

A COMPARATIVE DESCRIPTIVE STUDY OF THE
PERSPECTIVES OF FAMILIES AND NURSES REGARDING
THE NEEDS OF FAMILIES IN ADULT INTENSIVE CARE UNIT
IN TWO TERTIARY HOSPITALS IN ETHEKWINI DISTRICT

by

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Submitted in partial fulfilment of the requirements for
the degree of

MASTER OF NURSING IN CRITICAL CARE AND TRAUMA

at the

UNIVERSITY OF KWAZULU-NATAL

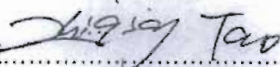
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March 2010

DECLARATION

I declare that this research project entitled "A COMPARATIVE DESCRIPTIVE STUDY OF THE PERSPECTIVES OF FAMILIES AND NURSES REGARDING THE NEEDS OF FAMILIES IN ADULT INTENSIVE CARE UNIT IN TWO TERTIARY HOSPITALS IN ETHEKWINI DISTRICT" is my own work. It is being submitted for the Masters' degree in nursing (Critical Care and Trauma Nursing) at the University of KwaZulu-Natal, South Africa.

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

SIGNATURE  DATE 08-03-2010
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This study has been approved for submission by the supervisor of this study, Professor B.R. Bhengu

SIGNATURE  DATE 26.10.2010
B.R. BHENGU

DEDICATION

This study is dedicated to my mother LI YING, and I will love her forever.

ACKNOWLEDGEMENTS

My thanks and appreciation to the following persons without whom this study and dissertation would not have been possible:

Professor BR Bhengu, my supervisor, for her teaching, support, caring, patience and expertise

Sister Meiko, for her constant assistance, support, and friendship

Yidu and Carly, my Father and my older sister, for their love and encouragement

Ms Catherine Eberle, for her professional editing of this study

All my friends and colleagues in Africa, for their sharing and support

God Jehovah, for his guidance and blessing.

ABSTRACT

AIM

The aim of this study was to describe and compare the needs of families of critically ill patients in two adult ICUs from both the family and the nurses' perspectives.

METHODOLOGY

A non-experimental descriptive survey design with a quantitative approach was used to explore the family members' needs in an ICU situation. For this study, a non-probability convenience sample of 50 critical care nurses and 50 family members from adult Intensive Care Units (ICUs) in two tertiary hospitals was used. The Critical Care Family Need Inventory (CCFNI) (Molter, 1979) was used as a data collection instrument.

FINDINGS

There were different perceptions of family needs between families and nurses. Nurses were accurate with 21 (47%) of the 45 families' need items which was less than half of their perceived family needs compared to family members' perceptions despite the fact that the two groups were in agreement with 5 of the first 10 most important needs. Recommendations for future practice included incorporation of educational programmes for critical care nurses concerning family needs in ICU settings, and the provision of specific in-service training to improve communication skills.

KEY CONCEPTS

Critical care unit, critical care nurse, critically ill patient, family, family member, needs, perception, critical care nursing.

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List of abbreviations

CCFNI	Critical Care Family Needs Inventory
CI	Confidence Interval
ICU	Intensive Care Unit
SANC	South African Nursing Council
SPSS	Statistical Package for the Social Sciences

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Chapter One

1.1 INTRODUCTION AND BACKGROUND

The Intensive Care Unit (ICU) could be defined as a highly specialised unit for the treatment of patients who present with life-threatening conditions (Bersten & Soni, 2003:03). The most common reasons for admission to an ICU are intensive monitoring and life-supportive care, or for intensive care that cannot be provided on a general medical or surgical floor (Bucher & Melander, 1999:52). Because the condition of patients in an ICU is usually critically ill and unstable, ICU nurses have historically focused more the on patient's need and less on their family members' needs. However, it is now well recognised that the hospitalisation of a patient in the ICU also results in a number of emotional and physical problems not only for the patients, but also for their families (Hammond, 1995).

