A descriptive survey of nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district

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DEDICATION

I, Ntombifuthi Jennet Ngiba, student number 211504450, declare that:

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This thesis has been examined and approved for submission

Supervisor: Prof P Brysiewicz Signed: [redacted] **Date:** 17 February 2023

Co-supervisor: Dr. Y.O Oyegbile [redacted] **Date:** 17 February 2023

DEDICATION

I dedicate this thesis to my wonderful mother, Thembekile Mokoena, for her endless love and acceptance.

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I would like to thank Jesus Christ for guiding me through each step of the way, granting me strength to complete this dissertation.

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ABSTRACT

Introduction: Family members have been found to provide valuable support in the emergency department where patients are critically ill and dependent on their loved ones (family) for decision-making and to communicate their wishes to healthcare workers. Literature documents reactions and responses of nurses to the presence of families, which appears to question their relevance in the emergency department.

Purpose: This study described the attitude of nurses regarding family importance in nursing care in the emergency departments at four hospitals, in eThekwini district, KwaZulu-Natal.

Methodology: This study adopts a quantitative, non-experimental, descriptive design and utilised the Families Importance in Nursing Care Nurses` Attitude (FINC-NA) questionnaire to obtain responses. The FINC-NA consists of 26 question items, and four subscales measured on a five-point Likert scale. Purposive sampling was used to collect data from 137 enrolled nurses and professional nurses working at the emergency department in one tertiary and three regional hospitals. Descriptive and inferential statistics were used to analyse the data.

Results: These revealed that enrolled nurses and professional nurses demonstrated supportive attitude towards families and recognised their importance in providing nursing care. The results shows that there are significant associations between the three sub-scales measured in the study. Although the family as a resource in nursing care (Fam-RNC) score was lower for nurses less than 40 years of age, p= 0.038; family as a burden (Fam-B) score was high for nurse managers and this corresponds with supportive attitude, p= 0.029; family as own resource (Fam-OR) scores were low for nurses with less than five years of working experience in the emergency department, p=0.03.

Conclusion: The study revealed that nurses generally have positive attitude towards family importance in the emergency department. However, elderly nurses and nurse managers appear to demonstrate supportive attitude to family members. These findings have significant implications for nurses to see family members as resources rather than perceived as burdens. Nurse managers should train and support nurses to demonstrate positive attitude towards family members in the emergency department.

Key words: attitudes; emergency department; family; nursing care

ABBREVIATIONS

BREC	Biomedical Research Ethics Committee
CFIM	Calgary Family Intervention Model
DoH	Department of Health
ED	Emergency Department
EMS	Emergency Medical Services
EN	Enrolled Nurse
Fam-B	Family as a Burden
Fam-CP	Family as a Conversational Partner
Fam-OR	Family as Own Resource
Fam-RNC	Family as a Resource in Nursing Care
FINC-NA	Family Importance in Nursing Care Nurses` Attitudes
ICU	Intensive Care Unit
KZN	KwaZulu-Natal
m	Mean
PN	Professional Nurse
SA	South Africa
SANC	South African Nursing Council
SD	Standard Deviation

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction and background

Families hold strong significance in the individual's life and are vital resources in times of health and sickness (Imanipour & Kiwanuka, 2020). Globally, the family holds value in its ability to be of use to both the patient and the nurse or healthcare provider caring for the patient (Hagedoorn, Paans, Jaarsma, Keers, van der Schans & Luttik, 2021). Families' presence may have a positive impact on the patient`s reaction to treatments since family can act as a buffer against patient anxiety, through support and their familiar caring (Østergaard, et al., 2020). The display of the healthcare provider's caring attitude towards the family can further enhance this (Duque-Ortiz & Arias-Valencia, 2020).

Globally, shifts have occurred in family structures and societies have re-appraised traditional concepts of who constitutes a family, leading to a re-defining of the concept of "family" (Kokorelias, Gignac, Naglie & Cameron, 2019). Traditionally, the definition of families is as:

> "Group of persons united by ties of marriage, blood, or adoption, constituting a single household; interacting and communicating with each other in their respective social roles of husband and wife, mother and father, son and daughter, brother and sister; and creating and maintaining a common culture" (Burgess & Locke, 1953, pg.7-8).

However, despite the age of the definition, reappraisals have not resulted in a generally agreed-upon definition of "family," and the definitions vary by discipline. Legally, the term family refers to a relationship that is connected through blood, custody, legal adoption, or marriage (Stych, 2019), while biological family is genetic, biological networks among people (Ionescu, 2020). Sociologically, family is a group of people living together (Erlingsson & Brysiewicz, 2015) and psychologically, family is a group of people with strong emotional ties (Umberson & Thomeer, 2020).

In Africa, disease, war, and poverty have forced the re-grouping of persons into different social networks that are defined as families (Mokomane, Roberts, Struwig & Gordon, 2019).

South Africa is no exception, where HIV/AIDS, crime, poverty, migration, COVID-19, catastrophic KwaZulu-Natal floods and the effects of apartheid pre and post 1994, have significantly shaped the family's structure, functioning and norms (Busayo, et al., 2022; Mokomane, Roberts, Struwig & Gordon, 2019).

Globally, healthcare delivery has witnessed a growing trend in the integration and involvement of the family in the care of patients, as healthcare providers have a chance to grow and build relationships with family members, thereby enhancing healthcare delivery (Emmamally & Brysiewicz, 2018; Oh, Kim, Yoo & Cho, 2018; Østergaard, et al., 2020). Studies highlight that the therapeutic nurse-family relationship has contributed to improved healthcare for patients by reducing emotional stress, and facilitating closeness and openness between the family, patient and other healthcare professionals (Duque-Ortiz & Arias-Valencia, 2020).

Additionally, a nurse-family relationship provides an opportunity to teach and involve family members in the care of the patient, which improves the safety of the patient and family satisfaction (Duque-Ortiz & Arias-Valencia, 2020). The healthcare settings with the potential to facilitate the inclusion of family-focused care is the emergency department (ED) (Emmamally, Erlingsson & Brysiewicz, 2022). In a fast-paced environment such as the ED, family plays a significant role in promoting the overall wellbeing of the critically ill patient (Emmamally & Brysiewicz, 2018).

However, as much as there are positive opportunities, the change and demand associated with the sudden admission of a family member to ED, may have negative effects on the family and render them powerless (Hoplock, Lobchuk, Dryburgh, Shead & Ahmed, 2019) Therefore, engaging with and involving family in caring for a patient in ED might empower the family to support the critically ill family member (Emmamally et al., 2022). The ED, being one of the hospital departments where additional information is often required from the family members, and most often requested to make decisions on behalf of the critically ill family member needing urgent attention, suggests that family members are relevant in achieving positive patient outcomes (Emmamally, Erlingsson & Brysiewicz, 2020).

The attitude of the nurse towards the family is important, especially in terms of how ENs and PNs engage with the family (Benzein, et al., 2008; Hori et al., 2020). In countries such as Sweden, United Kingdom, Korea, and Northern Ireland, extensive

research has examined nurses' attitude towards family's importance in nursing (Hori, et al., 2020; Oh et al., 2018; Østergaard, et al., 2020), and these studies suggest that nurses hold supportive attitudes towards families and consider the family as a support for quality nursing, allowing family collaboration and involvement in decision making ((Hori, et al., 2020; Oh et al., 2018; Østergaard, et al., 2020). Nurses believe that maintaining a good relationship with families is an important requirement for delivering care to patients and family (Cranley et al., 2021).

Although there appears to be no international guidelines on family involvement, engagement and collaboration, nurses continue to include families in the daily care of their loved ones (Mackie, Mitchell & Marshall, 2018) with studies showing nurses hold the belief that family engagement, involvement and collaboration is significant for the provision of quality nursing care (Imanipour & Kiwanuka, 2020; Østergaard et al., 2020). In Africa, there are more studies emanating from Intensive Care Units (ICUs) that encompass nurses' attitude towards the inclusion of the family, but there is a dearth of studies conducted in the ED (Imanipour & Kiwanuka, 2020; Naef, Brysiewicz, Mc Andrew, Beierwaltes, Chiang, Clisbee, de Beer, Kakazu, Nagl-Cupal & Price, 2021).

1.2 Problem statement

The challenges faced by the nurses during emergency situation (terminal and critical ill) of patients where the family who are powerless and psychological affected need to be involved in decision making during this trying times. However, the nurses should use their interpersonal relationship to educate the family of the patient in critical care settings.

In the ED, the primary goal is to assist the patient recover from life threatening conditions, hence health professionals are expected to deliver efficient care by performing several medical and technological procedures in an extremely short time (Emmamally, Erlingsson & Brysiewicz, 2020).

In the South African context, the large number of clients with life-threatening trauma, drugs, and alcohol intoxication demands that healthcare professionals are more concerned about restoration of life to the sick person rather than sharing the chaotic ED space with the family's presence (Makkink, Stein & Bruijns, 2021; Vento, Cainelli

& Vallone, 2020). This might leave the families traumatised when not informed about the health status of their loved ones. Therefore, admission of a family member to an ED is usually associated with substantial stress, role conflict, disruption of ordinary daily activities and possible variations in relations among family members (Almaze & de Beer, 2017).

Emmamally & Brysiewicz (2018), posited that the state of imbalance and the emotional turmoil that suddenly occurs within the family when a family member is admitted to the ED can be attributed to the lack of experience of acute admission in a critical care setting. The high morbidity and mortality rate associated with ED settings makes the family even more depressed and in great need of assurance, comfort, information, proximity, and overall support from healthcare providers, especially nurses (Brysiewicz & Chipps, 2017). A study of 353 families of patients admitted to ED in KwaZulu-Natal Province, South Africa, revealed that a small gap exists in family involvement in the ED and that there is a need for supportive family-focused interventions in the ED (Emmamally & Brysiewicz, 2019).

Therefore, there is a significant need to describe nurses' attitude about family importance in the ED in South Africa, since there has been inadequate research conducted in this area (Emmamally et al., 2020). The few research studies conducted in South Africa revealed there is an element of negativity in nurses' attitudes towards families, although not always captured in many studies (Emmamally & Brysiewicz, 2019). According to Cheruiyot & Brysiewicz (2019). Haskins et al. (2014), in a study conducted in South Africa, there are complaints by patients and external healthcare service users about nurses' being verbally abusive, rude and neglecting patients.

Another study conducted among professional healthcare workers in three EDs in KwaZulu-Natal showed that even though healthcare professionals working in the EDs make efforts at collaborating, involving, and supporting families, nurses` implementation is inconsistent with their practice (Emmamally & Brysiewicz, 2018). Russell (2020) posited that family-centred practices are difficult to implement consistently because they are unsuited to the ED culture, in which objectivity and detachment are significant in clinical decision-making. Slow evolution of family-centred care, lack of communication and limited understanding of family-centred care principles by healthcare professionals, including nurses, has resulted in difficulties to

implement a triad of cognitive, behavioural and attitudinal changes especially in the ED (Emmamally & Brysiewicz, 2018).

In the ED, the family is at the mercy of the nurses' attitude to provide care to the ill family member and to assist the family with the process of dealing with the sudden tragedy (Emmamally et al., 2022). Therefore, insight into nurses` attitude towards families is necessary to formulate policy, strategies and target interventions to improve family importance in nursing care in South Africa. Thus, any inconsistency in family importance, engagement, and involvement in the ED remains a gap and a problem that needs studying and addressing.

1.3 The purpose of the study

The purpose of this study is to describe the attitudes of nurses regarding family importance in nursing care in the emergency departments at four hospitals in eThekwini district, KwaZulu-Natal.

1.4 Research objectives

The research objectives of this study were:

- To describe the attitude of nurses regarding the importance of families in the ED.
- To identify factors associated with the most supportive attitude towards family importance in nursing care.

1.5 Research questions

The research questions addressed in this study were:

- What are the attitudes of nurses towards the importance of families in the ED?
- What are the factors associated with nurses' supportive attitude towards families in the ED?

1.6 Significance of the study

This study may prove to have significance for nursing in a variety of ways.

1.6.1 Nursing practice

The findings of this study will highlight what nurses currently perceive as the importance of families in the ED and this can help find ways to improve collaboration/engagement with families. Through this study, clinical nurses may be encouraged to evaluate their own attitudes and practices with families and this may serve to emphasise the importance of family nursing in the ED.

1.6.2 Nursing research

The outcome of this study will serve to contribute to a limited body of nursing research knowledge in this area, and the new information generated can possibly provide a platform for further research.

1.6.3 Nursing administration

Findings from this study may provide benchmarks for nurse administrators and policymakers on the formulation or reviewing of policies and protocols pertaining to nurses' collaboration or engagement with families in the ED.

1.6.4 Nursing education

This study may provide information regarding nurses` attitudes towards families and can possibly serve to highlight potential gaps in nurse education and provide direction to include family-focused care in nursing curriculum and training.

1.7 Operational definitions

Table 1 presents the operational definitions for the study.

Table 1. Operational definitions

Term	Definition
Attitude	Attitude is "latent hypothetical characteristic that is inferred from external observable cues" (Ajzen, 2005; Gaiseanu, 2020). In this study, attitude refers to an established manner of thinking or feeling by nursing staff about the significance of family in nursing care in the ED.

Term	Definition
Nurse	A person who has met the prescribed educational requirements for registration as a nurse in the regulations relating to the approval of and the minimum requirement of education and training of a learner leading to registration in the category of Professional Nurse and Enrolled nurse by South African Nursing Council (Government Gazette, 2020). In this study a nurse refers to a Professional Nurse and Enrolled Nurse working at the emergency department.
Emergency Department	In this study, emergency department (ED) refers to a 24-hour unit in a hospital that is staffed by medical officers and nurses who are expected to manage any presenting emergency (Meyer et al., 2018).
Family	Refers to a relationship between a group of people living together that is connected through blood, custody, legal adoption and marriage (Erlingsson & Brysiewicz, 2015; Ionescu, 2020). In this study family is who they say they are.

1.8 Conceptual Framework

The Calgary Family Intervention Model (CFIM) guided this study (Wright & Leahey, 2009). The choice of this model was because it was the first family intervention model to emerge within nursing; it has been influential in the development of family nursing globally and utilised by several researchers (Mileski et al., 2022).

