also needs it. There are many problems in the way the ICU nurses render psychosocial family care. Sometime during my rounds during visiting time, the patient is surrounded by family but there is no nurse, ICU environment is very threatening with all those monitors and machine so the nurses should be with there family, to support the family and to orientate the family as to what is going on with regard the patient but sometimes I end up assisting the relatives. According to the registered nurses scope of practice or according to our socialization as nurses we are taught that the patient should be treated holistically, but with ICU nurse find it a bit of a problem in understanding the patent should be treated holistically, why I saying this when you ask about the other aspect of the patient the nurse will tell you I am looking after the patient, meaning that she is rendering patient care, but she only consider one component out the three components because she was supposed to render quality patient care, she supposed to be an educator , she supposed to be a researcher, that involves problem solving as well and administration . I think most of the time the ICU nurses are failing to put themselves in the patient or relatives shoes because more than often there will be incidents where the relatives will recall they were not treated well or the staff were showing attitude to them, the staff reporting that they were becoming impossible of which really I do not see how the relatives are becoming impossible because I take that the impossibility that is being observed is the frustration the fear of the unknown that indicates what they are going what they need is our care as health workers, so it is interpreted as relatives are impossible but I don't see it that way. I say, for example if a patient is unknown the first thing when you take over is to make sure that the relatives are traced but more than often maybe a week after as elapsed going after the ICU nurses to make means to trace the relatives, because what I know the relatives are not sleeping they going form mortuary to mortuary to look for their relatives or one hospital to another. The nurses do make means to get this patient identified then the patient will be found. You know the patient in the ICU are critically ill may change anytime may become worse , but the nurses will not phone inform the relatives to say the condition and we would like you to come over, because though they are very sick the relative are still hoping that the loved will get better. (*Researcher probes: do you think ICU nurses needed support with regards support to provide psychosocial support to families of critically ill patients?*) *Participant*: Yes I do think they need to be supported, because as I have said the psychosocial support is very, very important without the family our care is not complete sometimes we get the report from the relatives that they were not informed the change of the condition of the loved one. This indicates that the nurses do not consider communicating with the family as their responsibility. There is the lack of consciousness I must say, sometimes I find the family in the corridor crying, the family supposed to be taken to the counseling room to be counseled, we having counseling rooms that are not used, sometimes I take the relatives there to comfort them and give them water, but really I am not satisfied about the way the relatives are taken care of, sometimes.

2. <u>***Researcher: What provision is made to support the ICU nurses to empower them to provide psychosocial support to critically patients?***</u>

Participants: As I am telling you there is something wrong, in critical care units there is a waiting /counseling room for the relatives here just nearby there is a waiting area in ICU (*name of ICU omitted*) there is counseling room for the relatives ICU (*name of ICU omitted*) there is a counseling room which could be used for the relatives to wait yet the nurses will not use it. We have policies and procedures that could guide the ICU nurses. As I am sitting I should do the administration for all the units, but they are specifically employed to perform the administration at a unit level and I find that their knowledge of the policies and the procedures is lacking, so I am always going after them reminding them of the procedures and policies and sometimes you have to remind one individual more than three times of the same policy or procedure, that she should be knowing by virtue of being a manager. So there is lack of balance. I extract the policies and procedures from DOH intranet that I feel is important for them to know, I e-mail it to them, and when I ask them in a meeting setting, what is their viewpoint no one know anything about those policies, at time maybe one or two will know about it. Sometimes I do it but at the end of the day when I go back and evaluate I find that there is still lack of knowledge of it, so I really don't know how we can balance it. It may be the individuals responsibility but what I know is one needs a car to reach your destination there is a driver we cannot all drive one car there should be driver and passengers, so the other nursing staff are passengers, unit manager is the driver so in order for that mission and vision to be attained she must instill it teach her staff commit her staff make them aware explain it to them and help the ICU nurses to commit themselves. But if you look the ICU nurse is a registered nurse with a scope of practice, with roles and responsibility of which if she can balance all these that is my feeling there will be no problems

3. <u>***Researcher: Do you think more could be done? If so what? Where? And How?***</u>

*Participan*t: Looking into the training program of the nurses, basic training all aspect of patient, emotionally, psychological aspect, economic etc, is being taught , So now why in this environment in ICU you should be more on the understanding side because you have been taught. But in the ICU course this provision of psychosocial support to patient's family should be much more emphasized. I think the unit manager need to take responsibility, because they expecting the manager to do everything, but it is up to her (unit manager) to instill this awareness in her staff. You know teach people what they like to be taught, you cannot just do it routinely for the sake of having a plan. I believe that before you actually teach somebody first assess the needs, there are needs that should be expressed by the staff, there are needs as a supervisor so you must find ways how to assess them before you actually come to the programme and also what I have noticed is the programme are being driven by the unit manager I believe that there should be participative management, the staff should be involved, if not it would be the unit managers programme. The topics which are the backbone of nursing for example the scope of practice if you can ask one of the nurses what is your scope of practice nobody will tell you but it is very much important, it is critical that you know your scope of practice.