There are a number of reasons which could lead to families being involved in a crisis once one of their relatives has been admitted into the ICU. Sudden illness, coupled with the awareness of a critical condition are likely to shock and disorganise the family. The threatening concern of the possible death and disability of a loved one becomes raised after admission (Lee and Lau, 2003). The highly technical environment of the ICU also may threaten families due to the presence of various devices such as monitors, drug infusion pumps, tubes,

as well as ventilators and the different sounds which are made by alarms (Pryzby, 2005). The ICU nurses' attitudes towards families could also affect the family members negatively (O'Malley, 1991; Plowright, 1998). Some ICU nurses may not always assess and recognise the needs of families, and their practice may be guided by the traditional approach which focuses on the patient only (Maloney, 1983). The rules and routines of the ICU such as limited visiting time, as well as the distance from home to the hospital also make families feel isolated from their loved ones, causing them to find it difficult to cope (Jamerson, 1996; Hughes, 2005). Families have to face all of these issues at the same time and have to adjust in different ways.

Furthermore, in South Africa violence related trauma is a frequent occurrence hence the suddenness of the event and added shock to the families of critically ill patients. More so trauma often affects young adults in the prime of their lives (Marais, 1998). Worse still, in recent years, the approach to critically ill patients has shifted from paternalism to information and inclusion of patients and families in decision making (Stricker, Niemann, Bugnon, Wurz, Rohrer & Rothen, 2007) now that people are more aware of their rights.

Due to the abovementioned reasons, family members are vulnerable to being involved in a crisis when their loved one is admitted in ICU. The issue of family needs in ICUs as a research topic therefore has been studied for the

past 30 years, especially with the introduction of the holistic approach, which involves families and meeting family needs when caring for a patient as a whole. The value of identifying and meeting family needs has been widely recognised, and studies (Hupcey, 1999; Pryzby, 2004; Fox, 2005; EL-Masri, 2006) show that meeting family needs would not only sort out problems for family members, but ultimately patients' outcomes would also be influenced positively (Hupcey, 1998; Willams, 2005).

One of the early researchers regarding family needs in ICU was Molter (1979) who developed an instrument called the Critical Care Family Need Inventory (CCFNI) which includes 45 family need statements, and is subsequently divided into five categories which are needs for support, comfort, information, proximity and reassurance. After Molter, many other researchers (Bouman, 1984; Leske, 1986; Chartier and Coutu-Wakulczyk, 1989; Bernstein, 1990; Daly, 1994; Lopez-Fagin, 1995; Mendonca and Warren, 1998; Takman, 2003; Maxwell, 2007) have followed this topic by different methods. However, the majority of these studies were conducted in Western and European countries. In the literature review, no similar studies were found in South Africa.

Few studies (O'Malley, 1991; Quinn, 1996; Despina, 2001) have been conducted from a nurses' perspective towards family needs in the ICU, while many studies (Lee and Lau, 2003; Engstrom, 2004; Hughes, 2005; Williams,

2005) focused on families' perspectives. It is critical to know what nurses perceive or think about family members' needs in an ICU, as nurses are the ones who spend most of their time with patients and family members in ICUs. Moreover findings from these previous studies (Norris, 1986; Quinn, 1996; Kleinpell, 1992) have revealed that nurses and families hold different perspectives regarding family needs in an ICU. As a result, without studying nurses' perceptions of family needs, the exploration of family members' needs in an ICU may not be complete.

This research will study family members' needs bilaterally from both the families' and the nurses' perspectives. The findings of this study will be described and compared in order to find out whether the family needs from the families' perceptions and from the nurses' views would be the same or not in local hospitals. It will also be interesting to know the extent and circumstances of family support in South Africa. This study is part of a large collaborative study in progress which is investigating family support needs and testing family support interventions.

1.2 THE RESEARCH PROBLEM

(1) Studies reveal a great need for family support in the ICU, because the critical and sudden nature of illness may lead to urgent and unexpected admissions to the ICU. The families are not usually prepared for these sudden

admissions. The ICU environment, with its high technology, flashing lights and activated alarms may upset the families. Nurses' attitudes and restrictive visiting policies could also affect family members negatively.

(2) Nurses are reported to be unable to meet family needs: because of 1) the focus that is on the patient's needs only; 2) a lack of knowledge about family needs identified in the literature; 3) a lack of time to meet the needs; 4) needs that are ignored or forgotten, and 5) a lack of understanding of the importance of family needs being related to patients' outcomes.

(3) Most studies regarding family needs in the ICU were conducted from families' perspectives, rather than nurses' views. It is significant to understand the perceptions of families' needs from the nurses' perspectives as well; otherwise it may be very difficult to draw a complete picture of family needs and to improve nursing care if only one side of the problem is considered.