The Calgary Family Intervention Model (CFIM) is an organising framework for conceptualising the connection between family dysfunction and the precise intervention offered by the nurse (Wright & Leahey, 2009). The model emphasises the importance of the family in nursing care (Mileski et al., 2022). In addition, the model focuses on the importance of nurses' attitudes and ability to provide an environment that is conducive for therapeutic conversations that are essential to promote healing and reduce the suffering associated with health problems, such as the admission of a family member to the ED (Broekema et al., 2018). Hence, the admission of a family member with acute illness results in families frequently feeling out of control and frightened as the family structure, development and functioning becomes disrupted (Emmamally & Brysiewicz, 2018).

The CFIM uses three domains of family functioning, namely cognitive, affective, and behavioural. There are different interventions that are useful in promoting, improving, and sustaining effective family functioning (Souza, 2018). Cognitive domain interventions are directed at changing the way in which the family perceives its health

problems to assist the family (Wright & Leahey, 2009; Mileski et al., 2022). The affective domain interventions are designed to reduce the intensive emotions that may hinder the families` problem solving efforts in dealing with the sudden admission of a family member in the emergency unit (Shajan et al., 2019). Behavioural domain interventions are aimed at assisting family members interact with one another (Mileski et al., 2022). These three domains of family functioning help to address the dysfunction caused by admission of a family member into the ED with the following interventions:

1.8.2.1 Commending family and individual strengths

According to Shajan (2019), when a nurse commends a family's competence, resilience, and strengths and offers them a new opinion or view of themselves, a context for change is created that allows families to view the health problem differently, discover their own solutions to problems and enhance healing.

1.8.2.2 Offering information and opinions

The offering of information and opinions from healthcare professionals is one of the most significant needs for families experiencing illness (Leahey & Wright, 2016). Therefore, nurses offering educational information is an important intervention as it comforts family members about certain aspects of the illness and which might reduce their level of stress (Duhamel & Talbot, 2004; Mileski et al., 2022).

The design of interventions for the affective domain of family functioning is to reduce or increase intense emotions that may be blocking families' problem-solving efforts (Souza, 2018).

1.8.2.3. Validating or normalising emotional responses

During a life-threatening illness, families frequently feel out of control and frightened. Therefore, it is vital for nurses to validate these emotions, and reassure and offer support to families that eventually they will adjust to and learn how to cope with the situation (Shajan et al., 2019).

1.8.2.4. Encouraging the telling of illness narratives

Nurses need to encourage family members to tell their illness narratives, stories of sickness and suffering, as well as stories of strength and tenacity (Wright & Bell, 2009). Through therapeutic conversations, nurses can create a trusting environment for open expression of family members' fears, anger and sadness about their illness experience (Sveinbjarnardottir & Svavarsdottir, 2019).

1.8.2.5. Drawing forth family support

Nurses can improve family functioning in the affective domain by helping family members to listen to each other's concerns and feelings (Wright & Leahey, 2009; Shajan et al., 2019). The nurse can be the catalyst that facilitates communication between family members or between the family and other healthcare professionals.

1.8.2.6. Interventions to change the behavioural domain of family functioning

Encouraging family members to be caregivers and offering caregiver support**.** Family members are often timid or afraid to become involved in the care of their ill family member unless a nurse supports them, and when they participate in patient care and report it makes them feel less helpless, anxious, and out of control (Shajan et al., 2019; Souza et al., 2018).

1.9 Dissertation layout

This dissertation consists of six chapters:

Chapter one presents a detailed introduction and background of family importance in nursing care especially in the emergency department, problem statement, research objectives, research questions, significance of the study to all nursing disciplines, operational definitions of terms, conceptual framework and a summary of the chapter.

Chapter two consists of a comprehensive literature review regarding family importance in nursing care and nurses` attitude globally, ED overview in South Africa, impact of an acute illness on families, family importance in nursing care and nurses` attitude in South African EDs. It also highlights the challenges associated with family importance and involvement in provision of nursing care in South Africa.

Chapter three is an introduction to the research methodology, outlining the research paradigm and design, study setting, population and sampling technique. Included in this chapter is the inclusion and exclusion criteria of study respondents, brief description of the research instrument, validity, reliability, data collection, data analysis, as well as ethical considerations, followed by a brief summary of the chapter.

Chapter four details the results, response rate, demographic information, total FINC-NA and subscales scores. Also included is a detailed description between associations, demographics and FINC-NA scale. Listed are the findings indicating

factors associated with positive attitude towards family importance, followed by a summary of the chapter.

Chapter five discusses the results and compares them to existing literature, looking at each subscale. Included at the end, is a summary of the chapter.

Chapter six highlights the summary of the research results, recommendations and limitations of the study, followed by a conclusion.

1.10 Summary of Chapter One

This chapter set the context of the study by providing an introduction and background to family importance in nursing care. It focuses on nurses` attitudes, and highlights the overview of South African EDs, as well as the emotional turmoil experienced by family members on admission of their loved ones to the ED. The background briefly elaborated on the definition of family, the importance of family in nursing care, and nurses` attitudes towards family importance in nursing.

In Chapter 2, the literature relating to nurses` attitude about family importance in the emergency department will be examined.

CHAPTER TWO: LITERATURE REVIEW

2.1 Literature search strategy

Mengist, Soromessa and Legese (2020) suggested that a literature review involves an identification and allocation of information about a topic, a systemic and thorough search of all published literature to identify significant information that is vital for a particular topic. Literature search engines used in this study include Google and Google Scholar, PubMed, EBSCO Host and ScienceDirect. Search terms included family importance in nursing, nurses' attitude, emergency department, family nursing, FINC-NA.

In this literature review, the topic that directed the literature search was family importance in the ED, nurses' attitudes, which drew results from critical care and family nursing journals. There was a scarcity of literature for South Africa, with most data sourced from European countries.

2.2 Introduction to family nursing

Nursing includes autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings (Luttik, 2020). This definition assigns family as a part of a nurse`s professional responsibility (Luttik, 2020), and the attitudes of nurses becomes significant when interacting with family members. Nurses can no longer overlook the needs of families, as families have become a vital partner in patient care (Kim, Oh & Son, 2020). Providing support to family members requires new competencies from nurses as they often talk to families about complex care situations and complicated family circumstances (Emmamally & Brysiewicz, 2019). Therefore, nurses need sufficient knowledge and skills about how family structures and processes work within families, as the future healthcare will depend more on the family (Luttik, 2020).

2.3 The concept of family

Conventionally, the definition of family is a group of individuals connected by blood, marriage or adoption, mainly centred on married couples, their dependents, and relatives. However, non-traditional families, including groups of individuals connected by neither blood, nor by marriage, exist and their numbers are increasing globally

(Child Trends, 2013; Kokorelias, Gignac, Naglie & Cameron, 2019). Family as an institution is extremely difficult to define as it is constantly in transition and never static (Smock & Schwartz, 2020). Demographic changes are evident globally in all aspects of society, and the concept of family is evolving with them (Lesthaeghe, 2020). The inability of family to remain static has resulted in several redefinitions of the concept "family," generally not agreed upon, and the definition varies according to disciplines (Smock & Schwartz, 2020).

In South Africa, family transformation has resulted in decorative family formations that had an impact on family functioning (Mutanda & Odimegwu, 2019). The role of extended families has diminished, replaced with new forms of support such as churches and neighbours` networks (Mokomane, Roberts, Struwig & Gordon, 2019). Several factors, such as COVID-19, reduction in fertility rate, changes in nuptial patterns, urban migration, high unemployment, HIV and AIDS, and the growing acceptance of alternative forms of domestic partnerships, have significantly changed the family structure in South Africa (Department of Social Development, 2021).

South Africa now celebrates a diversity of family structures, such as single mothers, non-related caregivers, guardians and reconstituted families, that goes beyond ties of blood, marriage, kinship and legal arrangements but originates from other social connections and identity ties (Mkhwanazi & Manderson, 2020). Marriage rates in South Africa are amongst the lowest globally as people choose to cohabitate (Department of Social Development, 2021). Nuclear families are the least common family form in South Africa as single parents, predominantly females, head many families (Mkhwanazi & Manderson, 2020). There are also polygamy family structures recognised in South Africa and form the basis of many families.

The HIV/AIDS pandemic contributed to the tremendous growth of child-headed households (Mokomane, Roberts, Struwig & Gordon, 2019), which results in family members finding support outside biological ties. Poverty and sickness have increased neighbourhood social ties (Simon & Khambule, 2022). Families are disaggregating along economic, gender and age fault line, thus changing family structures and functioning (Kokorelias, et al., 2019).

The common view on the changing family structure in South Africa is that the family`s ability to care for and protects its vulnerable members, namely children, the elderly

and the critically ill is significantly challenged (Department of Social Development, 2021). Lack of finances seems to be the main impediment to adequate family functioning in South Africa (Friedline, Chen & Morrow, 2021). High unemployment rate, strain on healthcare system and poverty, associated with COVID-19, has left South African families suffering and unable to care for themselves (Van der Berg, Patel & Bridgman, 2021). The care of orphans, the elderly, and the ill has been a widespread concern in policy documents and popular discourse (Hall & Sambu, 2019; Hall, & Mokomane, 2018).

The emerging family structures produce household units that have weak capabilities to support the care and welfare of family members under different circumstances (Makiwane, et al., 2017). This makes the family an integral part that needs care, especially healthcare. Although there are differences in the definition of family, family relationships other than marriage and marriage-like partnerships are critical for health across the life course globally (Woods, Bridges & Carpenter, 2020). Therefore, despite the variation and constant changes in family structures, family remains central to the organisation of society and health (Luttik, 2020).

2.4 Family importance in nursing globally

The need for urgent critical care due to acute illness, injuries, and the outbreak of the novel coronavirus disease-2019 (COVID-19) and the survival from critical illnesses are gradually increasing, and this has resulted in the expansion of critical care settings globally (Arabi et al., 2020). Globally, traumatic injuries account for approximately 5.8 million deaths per year, the leading cause being traffic crashes, homicide and suicide (Baru, Weldegiorgis, Zewdu & Hussien, 2020) Consequently, this has increased the number of patients requiring emergency care, resulting in a huge number of families presenting in EDs and ICUs (Imanipour & Kiwanuka, 2020).

Therefore, since more nurses encounter families, it is vital for them to recognise the importance of family as a unit in care provision (Emmamally & Brysiewicz, 2018). Nurses need to demonstrate a positive attitude when involving the family in care planning, direct delivery of care, providing psychosocial and informational support, collaborating and engaging with families (Nielsen, Egerod, Hansen & Angel, 2019).

In recent years, patients have been included as partners in their own care, however, this is not always possible because most of the patients that present in the ED are usually critically ill, sedated, have impaired Glasgow coma scale (GCS) and intubated (Emmamally et al., 2022). This results in the family having to make decisions on behalf of the patient who is critically injured and too ill to make decisions and communicate their wishes (Østergaard et al., 2020). This serves as evidence that family is significant in care-provision, as they play a vital role in promoting the psychological well-being of the critically ill patient through their caring, support and presence (Imanipour & Kiwanuka, 2020).

By effectively representing a critically ill patient, family members might reduce the patient`s unnecessary or prolonged stay in the ED, thus improving the patient`s outcome and quality of life (Duque-Ortiz & Arias-Valencia, 2020). Family collaboration, engagement and support are extremely imperative in nursing because family can be utilised as a resource by nurses in ED (Luttik, 2020). There is usually good narration of vital information, such as medical and surgical history, and mechanism of injuries, by the family or bystanders. Such history is significant and plays a huge role in the emergency management of critically ill patients that present in the ED. Additionally, family is important in nursing as it assists with easing the workload, giving nurses a sense of security and job satisfaction (Hori et al., 2020).

Family is important in nursing, being a conversational partner, the nursing staff can communicate with families about patient care (Imanipour & Kiwanuka, 2020; Østergaard et al., 2020). In the ED, critically ill patients often experience deterioration in health status, making it essential for the nurse to communicate such changes with the family. This includes planning next level of care for the patient together with the family (Emmamally & Brysiewicz, 2019). Involving the family members during the first contact of care, especially in the ED, saves time in future work (Østergaard et al., 2020). Therefore, it is significant for the nurse and the family to establish a reciprocal non-hierarchical relationship, which places family as an integral part of care-provision in the ED (Hori et al., 2020).

2.5 ED overview in South Africa

EDs are characteristically a 24-hour service run by medical officers and nurses who have to manage any presenting emergency (Meyer, Meyer and Gaunt, 2018). The

vital task of EDs in South Africa is to offer safe emergency healthcare to all in need, while adopting a fast, caring, cost-effective approach (Afaya, Bam, Azongo, Afaya, Yakong, Kpodo, Kaba, Zinle, Tayuu, Asantewaa & Adatara, 2021). South African government hospitals are underfunded, understaffed, and poorly resourced, contributing to the major pressure under which EDs operate (Afava et al., 2021). The ED deals with South Africa`s quadruple burden of disease (maternal, new-born and child health; HIV/AIDS and tuberculosis (TB); non-communicable diseases; violence and injury) and a high risk of workplace violence (Taljaard, Maharaj & Hendrikse, 2022).

The nursing staff serves on the frontline and often experience challenges of overcrowding, inadequate resources, and operational disorganisation (Afava et al., 2021). The ED environment is hectic, stressful, and frightening, with buzzing alarms, flashing lights and advanced equipment (Connolly, Jacobs & Scott, 2018); therefore, the ED environment can be overwhelming for the nurse, patient, and the family (Emmamally, Erlingsson & Brysiewicz, 2022). Additionally, the ED is associated with high mortality rates, as one in five patients in EDs do not survive (Zaidi, Dixon, Lupez, De Vries, Wallis, Ginde & Mould-Millman, 2019). In South Africa, the mortality rate of road traffic injuries is double the global rate and trauma mortality rate is six times higher (Almaze & de Beer, 2017; Zaidi et al., 2019). Despite the hectic overview of South African EDs, nurses have the duty to provide care to the sick person, as well as an environment that is conducive for family support, engagement and collaboration.

2.6 Impact of an acute illness on families

According to Emmamally and Brysiewicz (2018), critical illness and traumatic injuries occur suddenly, leaving the patient and their family insufficient time to prepare themselves physically, financially, and psychologically for the event. The admission of a family member into a fast-paced environment such as ICU and ED, along with high technology machines used therein, results in the family experiencing feelings of stress and anxiety (Emmamally & Brysiewicz, 2019).

Sudden admission of a family member into an ED is unexpected, and the family faces the likelihood that their loved one may die or be severely disabled (Emmamally & Brysiewicz, 2018). This makes it extremely difficult for the family to cope with the situation and results in the family experiencing an additional emotional turmoil

(Imanipour & Kiwanuka, 2020); these psychological repercussions could relate to the family`s lack of experience with such an event. It becomes a traumatic experience for the family because admission of their loved one into an ED can result in role conflict, extreme stress, interruptions of normal routines and changes in relationships amongst family members (Emmamally & Brysiewicz, 2018).

Additionally, the family has exposure to more stress and trauma when they see their critically ill family member experience pain and suffering, deterioration in condition and the high technology equipment the critically ill patient is connected to (Minton, Batten & Huntington, 2018); this leads to the family experiencing shock, anger, fear, anxiety, guilt, frustration, and depression (Minton, et al., 2018). Since family is extremely important in nursing, it is the responsibility of the frontline nurse to create an empathetic environment for family members of patients admitted in ED, by acknowledging their feelings, thoughts and needs, and having positive attitude when implementing interventions to reduce family stress levels (Imanipour & Kiwanuka, 2020).

2.7 Family importance in ED in South Africa

Accidental injuries, assault and transport accidents are the leading cause of non-natural cause of death in South Africa (STATS SA, 2018). In 2018, KwaZulu-Natal had the highest proportion of deaths due to non-natural causes (STATS SA, 2018). In South Africa most of ED admissions are due to traumatic injuries; approximately three-quarters of South Africans experience a traumatic event and under half experience trauma, or the unexpected death of a loved one (Lourens, Parker & Hodkinson, 2020). The incidence of trauma in South Africa is estimated to be 750 000 cases per year (STATS SA, 2018). Therefore, the emotional turmoil thrust upon South African families in the event of the sudden traumatic injury to a loved one is debilitating (Emmamally & Brysiewicz, 2019). Making the family dependent on the nurse in the ED is not only to provide acute care to their loved one but also to walk them through the process of dealing with their current crisis (Imanipour & Kiwanuka, 2020).

Family collaboration and engagement throughout the illness trajectory of patients suffering from acute conditions has received increasing focus from South African researchers (de Beer & Brysiewicz, 2019). In South Africa, family involvement in nursing is crucial as it ensures patient safety (Emmamally & Brysiewicz, 2018) and

contributes to a better course of treatment because the family can help remember vital information and discuss decisions with the patient, nurse and the doctor (Østergaard et al., 2020).

Vulnerable people, such as children, elderly and mental health care users` needs cannot be managed effectively without the involvement of family in the ED (Li, Srasuebkul, Reppermund & Trollor, 2018). For these vulnerable groups, family is important to give history to the nurse, listen to current management, make decisions and sign consent on behalf of the patient (Emmamally & Brysiewicz, 2018); this makes family important in nursing, especially in the ED where most patients who present there are critically ill, unable to communicate and dependent on their loved ones (family) to make decisions and communicate their wishes to healthcare workers (Østervang, Lassen, Øelund, Coyne, Dieperink & Jensen, 2022).

Zaidi et al. (2019) posited that South African EDs deal with the highest trauma load in the world and deal first-hand with South Africa`s quadruple burden of disease (communicable diseases, non-communicable diseases, injuries and HIV/AIDS). Therefore, for patients who present in South African EDs, mechanism of injury is not the only history required from family members, as vital information, such as medical history and significant information surrounding the onset of illness, is crucial (Li, Srasuebkul, Reppermund & Trollor, 2018). Thus, family is important in enduring the continuity of care even when the patient leaves the emergency department, as the family will be at home to ensure their loved one adheres to the medication and follows the discharge plan.

2.8 Challenges associated with family importance and involvement in care.

There are challenges experienced by nurses and other healthcare professionals that makes it difficult for family engagement and collaboration in South Africa (Emmamally & Brysiewicz, 2018). Caring for ED patients and relatives in Africa is extremely difficult, as nurses must treat the trauma patients and the disease burden (Zaidi et al., 2019). This poses a challenge to the family involvement in nursing, as nurses face challenges that make it extremely difficult for them to function effectively. The following challenges make it difficult to involve families in nursing care:

Inadequate preparation for ED role, sometimes nurses allocated to work in ED do not receive sufficient preparation and training (Afaya et al., 2021). Emergency care has extreme stress, quick changing scenarios and nurses must be competent and function as a large medical team (Huang & Wang, 2020); therefore, preparation is necessary.

Another challenge is verbal abuse directed at ED nurses from relatives or family members (Aljohani, Burkholder, Tran, Chen, Beisenova & Pourmand, 2021). Studies revealed that family members are sometimes unappreciative, rude and insulting to nurses (Alsharari, Abu-Snieneh, Abuadas, Elsabagh, Althobaity, Alshammari, Alshmemri, Aroury, Alkhadam & Alatawi, 2022). The level of workplace violence for nursing remains high even with the trend of under-reporting (Aliohani et al., 2021). Research has identified patients and their families as the largest perpetrators of violence towards nursing staff (Alshmemri et al., 2022), resulting in ED nurses avoiding families and viewing them as obstacles that hinder provision of emergency care to the critically ill patient. Lack of human resources, limited space and overcrowding in ED also contributes to poor proximity, support, communication, engagement and collaboration with family members (Emmamally &Brysiewicz, 2019), thus placing the nurse and family in vulnerable positions.

Problem-based care is also a barrier to family engagement, collaboration and involvement in nursing (Emmamally, Erlingsson & Brysiewicz, 2019). In the past two decades, problem-based learning has been applied in nursing specialties, such as paediatric nursing, fundamentals of nursing, medical-surgical nursing and technical skills in nursing (Huang & Wang, 2020). Problem-based care views the patient as single individual with the aim of identifying and solving problems, leaving no room for family engagement, support, collaboration and involvement. The delivery of care is personal in nature and propelled by nurses; the basis is mainly the nurse collecting and analysing patient data, and formulating a nursing diagnosis (Huang & Wang, 2020).

Additionally, critical care nurses' stress levels can also be threatening and negatively affect the acceptance of family's importance in nursing. Nurses working in critical care settings face exposure to unfriendly lighting, annoying noises, awkwardly placed equipment and overcrowding (Afaya et al., 2021; Emmamally et al., 2022). Budget cuts that result to limited resources, space and staff shortages that make it difficult for

nursing care to go beyond the patient and extend to family (Emmamally & Brysiewicz, 2019).

Other barriers and challenges include communication challenges, unrealistic expectations of patient's families, inappropriate treatment decisions and healthcare professionals being less truthful about patient's prognosis (Emmamally et al., 2020). This makes it extremely difficult for nurses to view family as an integral part and may result in the nurse perceiving family as an obstacle to emergency care (Brysiewicz & Emmamally, 2017).

However, it is mandatory for the nurse to possess the vital skill of dealing with stressors concurrently while providing quality care to the critically ill patient and devastated family (Imanipour & Kiwanuka, 2020; Emmamally & Brysiewicz, 2019). Despite the challenges, it is imperative for the nurse to navigate and fulfil his/her role and that includes identifying and understanding each family's needs, making the attitude of the nurses extremely important when interacting with and assisting families.

The increasing encounter of nurses with patients and their families in distress highlights the need to avoid perceiving patients as single individuals but rather view patients and their families as a unit that is entitled to receive care and assistance from healthcare workers (Nielsen et al., 2019; Emmamally & Brysiewicz, 2018). Therefore, nursing staff must be ready to meet patients' families, acknowledge their presence and include them in the unit of care, since quality of care for individual patients and families is influenced strongly by the attitude of nursing staff (Linnarsson et al., 2015; Emmamally & Brysiewicz, 2018).

2.9 Nurses' attitudes towards family importance globally

For high quality nursing care to be achieved, nurses need to have positive attitude towards families (Østergaard et al., 2020). Nurses' attitudes towards families affects their behaviour towards families, quality of care and patient outcomes (Mackie et al., 2018). The importance of involving family in nursing care is gradually increasing (Hagedoorn et al., 2018). Globally, the significance of supporting and involving both patients and their family members continues to be explored in different settings, such as ICU, cardiac units and paediatric units (Imanipour & Kiwanuka, 2020; Østergaard

et al., 2020; Broekema et al., 2018; Luttik, 2020; Ribeiro, Sousa, Santos, Silva & Sousa, 2018; Oh, Kim, Yoo & Cho, 2018; Hetland, McAndrew, Perazzo & Hickman, 2018).

Nurses are key professionals who can meet the needs of families and offer support during critical and difficult experiences (McAndrew, Schiffman & Leske, 2019). Nurses' attitudes towards family importance in nursing care is extremely crucial and affects their willingness to interact with and involve family in nursing care (Østergaard et al., 2020). Research shows that nurses hold positive attitudes towards family importance and involvement in care (Imanipour & Kiwanuka, 2020; Østergaard et al., 2020; Broekema et al., 2018; Luttik, 2020); nurses perceive families as an extremely important resource and part of their work, and postulate that it is vital to establish a good relationship with family (Hagedoorn et al., 2018).

Deciding to involve family in provision of care could address some emotional responses and developing support systems for families (Naef et al., 2021). Nurses consider families vital when organising treatment and establishing a holistic view of care (Naef et al., 2021). Nurses further verbalised that the needs of patients and families guide the engagement of nurses and families (Brysiewicz & Emammally, 2019).

Nurses' attitude towards family importance in nursing has been studied in different settings, such as paediatric units in Italy and Canada, surgical and psychiatric care in Iceland, critical and emergency care in Scotland, Iceland, Saudi Arabia and Sweden, general nursing in Sweden and the United States of America and cardiovascular care in Belgium (Angelo et al., 2014; Caty, Larocque, Koren, 2001; Blöndal et al., 2014; Sveinbjarnardottir et al., 2011; Hallgrimsdottir, 2004; Al Mutair, Plummer, Paul O'Brien & Clerehan, 2014; Linnarsson et al., 2015; Fisher et al., 20118; Saveman, Måhlén and Benzein 2005; Luttik et al., 2017). The above studies reveal nurses' hold positive attitudes towards family importance with differences for demographic variables, such as age, gender, length of experience and educational level (Hori et al., 2020).

However, some studies revealed younger nurses with minimal work experience hold limited positive attitude towards involving family in nursing care, as nurses often verbalise challenges and insufficient knowledge in how to work with families (Østergaard et al., 2020; Lueng et al., 2017). Primarily, the nurse-family relationship

power is nurse-driven, however, when families challenge nurses' authority and control nurses tend to feel disempowered and avoid interacting and engaging with families (Naef et al., 2021). Less supportive attitudes towards families arise in nursing care whennurses find it difficult to meet families from foreign cultures, and deal with demanding, troublesome, or suffering families (Konradsen et al., 2022). Nurses stationed in critical care settings believe medical and technical tasks are more important, and if they involve families, it will take too much time, thus delaying delivery of urgent medical tasks (Keil, Van Der Wege & Drees, 2019; Rubio-Navarro, García-Capilla, Torralba-Madrid & Rutty, 2020).

2.10 Nurses' attitudes about family importance in South Africa

The complexity of ED makes it a challenging setting for nurses to collaborate and engage with families (Emmamally and Brysiewicz, 2019). In developing African countries, nurses struggle with overcrowding, lack of resources, limited space, prioritising emergencies, linguistic and cultural diversity, and have little time to collaborate and connect with families (Emmamally et al., 2020). Due to this, nurses may try to avoid high-levels of physical and emotional demands, resulting in family members feeling neglected and avoided (Brysiewicz & Emmamally, 2017).

However, a study conducted by Emmamally et al. (2020) elicited that healthcare providers working in ED perceived a collaborative relationship with families as important despite the high patient volumes and limited resource entailed in the ED. Another study conducted in the ED in KwaZulu-Natal, South Africa, revealed nurses treat families in a dignified and respectful manner (Emmamally & Brysiewicz, 2018). Respect and dignity are extremely important in promoting good partnership and engagement with families (Duque-Ortiz & Arias-Valencia, 2020). An earlier study posited that nurses described an authentic intention of providing care with the purpose of promoting physical, emotional, and psychological wellbeing of the mother and child (North, Leonard, Bonaconsa, Duma & Coetzee, 2020). Therefore, nurses' practices and attitudes appear to facilitate family involvement successfully (North et al., 2020).

In contrast, even though healthcare professionals working in the EDs make an effort to collaborate, involve, and support families, their implementation of family collaboration, involvement and support is inconsistent with their practice (Emmamally & Brysiewicz, 2018; Luttik, 2020). A study conducted in KwaZulu-Natal revealed a

“cold reception” of family members by the ED staff (Brysiewicz, 2006). This study described ED healthcare workers, including nurses, as unsympathetic and uncaring (Brysiewicz, 2006). Reportedly, healthcare workers do not always use practices that encourage family participation and decision-making in the ED (Emmamally & Brysiewicz, 2018). Additionally, a study conducted in two state and one private hospital in KZN concluded that overall support from healthcare professionals in the ED, as perceived by families, was lower in comparison to other international studies (Emmamally & Brysiewicz, 2019). This indicates a gap in family support and family involvement in ED and the need to view family as important in nursing care provision.

Therefore, in acknowledging the significant role played by family in positive patient outcome, nurses are compelled to ethically and morally engage, collaborate, and involve families in healthcare (Brysiewicz & Emmamally, 2018). The perception of families should be as enablers to care especially in the ED (Almaze & de Beer, 2017; Brysiewicz & Emmamally, 2017).

2.11 Summary of Chapter Two

Chapter Two reviewed literature on the concept of family including its structures, functions, and socioeconomic characteristics, the emergency department environment overview and the challenges associated with involving families in care. Also discussed were the impact of an acute illness on the family, and family importance in nursing globally and in South African EDs. Documented were challenges associated with family involvement in nursing care in South Africa, and nurses’ attitudes towards family importance in nursing globally and in South Africa, focusing in KZN.

CHAPTER THREE: METHODOLOGY

3.1 Research paradigm and design

The positivist paradigm underpinned this study (Coleman, 2019). Positivism assumes that reality happens freely of humans, and attempts to understand the social world, such as the natural world (Rehman & Alharthi, 2016; Kumatongo & Muzata, 2021). The methodology of positivists tries to clarify relationships between variables usually using quantitative methods, including standardised measures and statistical techniques to observe the world objectively (Gemma, 2018). The ontology is that of realism with the epistemological position of objectivism (Coleman, 2019). There was a standardised questionnaire used to achieve this. This study used a quantitative, non-experimental, descriptive design. According to Bloomfield and Fisher (2019), the design of descriptive studies is to gain more information about characteristics in a field of study and their purpose is to deliver a picture of a situation as it happens naturally. Siedlecki (2020) posited that to answer a research question of “What is?” - a descriptive design is adequate.