(4) Family needs in South Africa: Both patients and families' needs for support in South Africa are a neglected area. The context of the previous studies is different, as mentioned before, most studies related to this topic have been done in Western and European developed countries, as a result, these may not present the reality of the problem in South Africa.

1.3 PURPOSE OF THE STUDY

To describe and compare the needs of families of critically ill patients in two adult ICUs from both the family and nurses' perspectives.

1.4 OBJECTIVES OF THE STUDY

1.4.1: To describe the family members' needs from families' perspectives

1.4.2: To describe the family members' needs from nurses' points of view

1.4.3: To compare the families' and nurses' perspectives of family needs in the ICU.

1.5 SIGNIFICANCE OF THE STUDY

(1) This study could improve ICU nurses' practice to meet particular family needs in ICU based on evidence and priority, through identifying family needs.

(2) In this study, the possible gap between the services that the local ICUs currently provide to meet family needs and the real family needs may be revealed. As a result, the study could assist the ICU in changing strategies of management and making more appropriate policies and procedures for meeting family needs.

(3) This study may contribute to the education of local ICU nurses and nurse students in terms of identifying different family needs in ICU. Moreover, further

studies such as establishing specific strategies of how to meet family needs could be based on the findings of this research.

1.6 OPERATIONAL DEFINITION OF TERMS

1.6.1 Adult Intensive Care Unit

The adult Intensive Care Unit (ICU) is a specially staffed and equipped hospital unit dedicated to the management of patients with life-threatening illnesses, injuries or complications (Bersten & Soni 2003, p. 03). In this study, the adult ICU is a unit where specially prepared and experienced staff treat adult patients rather than paediatric patients.

1.6.2 Critical care nurse

A critical care nurse is usually a clinical nurse specialist who obtained specific ICU training after the basic nursing educational requirements for all nurses. Critical care nurses work at an advanced level of patient care in a medical-surgical ICU. According to the South African Nursing Council (SANC), a critical care nurse is a registered nurse who holds an additional qualification in Medical-Surgical Nursing: critical care (Government Notice R212 of 1986, as amended). In South Africa, some registered nurses gain ICU experience without a specific ICU qualification. In the context of this study critical care nurse includes the latter category of ICU nurses.

1.6.3 Critical care nursing

Critical care nursing is a specialty area of nursing that involves caring for families and patients who are undergoing life-threatening illnesses or injuries or potentially life-threatening illnesses or injuries (ANNC, 1997).

1.6.4 Critical patient

Critical patient refers to the patient who has a life-threatening illness or injury, and who requires intensive medical or surgical intervention, treatment and further observation.

1.6.5 Family

Family can be described in many ways. Thirty years ago, a family was viewed as a group with kinship ties of blood and marital status, in a specific social context, each having their own roles and functions (Hymovich, 1979). This form of family was also referred to as an extended family. All known societies involve some form of family system, although the nature of family relationships is widely variable. In modern societies, the main family form is the nuclear family, although a variety of extended family relationships are also often found (Giddens, 2006).

This study was conducted in South Africa where the culture and the majority of families adopt the form of the extended family. As a result, in this study the

respondents will be selected from of extended family members, including all the target family members directly linked to the patients either by blood or marriage.

1.7 CONCLUSION

This chapter has presented the background to the problem, problem statement, purpose and objectives of the study including the significance of the study and operational definition of variables used in the study.

Subsequent chapters will present the background literature which includes the empirical and conceptually theoretical literature which supports this study. the methodology will be presented and a discussion of the findings will be set out in Chapters Three to Five respectively.

Chapter Two

LITERATURE REVIEW & THEORETICAL FRAMEWORK

2.1 INTRODUCTION

According to Brink (1996: 76) the literature review is a process that involves finding, reading, understanding and forming conclusions about published research and theories concerning a particular topic. The purpose of literature review can be seen as follows:

- to determine what is already known about the topic to be studied
- to obtain clues to the methodology and instruments to be used
- to refine certain parts of the study
- to identify information that may compare with new findings
- to inform or support the study

Polit & Beck (2003: 89) have pointed out that a thorough literature review provides a foundation on which to base new knowledge and is usually conducted well before any data are collected in quantitative studies.