3.2 Study setting

The study took place in four selected EDs in eThekwini district in KZN. Hospital A is a government hospital that is both regional and tertiary. Hospital B is a government hospital categorised as both regional and district level hospital, serving the population of inner and outer west of Durban. Hospital C is a government hospital, regional and district level, on the south coast of Durban. Hospital D is a regional government hospital. These selected hospitals provide health services at district, regional and tertiary level to rural, city, and informal dwelling populations. These hospitals serve at a regional and district level, and families accompany their sick relatives whether they were referred or for sudden admissions to the ED.

The purposeful selection of KwaZulu-Natal was because it has more than 19% of the South African population. Additionally, KwaZulu-Natal is a “hot spot” for trauma and violent cases; it had more than 500, 000 emergency medical services (EMS) call outs for trauma cases (Pule, 2021). In 2018, KwaZulu-Natal had the highest proportion of deaths due to non-natural causes (STATS SA, 2018). The purposeful selection of

Durban was because it is one of the primary spatial clusters of high trauma caseloads in KwaZulu-Natal (Pule, 2021). The selection of Hospitals A, B, C and D was because regional hospitals have the largest load of trauma admitted (Lutge et al., 2016), thus these are busy EDs with large numbers of patients presenting daily.

3.3 Study population

Na'Iya, Aminu, Rabiu, Nalado and Abubakar (2021) posited that it is impossible to focus on an entire population due to its size. Therefore, it is extremely essential for the sample to be like the population in significant aspects. According to LoBiondo-Wood & Haber (2021), population refers to an entire collection case that the researcher is interested in. The population of this study consisted of 170 ENs nurses and PNs working in the four selected EDs. The total population was 30 nurses from hospital A, 36 nurses from hospital B, 48 nurses from hospital C and 56 nurses from hospital D.

3.4 Sampling and sample size

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (LoBiondo-Wood & Haber, 2021). This study used purposive sampling. Purposive sampling refers to selective sampling, where the researcher intentionally selects certain respondents, events, elements, or incidents to include in the study (Campbell, Greenwood, Prior, Shearer, Walkem, Young, Bywaters & Walker, 2020).

The purpose of this study was to describe the attitude of nurses regarding family importance in nursing care in KwaZulu-Natal. The Family Importance in Nursing Care Nurses' Attitude (FINC-NA) questionnaire, consisting of 26 items, uses a 5-point Likert scale for responses, and the mean score used as the summary of statistics. According to Blondal et al. (2014), the average score of the FINC-NA questionnaire is 80 SD (10). Therefore, with the assistance of the statistician, the above was a baseline estimate. A sample size of 90 nurses was required to estimate the mean score to plus or minus three points (77-83), with 95% probability of including the true mean; if the non-response rate was 15%, the number of nurses targeted would be 106 to achieve the required sample size.

3.4.1 Inclusion criteria

According to Campbell et al. (2020), inclusion criteria refer to characteristics that a subject or element must possess to be part of the target population. In this study, all ENs and PNs working at the ED, who were willing to participate, were included in the study.

3.4.2 Exclusion criteria

Exclusion criteria are characteristics that can cause the exclusion of a subject or element from the targeted population (LoBiondo-Wood et al., 2021). The exclusion criteria were all nurses not qualified as ENs or PNs, and any ENs or PNs who were unwilling to participate in the study.

Table 2: Distribution of the population and the sample size

Hospital	Sample size	Percentage of the population	Sample size response	Percentage of sample size response
Hospital A	30	17.7	19	13.9
Hospital B	36	21.2	33	24.1
Hospital C	48	28.2	35	25.5
Hospital D	56	32.9	50	36.5
Total	170	100	137	100%

3.5 Research instrument

This study used The Families' Importance in Nursing Care – Nurses' Attitudes (FINC-NA) (refer to Appendix 3). The FINC-NA questionnaire is a 26-item scale, developed by Benzein and colleagues (2008). The tool has been used to measures nurses' attitude regarding the importance of families' presence in nursing care. The FINC-NA tool has been used in several studies in Sweden, Denmark, Japan, Uganda, Korea, Ontario, Canada, Hong Kong, and China, and was found reliable and valid (Benzein et al., 2008; Cranley et al., 2021; Gusdal et al., 2017; Hori et al., 2020; Østergaard et al., 2020).

Demographic characteristics include year of birth, gender, nurse qualification (ENs or PNs), year of qualification as a professional/enrolled nurse, and the name of healthcare setting. The FINC-NA has four subscales, namely Family as a Resource in Nursing Care (Fam-RNC), Family as a Conversational Partner (Fam-CP), Family as a Burden (Fam-B) and Family as its Own Resource (Fam-OR). The scoring of the FINC-NA instrument response uses a five-point Likert scale (5-Strongly agree, 4-Agree, 3-Neutral, 2-Disagree, and 1-Strongly disagree). The score ranges from 1 to 5 for each item and then from 26 (lowest) to 130 (highest) for the whole instrument. Regarding the scoring of the instrument, the higher the score the more supportive the nurse's attitude is toward families (Benzein et al., 2008).

The research instrument is further divided into four subscales with scores, i.e., Family as a Resource in Nursing Care (Fam-RNC) with a score range 1 to 50, Family as a Conversational Partner (Fam-CP) - score range 1 to 40, Family as a Burden (Fam-B) score range 1 to 20, and Family as its Own Resource (Fam-OR) - score range 1 to 20 (Saveman et al., 2011). Family as a burden (Fam-B) subscale consists of four negatively worded items, including the "*presence of family members makes me feel that they are checking up on me; the presence of family members holds me back in my work; I do not have time to take care of families; the presence of family members makes me feel stressed*". All the Fam-B subscale items were reverse scored.

According to LoBiondo-Wood et al. (2021), a structured questionnaire is the most appropriate tool to collect data because it is inexpensive and quick to use if one is collecting data from a large sample. A questionnaire is an ordinary tool not affected by the mood of the researcher or interviewer, and it is easy to check instrument validity. The research objectives, conceptual framework and literature guided the choosing of this instrument. The researcher obtained approval from the authors to use the instrument (refer to Appendix 10).

3.6 Data collection process

The Biomedical Research Ethics Committee (BREC) and KwaZulu-Natal Provincial Health Research Ethics Committee (PHREC) granted full ethical approval on the 4th of October 2021 (refer to Appendices 4 and 5). Gatekeepers' permission was obtained from four hospitals' management (refer to Appendices 6 to 9). There were emails and

telephone calls made to personal assistants of nursing managers about planned dates to visit the hospitals, followed by meet and greet meetings with the nursing managers in the study settings. Nursing managers facilitated the introduction to operational managers of the EDs and agreed on days appropriate for data collection. On the data collection days, the researcher spoke to ENs and PNs to explain the research projects.

There were four hospitals visited in one day, therefore, meeting the nurses happened at different intervals, which were during the morning briefing for hospitals B and C, teatime for hospital D, and lunch time for hospital A. The data collection process began on the 19th October 2021 for hospitals A, B, D and 2nd November 2021 for hospital C. The majority of night shift staff met after the morning handover, but to ensure more coverage of staff, the researcher had to work hand-in-hand with team leaders and unit managers to explain the research projects to the night staff members who were willing to participate.

The boxes were labelled appropriately; box 1 contained the completed questionnaires, and box 2 contained the completed informed consents with information sheet both boxes only permitted participants to put the questionnaire into it, not take out.

The researcher visited the EDs of selected hospitals after she had obtained permission from their operational managers. There was an explanation on the information sheet (document outlining the research) to respondents, declaration of consent obtained, and research questionnaires handed to the respondents. Data collection mainly occurred early in the morning to accommodate both day and night staff. Adjusted level one COVID-19 protocols were followed, which included wearing of masks, social distancing, and sanitisation, as well as washing of hands. The collection of the completed questionnaires occurred on the day the researcher visited the hospitals.

All these data collection instruments were near to the nursing station to allow easy access and to ensure that no one manipulates or throw the boxes away. Operational managers and team leaders were informed about the study, who in turn informed nurses who were not present when the researcher visited the institution, for example those on night shift, sick leave, annual leave or probably attending conferences or meetings. Therefore, the collection of data was from the 19th October 2021 until the 5th January 2022. After de-identifying the questionnaires with codes and numbers, data was entered into the SPSS software, version 27. Hard copies of all documents

utilised for data collection were enclosed in A4 envelopes, sealed and locked away, with only the researcher having access.

3.7 Data analysis

With the assistance of a statistician, the researcher developed a codebook to code the responses, and then entered into SPSS software. 137 questionnaires were completed and returned. Descriptive statistics was utilised to describe the demographics (frequencies for categorical variables, appropriate measure for central tendency i.e., mean (*m)* and standard deviation (*SD*) for numerical variables such as age and total subscales score) with the assistance of a statistician. The calculation of the total scores was by adding up the scores for the questions in that subscale and then the total of all the questions. The demographic variables assisted with identifying factors associated with attitudes regarding family importance in nursing.

The non-parametric statistics were tested for differences in attitude between subscales. A Kruskal-Wallis test calculated differences between the four subscales. The Mann-Whitney *U* test analysed the two subscales comparison. Family as a burden subscale (Fam-B), containing four negatively worded items was reverse-scored before analysis with a possible score range between 1 and 20; higher scores indicated a supportive attitude, i.e., perceived family less of a burden. The researcher selected to merge unit managers with PNs because according to the SANC, unit managers are captured as PNs. The categorisation of age was according to SANC annual reports. For adequate comparison, total scale and subscales (Fam-RNC, Fam-CP, Fam-B, Fam-OR) were converted to percentages because the questions were different. The following, including Master's degree, PhD, Emergency and Critical care nursing combined, were cleared from SPSS dataset as there were no respondents who reported having them.

3.8 Validity and reliability

Grove and Gray (2019) defines validity as the intensity to which a research tool measures what it is intended to measure. This study used the (FINC-NA) tool, developed in 2008, with a refinement and psychometric re-evaluation of the instrument occurred in 2011 (Maaskant, van Wessel, Seller-Boersma, Jongerden Paulus &

Eskes, 2022). The instrument has been found to be valid and reliable for clinical and research purposes (Imanipour & Kiwanuka, 2020). The FINC-NA satisfied content validity on development and the Cronbach's α for reliability of all items.

The manipulation of demographic data to match the South African context determined the validity in this study. To achieve content and face validity, there was a one-hour Zoom meeting arranged with the research supervisor, an expert in trauma/emergency nursing and family nursing, on the 8th of June 2021 at 14:00 hours. After a discussion of the questions, the conclusion was that the questions asked by the research instruments yielded answers to the research questions and objectives and were in line with the conceptual framework and literature review.

Table 3. Content validity

Research objective	Research question	Instruments` questions
Describe the attitudes of nurses regarding the importance of families in emergency departments of four hospitals in Kwa-Zulu Natal	What are the attitudes of nurses towards the importance of families in the ED?	Q 2,3,4,5,7,8,9,10,11,12, 13,14,15,16,17,18,19,20 21,22,23,26
Identify factors associated with the most supportive attitudes towards family importance in nursing care	What factors are associated with nurses' supportive attitude towards families in the ED?	Demographic data questions Q 1, 6,24

3.8.1 Reliability

The reliability of a research instrument denotes the consistency in measuring targeted attributes in a study (Grove et al., 2019). According to Fain (2020), reliability is concerned with accuracy, reproducibility, and comparison of measurement methods. To evaluate the internal consistency of the instrument, this study utilised the Cronbach`s alpha coefficient method to measure reliability (Grove et al., 2019); the Cronbach's α for the reliability of the factor dimensions ranged from .73 to .87. The

study used the revised instrument since it showed greater reliability than the original instrument (Cranely et al., 2022).

Imanipour and Kiwanuka (2020) also utilised the revised version of the instrument in their study titled, “Family Nursing Practice and Family Importance in Care Units: Perspectives of Nurses Working in Intensive Care Units in Uganda”. In the study Imanipour and Kiwanuka assessed the FINC-NA scale and obtained a Cronbach`s $\alpha$ of 0.864. For this study, the results of the Cronbach`s alpha was 0,852, which indicated high internal consistency.

Prior the start of the fieldwork, a pilot study was conducted. The purpose of this was to test the feasibility of the questionnaire, to determine the amount of time it takes to complete the questionnaire, establish if the instructions are clear and to find out if the respondents find any questions inappropriate. After receiving gatekeepers’ permission, a brief introduction meeting was held with the nursing manager as well as the unit manager of hospital A prior to conducting the pilot study to introduce the researcher and discuss dates that are suitable for data collection.

The questionnaire was administered to four nursing staff members in hospital A, two PNs and two enrolled nurses in the ED who were on duty that day, to represent as closely as possible the population with regard to qualifications. Participants completed the questionnaire within 40 minutes averagely. During a verbal discussion to receive feedback, the respondents stated the instructions were clear; questions were concise, easy to read and understand. There was no criticism offered, therefore, no changes made on the instrument. The pilot study data did not undergo analysis.

3.9. Ethical considerations

The University of KwaZulu-Natal Biomedical Research Ethics Committee (BREC), and the Provincial Health Research and Ethics Committee (PHREC) granted ethical approval and gatekeepers’ permission respectively (refer to Appendices 4 to 9) before data collection commenced. Respondents received information about their rights to participate in the study, as well as their right to withdraw at any time with no penalties for doing so, and that the decision not to participate would not result in any form of disadvantage. Confidentiality remained throughout the study as the consent forms were detached from the questionnaires. Copies of the questionnaires were coded and

numbered to de-identify them, and the drop off box was strategically placed to receive completed questionnaire. Consensus was reached with the nursing and unit managers of the EDs on days planned for data collection, and respondents completed all the required documents, which included the information sheet and the informed consent form.

On the days when the researcher collected data, the alert level 1 COVID-19 lockdown guidelines were observed. There was no known discomfort or inconvenience related to the study. There were no costs incurred by respondents due to their participation in the study, neither did they receive any incentives or reimbursements. The researcher followed fundamental ethical principles. There was respect for the nurses' workspace, there was no vulnerable population included in the study and there was mutual respect for recruited respondents who were part of the study.

3.9.1 Data management

Hard copies of the questionnaire remained locked in a cupboard during analysis. After the study, the supervisor will receive the hard copies and electronic data to lock away, and discard permanently after a period of five years, according to the university's policy. Data stored in electronic devices will be deleted permanently and hard copy data destroyed by shredding.

3.10 Summary of Chapter three

This study used a quantitative, non-experimental, descriptive design. The study occurred in four selected EDs located in the eThekwini district. The population of this study were ENs and PNs working in the four selected EDs. The research tool used was a 26-item scale (FINC-NA questionnaire). The chapter covered the inclusion and exclusion criteria, validity and reliability, data collection procedure, data analysis and ethical considerations.

CHAPTER FOUR: PRESENTATION OF THE RESULTS

4.1. Introduction to the data collection

This chapter presents the results of the data collected using the 26 item FINC-NA self-administered questionnaire, involving ENs and PNs (*n*=137) working at the ED of four government hospitals in eThekwini. The purpose of the descriptive survey was to describe ENs and PNs` attitude about family importance in the ED. The findings of the descriptive and inferential statistical analysis are presented in table format centered on the demographic data, the total and subscale scores of the FINC-NA [family as a resource in nursing care (Fam-RNC, family as a conversational partner (Fam-CP), family as a burden (Fam-B) and family as its own resource (Fam-OR)].

4.2. Response rate

Out of 170 questionnaires distributed to ENs and PNs in the EDs, 137 were returned and adequately completed, representing a response rate of 80.6%. In total, there were 137 questionnaires analyzed, which gave the researcher the opportunity to generalise about the total population (Campbell et al., 2020). The respondents consisted of 19 (13.9%) nurses from Hospital A, 33 (24.1%) nurses from Hospital B, 35 (25.5%) from Hospital C and 50 (36.5%) from Hospital D.

4.3. Demographics

The social demographic data included in this study consisted of age, gender, nursing category, nursing qualification, emergency/critical care specialty qualification, managerial and emergency department experience, and history of having a sick family member that needed treatment in the ED.

Of the 137 respondents, the majority were female (n=124; 90.5%). The respondents` ages ranged from 21 to 56 years (mean (*m*) 38.4, *SD* 9.1 years). ENs and PNs with the age range of 40 to 49 years formed the larger group (*n*=47; 34.3%) (Table 4). The average age for male nurses (n=13) was 36.8 years (*SD* 7.2; range 25 to 53 years) (Table 4).

The nursing category predominantly represented in this study were PNs (*n*=93; 67.9%) with the age range of 21 to 56 years. The ENs (n=44; 32.1%) age ranged from 25 to

56 years. Total nursing experience ranged from one to 33 years (*m*=10 years, *SD* 6.9 years). More than two-thirds of the respondents had nursing experience greater than six years (n=95; 69.8%). Those with ED experience ranged from one to 22 years (*m*= 5.9 years, *SD* 4.8 years).

The PNs had worked in the ED longer than the ENs, with 49.5% having six to 22 years' experience compared to 31.8% of the ENs. Only 22 (16.1%) respondents (PNs) had a specialty, 21 (95.5%) of which was emergency nursing and one (4.5%) was Critical Care Nursing. Sixteen (11.7%) respondents had managerial experience, ranging from one to 13 years, with a mean of 4.4 years (*SD* 3.7) (Table 4).

Table 4: Demographics of respondents (n=137)

Demographic variable	**n (%)**
Age (years) (*m (SD)*	38.4 (9.1)
Age groups (years) (*n*=136)	
<30	32 (23.5)
30 – 39	40 (29.4)
40 – 49	47 (34.6)
50 +	17 (12.5)
Gender	
Male	13 (9.5)
Female	124 (90.5)
Nursing category	
Enrolled Nurse	44 (32.1)
Professional Nurse	93 (67.9)
Education qualification	
Certificate in Nursing	44 (32.1)
Diploma in Nursing	76 (55.5)
Bachelor Degree in Nursing	17 (12.4)
Emergency/Critical Care Nursing qualification	
No	115 (83.9)
Yes	22 (16.1)
if yes, name (*n*=22)	
Emergency Nursing	21 (95.5)
Critical Care Nursing	1 (4.5)
Nursing experience (years)	
1 – 5	42 (30.7)
6 – 10	40 (29.7)
11 – 33	55 (40.1)
Experience in ED (years)	
1 – 2	45 (32.8)
3 – 5	32 (23.4)
6 – 22	60 (43.8)
Managerial experience	
No	121 (88.3)
Yes	16 (11.7)
If yes, number of years (*n* = 16)	

Demographic variable	n (%)
≤ 3	8 (50.0)
4-13	8 (50.0)
Family member admitted to ED	
No	54 (39.4)
Yes	83 (60.6)

Key: ED: Emergency department*; m*: mean; *SD*: Standard deviation

4.4. Nurses' attitudes about family importance in nursing

As shown in Table 5, the mean (*SD*) score on the total FINC-NA scale was *m*=93.69 (*SD* 14) with the range of 57 to 130, and was *m*=72.07 (*SD* 10.77) when converted to a percentage. This indicates that emergency department PNs and ENs in this current study hold a supportive attitude about the importance of families in nursing care.

The mean (*m*) of nurses` attitudes towards Fam-B (reversed scale) *m*=65.66 (*SD* 18.21) and Fam-OR *m*=69.60 (*SD* 15.29), respectively, were less supportive compared to Fam-RNC. Nurses` attitudes were relatively supportive towards Fam-CP, reflected by the mean (*SD*) score of *m*=75.18 (*SD* 12.81). For ease of interpretation, as well as to allow cross comparison to different studies, there is separate presentation of the sub-scales, including raw scores, which were converted to percentages.

Table 5: FINC-NA total scale and sub-scale scores (n=137)

Variable	Raw scores			Scores converted to 100 points		
	m (*SD*)	Min	Max	*m* (*SD*)	Min	Max
Total FINC-NA	93.69 (14)	57	126	72.07 (10.77)	44	97
Fam-RNC	36.56 (7.12)	17	50	73.12 (14.25)	34	100
Fam-CP	30.07 (5.12)	17	40	75.18 (12.81)	43	100
Fam-B*	13.13 (3.64)	4	20	65.66 (18.21)	20	100
Fam-OR	13.92 (3.06)	7	20	69.60 (15.29)	35	100

Key: Fam-RNC family as a resource in nursing care; Fam-CP family as a conversational partner; Fam-B family as a burden; Fam-OR family as own resource*; m*: mean; *SD*: Standard deviation; * Subscale score reversed

4.4.1. Family as a resource in nursing

The majority of the respondents (n=37; 27%) agreed and (n=59; 43.1%) strongly agreed that a good relationship with family members gives them job satisfaction. Just

over two-thirds of the respondents agreed (n=47; 34.3%) and strongly agreed (n=42; 30.7 %) that getting involved with families gives them a feeling of being useful. A minority (n=38; 27.7%) agreed and (n=28; 20.4%) strongly agreed that the presence of family members gives them a feeling of security. Table 6 presents the Fam-RNC questions scores, arranged from lowest to highest.

Table 6: Responses to individual sub-scale Fam-RNC items

Family as a Resource in Nursing Care (Fam-RNC)	Strongly disagree %	Disagree %	Agree %	Strongly agree %	Mean (SD)
The presence of family members gives me a feeling of security	15.3	12.4	27.7	20.4	3.26 (1.33)
It is important to spend time with families	10.3	17.5	20.4	23.4	3.28 (1.30)
The presence of family members eases my workload	13.9	14.6	21.9	24.1	3.28 (1.35)
Family members should be invited to actively take part in planning patient care	8.8	8.0	22.6	31.4	3.60 (1.25)
The presence of family members is important for the family members themselves	4.4	10.9	32.8	29.9	3.73 (1.13)
I gain a lot of worthwhile knowledge from families which I can use in my work	2.9	7.3	36.5	26.3	3.76 (1.02)
Family members should be invited to actively take part in the patient's nursing care	5.8	8.8	25.5	38	3.81 (1.20)
Getting involved with families gives me a feeling of being useful	1.5	5.8	34.3	30.7	3.87 (0.97)
The presence of family members is important to me as a nurse	4.4	4.4	28.5	40.1	3.96 (1.10)
A good relationship with family members gives me job satisfaction	2.9	4.4	27	43.1	4.03 (1.05)

Key: *m*: mean; *SD*: Standard deviation; % percentage; Sub-scale items re-ordered according to mean from lowest to highest value.

4.4.2. Family as a conversational partner

The mean score for Fam-CP was 75.18% (*SD* 12.81), with scores ranging from 43 to 100 with possible score range of 20 to 100 (Table 5). The majority of respondents (n=110; 80.3%) agreed (n=34; 24.8 %) and strongly agreed (n=76; 55.5 %) that it is important to find out about the patient's family members, followed by 73.7% of the respondents who agreed (n=48; 35%) and strongly agreed (n=53; 38.7%) to ask family members to take part in discussions about patient care during their first encounter. A minority of the respondents (n=31; 22.6%) agreed and (n=24; 17.5%) agreed strongly on inviting family members to speak when planning care (Table 7).

Table 7: Responses to individual sub-scale Fam-CP items

Family as conversational partner (Fam-CP)	Strongly disagree %	Disagree %	Agree %	Strongly agree %	Mean (SD)
I invite family members to speak when planning care	10.9	8.8	22.6	17.5	3.27 (1.18)
I invite family members to actively take part in the patient's care	3.6	14.6	23.4	25.5	3.53 (1.13)
I always find out what family members patients' have	5.1	15.3	27	28.5	3.58 (1.20)
I invite family members to have a conversation at the end of the care period	5.8	7.3	30.7	27.7	3.67 (1.13)
Discussion with family members during first care contact saves time in my future work	4.4	5.8	32.1	27.7	3.73 (1.07)
I ask family members to take part in discussions from the very first contact, when a patient comes into my care	5.1	6.6	35	38.7	3.96 (1.12)
I invite family members to speak about changes in the patient's condition	0.7	2.9	37.2	35.8	4.04 (0.88)
It is important to find out what family members a patient has	2.2	2.2	24.8	55.5	4.29 (0.96)

Key: *m*: mean; *SD*: Standard deviation; % percentage; Sub-scale items re-ordered according to mean from lowest to highest value.

4.4.3. Family as a burden

The mean score for Fam-B was (*m*=65.66, *SD* 18.21), range 20 to 100 with possible score range of 20 to 100 (Table 5). There was negative wording for this subscale and consequently, it was reversely scored. More than half of the respondents (n=27; 19.7%) disagreed and (n=54; 39.4%) strongly disagreed with the statement that the presence of family members makes them feel stressed. However, (n=31; 22.6%) agreed and (n=23; 16.8%) strongly agreed that the presence of family members makes them feel that they are checking up on them. (Refer to Table 8)

Table 8: Responses to individual sub-scale Fam-B

Family as a Burden (Fam-B) *	Strongly disagree %	Disagree %	Agree %	Strongly agree %	Mean (SD)
The presence of family members makes me feel that they are checking up on me	21.2	14.6	22.6	16.8	3.01 (1.38)
The presence of family members holds me back in my work	24.1	16.8	16.8	16.1	3.16 (1.39)
I do not have time to take care of families	27	14.6	13.9	13.1	3.28 (1.35)
The presence of family members makes me feel stressed	39.4	19.7	10.2	10.2	3.68 (1.36)

Key: *m*: mean; *SD*: Standard deviation; % percentage; * Subscale score reversed; Sub-scale items re-ordered according to mean from lowest to highest value.

4.4.4. Family as own resource

Fam-OR subscale refers to the perception of nurses to viewing families as capable of having their own resources for coping. The mean score for Fam-OR subscale was (*m*=69.60, *SD* 15.29) range 35 to 100 with possible scores 20 to 100 (Table 5). Most of the respondents (n=41; 29.9%) agreed and (n=38; 27.7%) strongly agreed they see themselves as a resource for families. A lower percentage of respondents (n=43; 31.4%) agreed and (n=25; 18.2%) strongly agreed to encouraging families to use their own resource so that they have the optimal possibilities to cope with situations themselves (Table 9).

Table 9: Responses to individual sub-scale Fam-OR

Family as own resource (Fam-OR)	Strongly disagree %	Disagree %	Agree %	Strongly agree %	Mean (SD)
I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves	13.1	13.1	31.4	18.2	3.28 (1.28)
I ask families how I can support them	5.1	13.9	25.5	20.4	3.42 (1.12)
I consider family members as co-operating partners	3.6	3.6	29.2	21.2	3.53 (1.07)
I see myself as a resource for families so that they can cope as well as possible with their situation	3.6	9.5	29.9	27.7	3.69 (1.09)

Key: *m*: mean; *SD*: Standard deviation; % percentage; Sub-scale items re-ordered according to mean from lowest to highest value.

4.5. Associations between demographics and FINC-NA scale

For each student there was a calculation of the sum of the scores of the questions in each of the four subscale sections and the overall sum. The frequency distribution of these sums were normally distributed (Kolmogorov-Smirnov, Shapiro-Wilk's test for normality) and the means (SD) of these total scores are presented as measures of central tendency (Biu, Nwakuya & Wonu, 2020).

On examining the total FINC-NA scale score and the four sub-scales, there were associations between three of the sub-scales (Fam-RNC, Fam-B, Fam-OR) and three of the demographic variables (age, managerial experience, years of working experience in ED). The associations were not uniform for the same demographic variable or the same sub-scale.

There was a significant difference between Fam-RNC and age groups (*m*= 69.13, *SD* 13.58, 21-29 years vs *m*=70.70 *SD* 15.60, 30-39 years; vs. *m*=76.35 *SD* 11.03, 50+ years; *m*=76.81 SD 13.89, 40-49 years; *K* = 8.42, *p*= 0.038) (Table 6).

In addition, significance was shown between Fam-B and respondents with no managerial experience (*m*= 64.50%, *SD* 18.21) compared to those with managerial experience (*m*=74.38%, SD 16.22; K=-2.18, *p*=0.029) (Table 6).

Lastly, there was an association shown between Fam-OR and years of working experience in the ED (*m*= 69.60%; *m*=64.8 *SD* 16.57 2-5 years; vs *m*=69.44 *SD* 12/12 1-2 years; vs *m*=70.5 *SD* 15.54 11-15 years; vs *m*=75.12 *SD* 13.91 6-10 years; *K* = 10.01, *p*=0.039) (Table 6).

The sub-scale of Fam-CP and the total score showed no significant associations to any of the demographic variables. In summary, the majority of the demographic variables showed no significant associations with the total FINC-NA score or the sub-scale scores, namely gender, nursing category, educational qualification, inclusive of an Emergency/Critical Care Nursing qualification, nursing experience generally and more specifically in the ED, and lastly if a family member needed to access the ED.

Nurses who indicated having one to two years of experience in the ED scored significantly lower on the Fam-OR subscale (p = 0.03) than those with more than two years of experience. Nurses with no managerial experience scored significantly lower on the Fam-B subscale (p = 0.029) than those with managerial experience. Nurses who scored significantly high on the Fam-RNC subscale (p =0.038) were aged 40 and above.