In terms of this study which is to explore family members' needs in ICU, the literature review will be conducted from four aspects, namely:

- family members' needs and experiences toward the admission
- family members' needs from the family members' perceptions

- family members' needs from nurses' perceptions
- reasons causing family needs to be unmet and strategies to meet family needs

2.2 FAMILY MEMBERS' NEEDS AND EXPERIENCES

Families are usually severely affected on admission and when the condition of the patient takes a turn. The perceptions and attitudes of both families and nurses towards ICU admission play a great role. Therefore this section deals with these aspects (Bucher & Melander, 1999).

2.2.1 Feelings and experiences of family members towards the admission

The admission of a relative to an ICU following a critical illness is viewed as a crisis for both the patient and his/her family members (Molter, 1979; Leske, 1986). The sudden illness and unplanned admission affect the family and its function. The threat of possible death brings a host of additional alterations to the family (Bucher & Melander, 1999). Having a relative admitted to an ICU qualifies as a traumatic stressor which can trigger family members' feelings of distress, anxiety, fear and helplessness (Millar, 1991; Holden, 2002). In addition, families may feel a sense of guilt or responsibility for their relatives' admissions and may berate themselves for not seeking medical assistance earlier (Zainal and Scoles, 1997). During the patient's stay in the ICU, the

situation for relatives is generally described as a disrupted emotional state characterised by feelings of uncertainty (Jamerson, 1996. Van Horn and Tesh, 2000).

Family members are also impacted on physically by the unexpected admission, and symptoms such as sleep disturbance and impaired nutrition may occur (Van Horn and Tesh, 2000a).

Role alterations, uncertainty, anxiety, depression, loss of control, being in an unfamiliar environment, isolated from the patient, financial constraints and fear of loss are some of the factors that have been shown to cause family crisis and disorganisation during the period of admission, as well as the further ICU stay (O'Malley, 1991; Jamerson, 1996; Mendonca & Warren, 1998; Lee & Lau, 2003).

2.2.2 Family members' needs from family members' perception

Studies (Daley, 1984; Bouman, 1984; Lee and Lau, 2003; Williams, 2005; Freitas, 2007) have engaged with the needs of family members who have a critically ill patient in the ICU from family members' perspectives. The majority of these studies have adopted a quantitative approach utilising Molter's Critical Care Family Needs Inventory (1979) which is a major study that identified a number of needs of relatives of critically ill patients. In this study

40 relatives were investigated with a structured interview technique through the CCFNI. In the findings of this study, the needs which related to hope, information and visiting were rated as the highest. However, Molter's approach has been criticised for failing to address the more subjective, or less tangible aspects of families' experiences (Zainal and Scoles, 1997).

The early study from Daley (1984) identified the need to know the patient's outcome, the treatment, the environment; that the best care is being given and to be called at home when the patient's condition changes as the first five most important needs expressed by family members.

Bouman (1984) also showed similar results which are that: the best care is being given, the progress, the outcome, being called at home, as well as knowing exactly what is being done for the patient.

Lee and Lau (2003) conducted a study to measure family needs in the ICU in Hong Kong. The top five needs from family members' perceptions were (1) to know the expected outcome (2) to have questions answered honestly (3) to be called at home about changes in the patient's condition (4) to be assured that the best care possible is being given to the patient, and (5) to know that the patient is being treated medically.

In Williams' study (2005), the key needs of family members with a relative in ICU were indicated as follows (1) to feel there is hope, (2) proximity to the patient, (3) honest information regarding the patient's progress/prognosis. (4) reassurance and relief from anxiety, (5) to feel that the patient is receiving high quality care, (6) to feel that ICU staff care about the patient, (7) to provide reassurance and support to the patient.

Freitas and colleagues (2007) have conducted a study recently in Brazil regarding family needs in public and private hospitals. The first five most important needs in the two hospitals were as follows, 1) to know the expected outcome, 2) an explanation of the ICU environment before going into it for the first time, 3) to talk to a doctor every day, 4) to have a person to call at the hospital when family are unable to visit and 5) to have questions answered honestly.

Although studies have made great progress since the early days when Molter (1979) started to investigate family needs in the ICU, today, studies from different locations and cultural backgrounds in the world have shown similar findings with regard to family needs in ICUs from families' perceptions.