In this study, the demographic factors associated with supportive nurses' attitude were those whose ages were equal to and greater than 40 years, having managerial experience and having more than five years of working in the emergency department. Table 10 presents a subscale comparison and associations of FINC-NA scores.

Table 10: Association between demographics and subscale scores of FINC-NA (*n*=137)

Demographic	n	Fam-RCN	Fam-CP	Fam-B*	Fam-OR	Total FINC-NA
		m(SD)	*m (SD)*	*m (SD)*	*m (SD)*	*m (SD)*
Age (*n*=136) (years)						
<30	32	69.13 (13.58)	71.64 (11.86)	69.84 (15.53)	66.41 (13.63)	69.59 (9.82)
30 – 39	40	70.70 (15.60)	74.19 (12.99)	64.13 (17.32)	71.50 (16.88)	70.88 (11.59)
40 – 49	47	76.81 (13.89)	78.46 (12.27)	65.21 (20.22)	71.60 (15.36)	74.73 (11.16)
50 +	17	76.35 (11.03)	75.35 (14.81)	61.76 (19.36)	66.47 (13.78)	72.26 (8.79)
***p*-value**		**0.038***	0.09	0.41	0.19	0.06
Gender						
Male	13	71.38 (13.28)	75.19 (10.33)	73.85 (15.57)	69.23 (12.22)	72.60 (9.21)
Female	124	73.31 (14.38)	75.18 (14.38)	64.80 (18.31)	69.64 (15.62)	72.01 (10.95)
***p*-value**		0.68	0.86	0.08	0.9	0.70
Nursing category						
Enrolled Nurse	44	74.09 (12.37)	76.88 (10.77)	63.07 (18.53)	71.14 (15.81)	72.80 (8.41)
Professional Nurse	93	72.67 (15.10)	74.38 (13.65)	66.88 18.03)	68.87 (15.08)	71.72 (11.75)
***p*-value**		0.91	0.34	0.33	0.57	0.72
Educational qualification						
Certificate in Nursing	44	74.09 (12.37)	76.88 (10.77)	63.07 (18.53)	71.14 (15.81)	72.80 (8.41)
Diploma in Nursing	76	73.95 (14.93)	75.46 (14.03)	66.32 (18.61)	69.14 (15.95)	72.50 (12.13)
Bachelor Degree in Nursing	17	66.94 (14.92)	69.56 (10.91)	69.41 (15.40)	67.65 (10.62)	68.24 (9.38)
***p*-value**		0.21	0.16	0.44	0.76	0.34
Emergency/Critical Care Nursing qualification						
Yes	22	69.27 (15.63)	74.43 (12.53)	67.73 (16.09)	69.32 (14.50)	70.63 (11.14)
***p*-value**		0.24	0.81	0.51	0.96	0.40
If yes, name (*n*=22)						
Emergency Nursing	21	70.67 (14.55)	74.52 (12.84)	68.57 (15.98)	69.29 (14.86)	71.32 (10.93)
***p*-value**		0.13	0.81	0.23	0.87	0.13
Nursing experience (years)						
1 – 5	42	69.57 (13.06)	72.08 (10.50)	69.17 (13.70)	66.90 (14.31)	69.87 (9.03)
6 – 10	40	73.30 (14.83)	76.88 (13.82)	61.75 (19.53)	69.63 (18.31)	72.06 (11.26)
11 – 33	55	75.71 (14.36)	76.32 (13.44)	65.82 (19.90)	71.64 (13.47)	73.75 (11.49)
***p*-value**		0.046	0.10	0.21	0.24	0.11
Experience in ED (years)						
1 – 2	45	72.89 (14.43)	75.50 (11.81)	69.00 (16.84)	66.44 (14.25)	72.10 (10.51)
3 – 5	32	70.75 (13.28)	71.72 (14.01)	64.06 (17.34)	66.41 (16.76)	69.35 (10.06)
6 – 22	60	74.57	76.79	64.00	73.67	73.49

Demographic	n	Fam-RCN	Fam-CP	Fam-B*	Fam-OR	Total FINC-NA
		m(SD)	*m (SD)*	*m (SD)*	*m (SD)*	*m (SD)*
		(14.66)	(12.73)	(19.55)	(14.49)	(11.22)
***p*-value**		0.32	0.15	0.34	**0.03***	0.19
Managerial experience						
Yes	16	69.75 (17.60)	74.53 (13.82)	74.38 (16.22)	69.69 (14.20)	71.92 (12.71)
***p*-value**		0.51	0.84	**0.029***	0.9	0.91
If yes, state years (*n* = 16)						
≤ 3	8	69.50 (16.27)	74.06 (12.81)	78.12 (16.68)	68.13 (11.63)	72.02 (1.24)
4-13	8	71.00 (19.83)	74.06 (15.52)	75.00 (10.00)	70.63 (17.41)	72.50 (14.62)
***p*-value**		0.67	0.75	0.79	0.87	0.75
Family member been sick & needed ED						
Yes	83	72.80 (15.27)	75.24 (12.86)	67.17 (18.42)	69.82 (15.76)	72.22 (11.15)
***p*-value**		0.90	0.66	0.22	0.68	0.45

Key: Fam-RNC family as a resource in nursing care; Fam-CP family as a conversational partner; Fam-B family as a burden; Fam-OR family as own resource*; m*: mean; *SD*: Standard deviation; * Subscale score reversed; Significance was set at *p*= 0.05.

4.6 Summary of Chapter Four

This chapter detailed the results of the analysis, involving descriptive and inferential (non-parametric) statistics of the FINC-NA questionnaire, including the demographics of the respondents. Overall, ENs and PNs in this study held positive attitudes regarding family importance in nursing care. The subscale for Fam-CP had the highest mean percentage, but showed no significant association to any of the demographic variables. There was statistical significance shown for subscales Fam-RNC and age, Fam-B and managerial experience, and Fam-OR and ED experience. The next chapter discusses the key findings.

CHAPTER FIVE: DISCUSSION

5.1 Demographics

In this current study, the majority of the respondents were female; this was no surprise since nursing is predominantly a female profession rather than male, tracing nursing history to Florence Nightingale's work during the Crimean War (Klimek, 2022). This is in keeping with the large percentage of female nurses in the province of KwaZulu-Natal, where nursing manpower constitutes 90% female nurses with PNs contributing to the larger female number (52%) (SANC, 2022). According to the South African Nursing Council (SANC, 2022), the province of KwaZulu-Natal has a large proportion of PNs compared to ENs, which is in keeping with the demographic results of this current study. This was also in line with a study conducted by Mackie et al. (2017) in Australia, where there was a greater number of PNs compared to ENs.

In this study, the majority of respondents fell within the age range of 40 to 49 years, similar to SANC age distribution, which revealed that in South Africa there are (n=40 346; 26%) PNs aged 40 to 49 and (n=19 373; 34%) ENs aged 40 to 49 (SANC, 2022). This and other studies associate older nurses with positive supportive attitude, which could be a contributing factor for the positive, supportive total FINC-NA score obtained in this study (Konradsen et al., 2019; Luttik et al., 2017).

In this study there was no significant association of total FINC-NA score with any of the demographics. This is dissimilar to an European study conducted by Shamali et al. (2022), where the authors found that nurses with experience in serious illness within their own family obtained a total FINC-NA score 1.305 (p= .002) points higher than nurses who had no experience with serious illness within their family. However, when comparing total FINC-NA scores to other studies, there were more similarities discovered (high scores), revealing supportive attitudes held by nurses.

5.2 Total FINC-NA scale score

In general, nurses` attitudes were supportive regarding family importance in nursing care, with the total score on FINC-NA scale m=93.69; total scores obtained varied from 57 to 126 (44% to 97%). This finding is consistent with earlier studies conducted in Europe that revealed that family is highly valued as an important institution related to health and well-being, especially in nursing (Shamali et al., 2022; Zwicky et al.,

2022; Hagedoorn et al., 2021). When compared to a Ugandan study (*m*=90.6; *SD* 14.7) conducted by Imanipour and Kiwanuka (2020), the mean score of the total FINC-NA scale of this current study was slightly higher, thus more supportive.

Additionally, the results of the present study, even though slightly higher, were close to the results obtained when using the FINC-NA scale in other contexts in Portugal; for example, in a Portuguese study conducted on the importance of families in nursing care, the authors obtained an average score of *m*=79.2 (*SD* 7.5) (Fernandes et al., 2015). Similarly, in a study by Nóbrega et al. (2020) on the integration of families in community nursing care for people with psychiatric illness, there was a total FINC-NA scale average value of *m*=86.0 (*SD* 9.3) obtained, which contrasted with the *m*=93.69 (*SD* 14) score in the current study.

Literature often reveals the necessity of nurses connecting with the family, with the nurse viewed as the driver in relating, connecting and supporting families to cope with the complexities of the ED experience (Emmamally & Brysiewicz, 2018). Nurses are in the ideal position to promote family involvement in patient care, but the attitudes and beliefs they hold may help or hinder this practice (Mackie, Marshall & Mitchell, 2017). Therefore, findings of this study reveal that the ENs and PNs working in ED are more likely to involve family in nursing care due to their supportive attitude.

The majority of ENs and PNs in this study held a supportive attitude about family importance in nursing care. Similar observations were noted in a Swedish, Ugandan, and a multi-national study, which included Sweden, Canada, Hong Kong and China, where nurses reported having supportive attitudes regarding the importance of families in nursing care (Imanipour & Kiwanuka, 2020; Cranley, Lam, Brennenstuhl, Kabir, Boström, Leung & Konradsen, 2021). Internationally, there are gradual developments of evidence that emphasise the importance of families and family involvement in healthcare services for patients, and for family members (Cranely et al., 2021).

5.3 Family as a resource in nursing care

Family as a resource in nursing care implies valuing families` presence in nursing care, inviting them to take part in the care of their family member, thus creating a good family-nurse relationship, with the family as significant co-operating partners (Benzein

et al., 2008). The mean Fam-RNC subscale score for this study (*m*=36.0; *SD* 4.0) was similar to the study conducted in Japan by Hori et al. (2020).

Nurses aged 40 years and above scored significantly higher on the Fam-RNC than those aged 21 to 29 years. This is similar to a Swedish study conducted by Konradsen and colleagues in 2009 and 2019, where elderly nurses' attitudes (higher ages) were significantly associated with positive attitude in all FINC-NA subscales (Konradsen, Kabir, Boström & Årestedt, 2022) compared to younger nurses. This can be attributed to the younger nurses being more focused on individual patient management and improving their own abilities and skills to act as ENs or PNs within the multidisciplinary healthcare system, whereas nurses aged 40 and above might be more experienced and interested in viewing the patient and the family as one unit that is entitled to receiving healthcare (Luttik et al., 2017).

Findings obtained in this current study revealed there is a relationship between age of nurses, experience in the ED and the positive attitudes held by respondents towards recognising families as a resource in nursing care; a brief explanation is that there is an overlap between these two variables (older age and ED experience). According to Barreto et al. (2021), nurses with longer professional working time are generally those of older age, therefore, have more confidence to work with families and are more likely to recognise families as a significant resource in nursing care compared to younger nurses.

This was in keeping with a study conducted by Zwicky et al. (2022), in which the results suggested that better practice skills (gained from experience which is more likely to be with older age) in a critical care setting were associated with more open attitude regarding valuing family as a resource in nursing care (Barreto et al., 2021). Therefore, more research is necessary to enhance the development of undergraduate nurses` skills and competencies required for taking care of the patients and their families. Additionally, there is a need to train novice nurses in family assessment, communication with family and family interventions, redirecting them to view the family as a resource in nursing care rather than on physical care, patient safety and building a relationship with the multidisciplinary team (Gusdal et al., 2017).

There is a significant need to include family nursing in the new SANC nursing curricula, to prepare the upcoming nursing workforce who will be prepared and equipped to

engage, involve, support and view family as an important part of nursing in South Africa (Emmamally & Brysiewicz, 2018). It is extremely fundamental that ENs and PNs value family as an integral resource in nursing care rather than a burden or obstacle (Zwicky et al., 2022).

5.4 Family as a conversational partner in nursing care

Viewing family as a conversational partner can be described as having discussions with families about family structure and planning of patient care (Benzein et al., 2008). Research has revealed that a good communication relationship is easier to ensue if the nurse has faced serious illness within their own family (Shamali et al., 2022; Benzein et al., 2008). This is evident in a study about nurses` attitudes regarding family importance in nursing care conducted by Østergaard et al. (2020) in Denmark, in which the authors found that nurses who reported experience with illness within their own family scored significantly higher on Fam-CP subscale (p=.026) compared to those without experience. However, in this current study family as a conversational partner was not linked or associated with age, educational qualifications, years of nursing experience and managerial experience.

The scores for Fam-CP for this current study were slightly higher than the study conducted by Hagedoorn et al., (2021) in the Netherlands, where the authors found m=26.9; (SD 4.8). This means that ENs and PNs in this present study are more likely to engage with the patient`s family members and have a dialogue with them. More than half of the respondents reported that they invited family members to speak about changes in the patients` condition. This agrees with research conducted in Uganda, by Imanipour and Kiwanuka (2020), where the majority of ICU nurses strongly agreed to inviting the family for discussion when a patient`s condition deteriorates.

Conversely, on the very same subscale of Fam-CP, there was a minor difference noted. In this study, a significant percentage of the respondents agreed to inviting family to actively take part in patient care, which was slightly higher than the studies conducted by Østergaard et al. (2020) and Imanipour and Kiwanuka (2020) where less than 30% respondents agreed to doing so. Even though almost half of the respondents agreed to the above statement, its application to practice remains enigmatic in South Africa, a country that still struggles with inconsistency of implementing the

collaborative aspect of patient-and-family-centered care practices, exacerbated by COVID-19 (Jarvis, Oyegbile & Brysiewicz, 2021; Emmamally & Brysiewicz, 2018).

5.5 Family as a burden

Fam-B subscale score was lower compared to a multinational comparative study of nurses` attitudes regarding family importance in nursing conducted by Cranley et al. (2021), where the authors found Fam-B average value of m=14.3 (*SD* 3.6) in Canada and m=16.3 (*SD* 3.3) in Sweden. However, Fam-B subscale score for this current study was higher compared to the very same study conducted by Cranley et al. (2021) in China (*m*=11.2; (SD 2.6).

According to Fernandes, Magalhães, Silva and Edra (2022), even though a large percentage of nurses demonstrated positive attitude towards family importance in nursing care, many nurses still consider family as a burden in nursing, especially in the context of COVID-19 pandemic, which might have aggravated this consideration. The World Health Organization (WHO) declared the COVID-19 pandemic a public health emergency of international concern, forcing healthcare institutions worldwide to introduce strict rules to reduce the impact of the disease (World Health Organization, 2020); this included the ban of and limiting family members visiting hospitals, thus reducing the number of encounters the nurses and the family might have (Hugelious, Harada & Marutani, 2021).

However, in this study, which was conducted towards the end of 2021, when South Africa had recently been placed on an adjusted Alert Level One regulations, as per disaster management act of 2022 (strict wearing of mask, social distancing, restricted visiting hours and limited number of relatives allowed per individual at hospitals), Fam-B subscale findings were slightly positive, meaning the respondents did not consider family as a burden in nursing care (Moonasar, Pillay, Leonard, Naidoo, Mngemane, Ramkrishna, Jamaloodien, Lebese, Chetty, Bamford & Tanna, 2021).

The majority of the respondents disagreed and strongly disagreed with the statement that they do not have time to take care of families. A significant proportion of respondents reported not feeling stressed by presence of family members and (n=56; 41%) said the presence of family members does not hold them back in their work.

Although a large percentage of ENs and PNs disagreed strongly with viewing family as a burden in nursing, many nurses (n=54; 39.4%) reported that the presence of family members makes them feel they are being supervised or checked upon. This is consistent with the study conducted by Imanipour and Kiwanuka (2020), where nurses felt that family members were checking up on them. Viewing family as a burden may hinder the appropriate care rendered by the family, thus disturbing family engagement and involvement (de Beer & Brysiewicz, 2019; Hagedoorn et al., 2021). Placing the family in a double challenge state, i.e., the feeling of uncertainty, psychological distress, emotional turmoil and loss of control that the family will experience with a sudden admission of a family member into the ED, as well as insignificant supportive attitude associated with viewing family as undesirable and a burden in nursing care, might be disadvantageous to the family as a unit (de Beer & Brysiewicz, 2019; Regaira-Martínez & Garcia-Vivar, 2021). This could result in negative long-term consequences, such as prolonged anxiety, depression, post-traumatic stress disorder and complicated grief for families (de Beer & Brysiewicz, 2019).

According to a study conducted by Zwicky et al. (2022) in six ICUs and two Neonatal Intensive Care Units in Switzerland, nurses` clinical specialty had a significant influence on their attitude towards the Fam-B subscale. However, in this study, managerial experience had a significant influence on nurses` attitude; nurses without managerial experience had significantly low scores on the Fam-B subscale compared to nurses with managerial experience. Nurses lacking managerial experience might experience barriers at an individual nursing level, including lack of skills in family engagement, disruption in workflow or feeling observed through families` presence (Zwicky et.al, 2022; Hori et al., 2020).

Prioritising emergency nursing care while simultaneously dealing with the anxieties of the families of critical ill patients can be extremely challenging for nurses who are not familiar with family engagement and interaction at a managerial level (Emmamally et al., 2022; Afava et al., 2021). There is no question that nursing is a stressful profession and a fast-paced environment with impracticable events, such as the ED, making the job even more stressful for ENs and PNs working in that department (Keil et al.,2019; Rubio-Navarro et al., 2020).

This can make it extremely difficult for a nurse without managerial experience who has never encountered or interacted with family members in complex situations, whereas nurses with managerial experience have dealt with and resolved several complaints from family members and due to their managerial experience, find it easy to work with families and view the family as less of a burden (Keil et al., 2019). Nurses in managerial positions often liaise with families, encounter families in complex situations and have developed approaches to engaging with families and acknowledge their importance in nursing care, and therefore, will score higher than nurses who lack such skills and approach (Hori et al., 2020).

In contrast, the lower scores obtained by nurses without managerial experience can be attributed to the familiar belief that they are “too busy” providing complex emergency care to the individual patient and do not have enough time to acknowledge families or to spend time caring for families (Emmamally & Brysiewicz, 2018; Zaidi et al., 2019) There is no doubt that in developing countries, such as South Africa, ENs and PNs working in ED have the challenge of dealing with the entry of new patients while managing the existing admissions of critically ill patients, with limited resources, few skilled nursing staff and a backlog of patient admissions (Afaya et al., 2021). Therefore, the role of the ENs and PNs to care for both the family and the patient might appear difficult to navigate and fulfil, resulting in the nurse feeling stressed and that family presence holds them back in their “already hectic” work.

This limiting belief needs addressing by adequate in-service education and staff development in the emergency department. Policies and guidelines need formulating, and be clear and precise, and directed towards the essential needs of families in the ED. The expectations of family members need defining in order to build the role of a nurse working in the ED upon this understanding and to address these needs effectively (Emmamally et al., 2020). Clarity with policies and guidelines will result in nurses seeing the importance of family in nursing to the extent that they value family as a resource in nursing care, as a conversational partner and most significantly, family as its own resource (Deatrick, 2017).

5.6 Family as own resource

In this current study, the Fam-OR subscale mean score results, even though slightly lower, are close to the results obtained from a study conducted by Cranely et al.

(2022), in Canada, (*m*=15.7; *SD* 20.6), China (*m*=15.6; *SD* 2.4) and Sweden (m=15.8; *SD* 3.1). Conversely, the Fam-B subscale score was slightly higher than the average value of *m*=13.6 (*SD* 2.7) obtained by Hagedoorn et al. (2021) in the Netherlands and *m*=11.9 (*SD* 2.4) retrieved by Blöndal et al. (2014) in Iceland.

In this study, ENs and PNs with ED working experience of one to two years were associated with less supportive attitude in the Fam-OR subscale. Literature suggests that limited number of years of work experience is significantly associated with fewer positive attitudes towards the importance of family (Hagedoorn et al., 2021; Østergaard, et al., 2020). Generally, this is due to the belief that nurses with fewer years of experience may still be in the process of learning skills and gaining expertise with their relationships with the patients, providing nursing care to the patient and patient safety, thus, the family becomes less of a priority (Hagedoorn, 2020).

Lack of policies, guidelines and standard of practice that can introduce newly employed nurses to family importance, engagement, involvement and collaboration in the ED results in nurses with less working experience in ED alienating family from nursing care at the beginning of their employment (Deatrick, 2017; Puurveen, Baumbusch & Gandhi, 2018). Gusdal et al. (2017) posited that nurses` knowledge about existing policy in hospitals regarding family involvement positively influences nurses` attitudes. In South Africa, there is a need for the Department of Health (DoH) to formulate policy on the importance or recognition of family in the ED, and this should form part of the orientation programmes of newly employed nurses. Additionally, the new curricula proposed by the SANC for nursing students, needs to include the importance of family in care in the ED, and nursing students must develop the competencies to work with families.

5.7 Summary of Chapter Five

This chapter provides a detailed discussion of the results compared to other studies, detailing the similarities as well as differences in the findings. The discussion of demographic data and total score drew supportive evidence from previous similar studies. The chapter described possible reasons for the significant associations between Fam-RNC and age, Fam-B and managerial experience, and Fam-OR and years of working experience. Also highlighted were suggestions to provide a way forward for better results in FINC-NA.

CHAPTER SIX: SUMMARY, RECOMMENDATIONS AND LIMITATIONS

6.1 Summary of the findings

The summary presented according to the study objectives.

6.1.1 Objective 1: To describe the attitude of nurses regarding the importance of families in the ED

The ENs and PNs working in the ED have a positive attitude regarding family importance in nursing. The overall FINC-NA total score as an average indicated that the respondents held a positive and supportive attitude. Results revealed ENs and PNs in this current study valued the family as a resource in the ED, which is extremely significant for creating a better family-nurse relationship. The Fam-CP subscale findings showed that ENs and PNs working in ED are likely to engage in conversations with the patients' families.

The total mean score on the FINC-NA, as well as the mean of all subscales of this study, are in keeping with the findings of other studies across the world, which yielded supportive attitudes Imanipour & Kiwanuka, 2020; Hagedoorn et al., 2021) indicating that ENs and PNs in this study have positive attitudes (the higher the score the more supportive nurses` attitudes are towards family's importance in nursing care).

6.1.2 Objective 2: To identify factors associated with the supportive attitude towards family importance in nursing care

In this current study, ENs and PNs that are older in age were associated with the highest supportive attitude regarding family as a resource in nursing care (Fam- RNC and age group). Managerial experience was another factor associated with the highest supportive attitude regarding family importance in nursing care in the ED. Nurses with managerial experience regarded family as less of a burden (supportive attitude) compared to nurses without such experience.

Lastly, nurses with more than five years of working experience in the ED were associated with a greater supportive attitude with regard to the family as its own resource compared to nurses with less years' experience.

6.2 Limitations of the study

The first limitation concerns representativeness of the sample, as there were only n=13 (9.5%) male nurses in this study. The study took place in one province in South Africa; potential respondents in other provinces may have different views. It should be noted that the study was conducted by a nurse, which may have influenced the respondents who participated in the study and the answers given.

Data collection happened during the COVID-19 pandemic and therefore will not be able to describe family importance in nursing care in the emergency department after the COVID-19 pandemic.

Additionally, the study only addressed the importance of family from the nurse's perspective with no information of this phenomenon from the viewpoint of the patient and their families.

6.3 Recommendations of the study

A number of recommendations arose from the study and these are discussed below.

6.3.1. Recommendations for nursing practice

One recommendation is that ED units formulate strategies such as guidelines or standards of practices that will facilitate the provision of a supportive attitude towards family as a resource in nursing care for nurses aged 21 to 39 years. Thus, enabling these nurses to feel safe even when families are present at the bedside in the ED. ED nurses should promote a supportive family collaboration attitude in the ED environment.

6.3.2 Recommendations for nursing education

Nursing education should emphasise the importance of engaging with families in the clinical area. Therefore, teaching nurses the importance of family in nursing care is key to building their capacity for skill in working with families (Zwicky et al., 2022).

Managers of hospitals, clinics, colleges, and universities should facilitate the provision of adequate and continuous education about the significance of a supportive attitude towards family importance in nursing care in the ED. The emphasis should be on nurses who are younger and with less years of experience in the ED.

6.3.3 Recommendation for nursing research

There appears to be a scarcity of research conducted on the importance of family in nursing research in South Africa; hence, there is a strong recommendation to conduct such a study in other provinces in South Africa. Future research can address the roles of ENs and PNs in ED more practically, with feasible suggestions on maintaining positive caring attitudes for the families while dealing with the stressors of several responsibilities within the ED.

6.3.4 Recommendations for nursing administration

There is a significant need to formulate policies that encourage family importance in nursing care in a fast-paced environment such as the ED. Guidelines and policies regarding families must ensure proper implementation within the constraints of the ED.

6.4 Conclusion

Nurses play a significant role in supporting patients and their family members through health and illness. Nurses` knowledge and skills in family nursing prepares them to work with families, but their attitude towards families seems to be a vital determinant of nurse-family engagement practices. Family importance, presence, engagement and involvement in nursing care may challenge nurses to reconsider their roles and responsibilities with family members; however, this might make the nurse feel uncertain and controlled by family members. Even though findings of this study revealed that ENs and PNs have a positive attitude, the significant associations between Fam-RNC, Fam-B and Fam-OR and three of the demographic variables (age, managerial experience, years of working experience in ED), suggests that family importance in nursing care practices have not yet been sufficiently explored in emergency care delivery.

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APPENDIX 1: INFORMATION SHEET FOR RESPONDENTS

Date: ……

Dear Ms./Mrs./Mr.,

I am Ntombifuthi Jennet Ngiba, from the University of KwaZulu-Natal, School of Nursing and Public Health, doing Masters in Critical Care and Trauma. My contact details are cell number [redacted], email address 211504450@stu.ukzn.ac.za

I am inviting you to participate in a descriptive survey of nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district. The aim and purpose of this research is to describe nurses` attitudes about family importance in nursing care, in four selected emergency departments in eThekwini district. The study is expected to enroll 90 respondents from four hospitals (hospital A: 22 respondents; hospital B: 23 respondents; hospital C: 23 respondents and hospital D: 22 respondents). It will involve completing a research questionnaire. The researcher will be available telephonically or via digital platforms to answer questions you might have regarding the questionnaire. The duration of your participation, if you choose to enroll and remain in the study, is approximately one hour to complete the questionnaire only. The study has no funding from any organisation.

There is no known discomfort or inconvenience related to the study. Possible direct benefits of the study are that it might help you to reflect on your attitude about family importance. The findings of this study may give a clear picture of nurses' attitudes towards families in the emergency department, which may assist with the formulation or reviewing of policies and protocols pertaining to attitude of nurses towards families receiving nursing care in the emergency department. Your participation in this study is voluntary, and you have the right to refuse to participate or withdraw from participating at any time. A decision not to participate will not result in any form of disadvantage. There will be anonymity maintained at all times.

This study has been ethically reviewed and approved by the UKZN Biomedical research Ethics Committee (approval number: BREC/00003062/2021), and KwaZulu-Natal Department of Health (NHRD Ref: KZ_202107_024).

In the event of any problems, concerns or questions you may contact the researcher on cell number 0[redacted], email address 211504450@stu.ukzn.ac.za, or the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: +27 31 2602486 - Fax: +27 31 2604609
Email: BREC@ukzn.ac.za

Please note that some of the information obtained from you before you chose to withdraw may have been modified or used in reports and publications and cannot be removed once used; however, the researchers promise to comply with your wishes as much as is practicable.

Participation in the study will incur no costs for the respondents. There are no incentives or reimbursements for participation.

There will be confidentiality maintained throughout, and you do not have to disclose your name. The raw digital data will be stored on the researcher's computer, and accessed and controlled via strong password protection. There will be a date arranged for feedback to the respondents and presentation of the results. The publishing of the findings will be in accredited academic journals.

APPENDIX 2: DECLARATION OF CONSENT

I …… (Name) have been informed about the study entitled “A descriptive survey of nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district” by Ms. N.J, Ngiba.

I understand the purpose and procedures of the study.
I have had an opportunity to answer a questionnaire about the study and have had answers to my satisfaction.
I declare that my participation in this study is voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

There is no anticipated research-related injury by participating in the study.
If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher on cell no. [redacted], email address 211504450@stu.ukzn.ac.za

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: +27 31 2602486 - Fax: +27 31 2604609

Email: BREC@ukzn.ac.za

_____ _____

Name & Signature of Respondent **Date**

APPENDIX 3: FINC-NA QUESTIONNAIRE

Age: …… years

Gender: Male ☐ Female ☐

Nursing category: Enrolled nurse ☐ Professional nurse ☐

Unit manager ☐

Nursing experience: …… Years

Educational Qualification: Certificate ☐ Degree ☐ Masters ☐

PhD ☐

Other- specify ……

Nursing experience in the Emergency Department: ……. Years

Do you have trauma/casualty/critical care specialty? Yes ☐ No ☐

If yes, please describe……

Do you have managerial experience? Yes ☐ No ☐

If yes, experience: ……. Years …… Months

Has a member of your family ever been seriously ill and in need of professional care in the ED?

Yes ☐ No ☐

Instructions for completing the questionnaire

The questionnaire consists of a number of general statements about the importance of the family in nursing care. The statements are similar but not identical. They do not appear in any particular order. Please, respond to these statements quickly, giving the first reaction that comes into your head when you read them. Put a cross in the box that best describes your thoughts in response to each statement.
The term *family* refers to the patient/client and family members, friends, neighbours, or significant others.
You are welcome to make comments in the space provided at the end of this questionnaire.

Put a cross in the box which best describes your thoughts about the respective statements

		Strongly disagree				Strongly agree
1.	It is important to find out what family members a patient has	1	2	3	4	5
2.	The presence of family members holds me back in my work	1	2	3	4	5
3.	A good relationship with family members gives me job satisfaction	1	2	3	4	5
4.	Family members should be invited to actively take part in the patient's nursing care	1	2	3	4	5
5.	The presence of family members is important to me as a nurse	1	2	3	4	5
6.	I ask family members to take part in discussions from the very first contact, when a patient comes into my care	1	2	3	4	5
7.	The presence of family members gives me a feeling of security	1	2	3	4	5
8.	I do not have time to take care of families	1	2	3	4	5
9.	Discussion with family members during first care contact saves time in my future work	1	2	3	4	5
10.	The presence of family members eases my workload	1	2	3	4	5
11.	Family members should be invited to actively take part in planning patient care	1	2	3	4	5
12.	I always find out what family members a patient has	1	2	3	4	5
13.	The presence of family members is important for the family members themselves	1	2	3	4	5
14.	I invite family members to have a conversation at the end of the care period	1	2	3	4	5
15.	I invite family members to actively take part in the patient's care	1	2	3	4	5
16.	I ask families how I can support them	1	2	3	4	5
17.	I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves	1	2	3	4	5
18.	I consider family members as co-operating partners	1	2	3	4	5
19.	I invite family members to speak about changes in the patient's condition	1	2	3	4	5
20.	Getting involved with families gives me a feeling of being useful	1	2	3	4	5
21.	I gain a lot of worthwhile knowledge from families which I can use in my work	1	2	3	4	5
22.	It is important to spend time with families	1	2	3	4	5
23.	The presence of family members makes me feel that they are checking up on me	1	2	3	4	5
24.	I invite family members to speak when planning care	1	2	3	4	5
25.	I see myself as a resource for families so that they can cope as well as possible with their situation	1	2	3	4	5
26.	The presence of family members makes me feel stressed	1	2	3	4	5

Comments:

.....

.....

.....

Thank you for your co-operation

APPENDIX 4: APPROVAL LETTER FROM KZN DEPARTMENT OF HEALTH

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202107_024

Dear Ms NJ Ngiba
(UKZN)

Approval of research

1. The research proposal titled **'A descriptive survey of nurses' attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini District'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at Addington, King Edward VIII, RK Khan and Prince Mshiyeni Memorial Hospital.

2. You are requested to take note of the following:
   a. *All research conducted in KwaZulu Natal must comply with government regulations relating to Covid 19. These include but are not limited to, regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 24/09/2021

APPENDIX 5: ETHICAL APROVAL FROM BREC

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

04 October 2021

Miss Ntombifuthi Jennet Ngiba (211504450)
School of Nurs & Public Health
Howard College

Dear Miss Ngiba,

Protocol reference number: BREC/00003062/2021
Project title: A descriptive survey of nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district
Degree: Masters

EXPEDITED APPLICATION: APPROVAL LETTER

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application.

The conditions have been met and the study is given full ethics approval and may begin as from 04 October 2021. Please ensure that outstanding site permissions are obtained and forwarded to BREC for approval before commencing research at a site.

This approval is subject to national and UKZN lockdown regulations, see (http://research.ukzn.ac.za/Libraries/BREC/BREC_Amended_Lockdown_Level_1_Guidelines.sflb.ashx). Based on feedback from some sites, we urge PIs to show sensitivity and exercise appropriate consideration at sites where personnel and service users appear stressed or overloaded.

This approval is valid for one year from 04 October 2021. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2020) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be noted by a full Committee at its next meeting taking place on 09 November 2021.

Yours sincerely,

[redacted]

Prof D Wassenaar
Chair: Biomedical Research Ethics Committee

Biomedical Research Ethics Committee
Chair: Professor D R Wassenaar
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

APPENDIX 6: LETTER OF PERMISSSION

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

KING EDWARD VIII HOSPITAL
CLINICAL MANAGER
Corner of Sydney and Rick Turner Roads, Umbilo, Durban
Private Bag x02, Congella 4013
Tel: 031 360 3854 Fax: 031 206 1457 Email: KE8.MedicalManagerSecretary@kznhealth.gov.za
www.kznhealth.gov.za

Ref.: KE 2/7/11(10/2021)
Enq.: Mr L.S Ngcobo
Research Programming

11 October 2021

University of KwaZulu-Natal
Durban
4041

Dear Ms. N.J Ngiba
BREC REFERENCE NO: IREC00003062/2021

Protocol: " A descriptive survey of nurses attitudes regarding family importance in nursing care in four selected departments in eThekwini district."

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 Clinical Head/Assistant Nursing Manager
* 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

[redacted]

SUPPORTED/NOT SUPPORTED

DR. V KALALA
CLINICAL MANAGER

11/10/2021
DATE

GROWING KWAZULU-NATAL TOGETHER

APPENDIX 7: LETTER OF PERMISSION

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE: Senior Manager: Medical

Postal Address : Mangosuthu Highway, Private Bag X 07, Mobeni
Physical Address
Name of Directorate: Prince Mshiyeni Memorial
Tel: 0319078317 Fax: 0319061044 Email address: myint.aung@kznhealth.gov.za
www.kznhealth.gov.za

Enquiry: Dr M AUNG
Ref No: 31/RESH/2021
Date: 11/08/2021

TO: Ntombifuthi Jennet Ngiba

RE: LETTER OF APPROVAL TO CONDUCT RESEARCH AT PMMH

Dear Researcher;

I have pleasure to inform you that approval has been granted to you by PMMH to conduct research on **"A descriptive survey of nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district"**.

Please note the following:

1. Please ensure this office is informed before you commence your research.
2. The institution will not provide any resources for this research.
3. You will be expected to provide feedback on you finding to the institution.

The management of Prince Mshiyeni Memorial Hospital reserves the right to terminate the permission for the study should circumstance so dictate.

With kind regard

[redacted]

MYINT AUNG
Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317; Fax: 031 906 1044
myint.aung@kznhealth.gov.za

APPENDIX 8: LETTER OF PERMISSION

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address : R.K. Khan Circle
Physical Address : CHATSWORTH
Tel: [031] 4596001 Fax:[031] 4011247 Email:Dianne.naicker@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
R.K. KHAN HOSPITAL
OFFICE OF THE SENIOR
MANAGER: MEDICAL SERVICES

ENQUIRIES: DR B.S. MADLALA

11 OCTOBER 2021

Ms Ntombifuthi Ngiba
UKZN Research Student

Dear Ms Ngiba

RE: PERMISSION TO CONDUCT RESEARCH STUDY: FAMILY IMPORTANCE IN NURSING, LOOKING AT NURSES' ATTITUDES

Permission is granted for you to conduct the above study at this institution.

Yours faithfully

[redacted]

DR B.S. MADLALA
SENIOR MANAGER: MEDICAL SERVICES

APPENDIX 9: LETTER OF PERMISSION

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ADDINGTON HOSPITAL

Erskine Terrace, South Beach, DURBAN 4001
Postal Address: P.O. Box 997, DURBAN 4000
Tel: 031 3272970 Fax: 031 3683300
Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.com

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Reference: *9/2/3/R*

Date: 19th October 2021

Principal Investigator:
- **Miss Ntombifuthi Jennet Ngiba**

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "A DESCRIPTIVE SURVEY OF NURSES' ATTITUDE REGARDING FAMILY IMPORTANCE IN NURSING CARE IN FOUR SELECTED EMERGENCY DEPARTMENTS IN ETHEKWINI DISTRICT "

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the 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. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.

[redacted]

DR M NDLANGISA
CHIEF EXECUTIVE OFFICER
ADDINGTON HOSPITAL

APPENDIX 10: APPROVAL LETTER FROM THE AUTHOR OF THE QUESTIONNAIRE

From: Britt-Inger Saveman <[redacted]
Sent: Monday, 02 March 2020 10:14 AM
To: Petra Brysiewicz <Brysiewiczp@ukzn.ac.za>
Cc: Eva Benzein <[redacted]>; Kristofer Årestedt <[redacted].se>
Subject: Re: Permission to use FINC-NA

Dear Petra,

Nice to hear that you are about to use the FINC-NA. We have throughout the years given permission to use the instrument to researchers in many countries. As you probably have seen when searching for studies using FINC-NA, it is used in several countries and various care settings.

You hereby have our permission to use our instrument in its original version, but no changes should be made without acceptance from us. The English version is attached in this letter.
Hopefully, we will receive a final version of the study.

All the best,
Britt-Inger

APPENDIX 11: LETTER FROM THE LANGUAGE EDITOR

Gill Smithies

Proofreading & Language Editing Services

[redacted], 4126, KwaZulu Natal

Cell: [redacted] E-mail: [redacted]

Work Certificate

To	Ms. N. J. Ngiba
Address	School of Nursing and Public Health, college of Health Sciences, University of KwaZulu Natal
Date	15/10/2022
Subject	Thesis: A descriptive survey of enrolled and professional nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district
Ref	NJN/gs/01

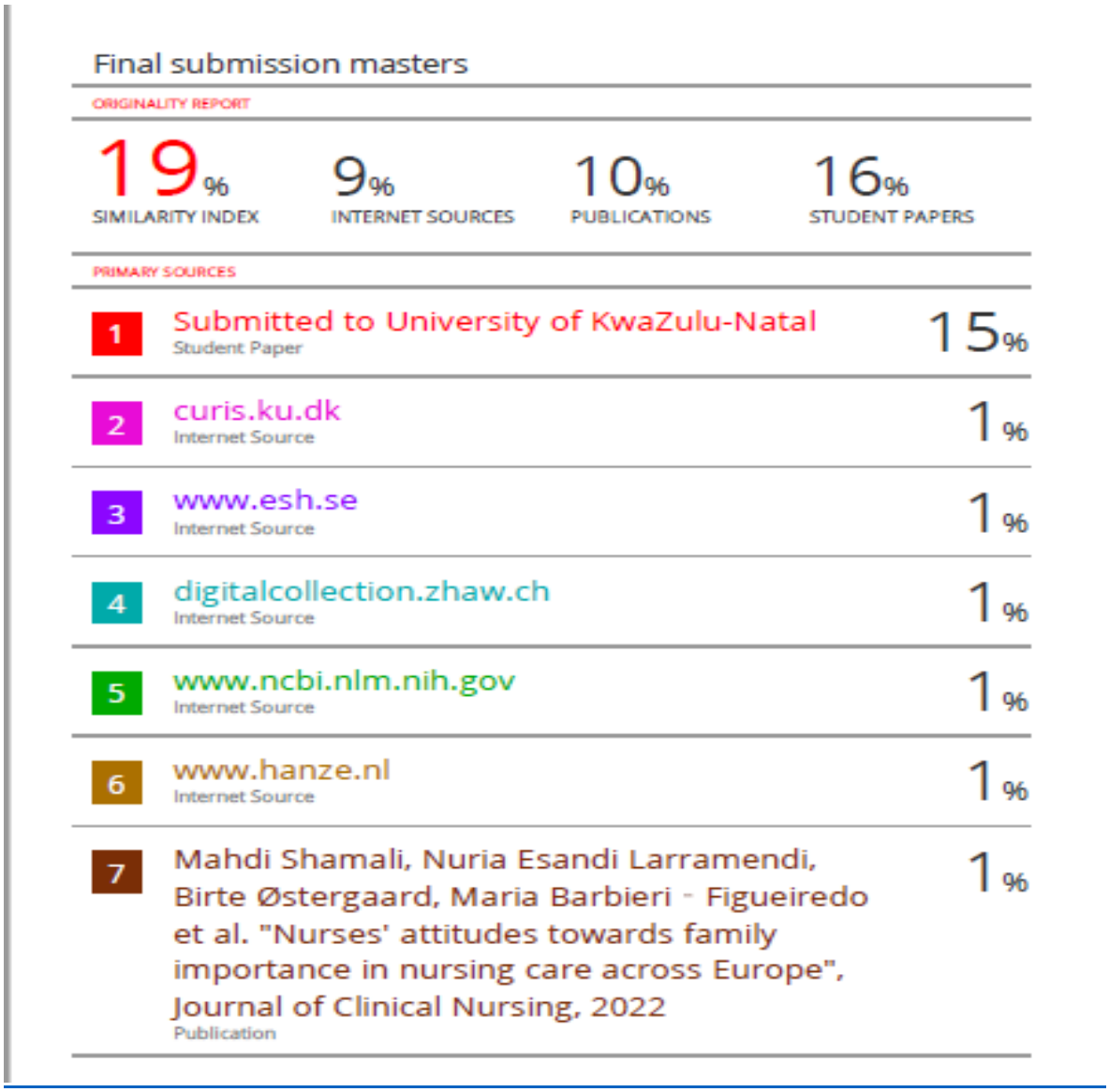
I certify that I have edited the following thesis for language, grammar and style, and made appropriate recommendations,

A descriptive survey of enrolled and professional nurses` attitudes regarding family importance in nursing care in four selected emergency departments in eThekwini district, by N. J. Ngiba,

to the standard as required by the University of KwaZulu Natal.

Gill Smithies

APPENDIX 12: TURNITIN REPORT



Final submission masters

ORIGINALITY REPORT

19%	9%	10%	16%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to University of KwaZulu-Natal Student Paper	15%
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7	Mahdi Shamali, Nuria Esandi Larramendi, Birte Østergaard, Maria Barbieri - Figueiredo et al. "Nurses' attitudes towards family importance in nursing care across Europe", Journal of Clinical Nursing, 2022 Publication	1%