2.2.3 Nurses' attitudes towards family needs

Chesla and Stannard (1997) advocated that nurses' attitudes towards family

members may be guided by their habits of traditional practice, by the individual nurse's education, knowledge, work experience, and his/her perception of the family's needs.

Although many ICU nurses have engaged with family-centred and holistic care approaches, they still have many negative beliefs and attitudes towards family members. Plowright's study (1998) has shown that nurses believe that their practice will be disrupted by family members visiting when they are busy caring for patients, therefore, nurses may restrict visiting time, or tell family members to leave because the patients need rest, or use other reasons to limit them. Plowright (1998) pointed out that nurses with more ICU work experience may understand better the importance of the physiological and psychological effects of visiting. This may be because they have experienced many situations in which both family members and patients benefited from adequate visiting.

Maloney (1983) reported that nurses responses to meeting family needs were not solely a nursing responsibility. Family needs were perceived as less important than meeting patient care needs. In this study, families and nurses regarded visitation as stressful; families experienced an increased level of anxiety, and nurses felt threatened when dealing with families.

Kirchhoff (1993) and Simon (1997) suggested that some nurses have a tendency to restrict family visitation, despite their understanding of the importance of visiting for both the patient and family members. Often, just for their convenience of work; family members are still treated negatively by nurses.

2.3 FAMILY MEMBERS' NEEDS FROM NURSES' PERCEPTIONS

Few studies have been found that were conducted from nurses' perspectives regarding family needs in the ICU. O'Malley (1991) conducted a study in Australia aimed at examining family needs from the nurses' points of view. A questionnaire adapted from the CCFNI was used. The result showed that the cognitive needs (knowledge of treatment, quality of information and access to information) ranked higher than psychological needs (including relatives' psychosocial needs, assurance regarding competence of staff and changes in condition of care and anticipatory needs) and physical needs. The results also showed that the majority of nurses perceived that family needs were important, and 85% indicated that they felt able to meet these needs. However there was variation in the responses of nurses from different ICUs and with varying experience. O'Malley (1991) suggested that further study should test the influence of nursing experience, education and nurses' perceptions towards family needs.

In Quinn's study (1996), the needs of relatives visiting adult ICUs were compared to relatives' and nurses' perceptions. In the conclusion of this study, Quinn (1996) pointed out that relatives and critical care nurses differ in their perceptions of the importance of the need to visit the patient. In addition, education levels and work experience may affect nurses' ability to accurately assess family needs. Even some nurses in this study who hold a post-basic qualification did not reflect an accurate knowledge of the importance of relatives' needs. Quinn (1996) suggested that the needs of relatives in critical care units should be part of the curriculum of all post-basic critical care nursing courses.

Despina (2001) studied nurses' perceptions of family care in Greece. This study showed that most nurses agreed that family members had obvious needs for care, such as education, and emotional support. However inadequate training for meeting family needs was reported from most nurses in this study.

Studies (O'Malley, 1991; Quinn, 1996a, b; Mendonca and Warren, 1998; Kosco and Warren, 2000) have shown that nurses may not always think and assess the needs of families in the same manner as families themselves experiencing their own needs. Jacono (1990), leske (1992), and Walters (1995) indicated that there were important differences between nurses and

families in perceived family needs. Kosco and Warren (2000) reported that nurses agreed with families on only 4 of 10 identified family needs. Maxwell (2007) also reported that nurses and family were in agreement with 5 of 12 of the most important family needs. The most common differences in perceptions towards family needs between families and nurses concerned visiting, involvement, family role, nurse's role in ICU (Jacono, 1990; Williams, 2005; Fox, 2005).

2.4 REASONS CAUSING FAMILY NEEDS TO BE UNMET

Another study from O'Malley (1991) revealed that reasons which may affect nurses' perceptions towards their responses to family needs are whether nurses perceive family needs as important, the ability to meet these needs, the ICU environment and time available. It is true that ICU nurses frequently have to deal with patients, and need to respond rapidly to patients' condition changes at any time, while also answering questions from family members. These significant factors would influence nurses' attitudes and their ability to meet families' needs.

Daley (1984) has indicated 5 possible reasons why family needs are not met by nurses, namely (1) lack of time to meet the needs; (2) the need is ignored or forgotten. (3) the focus is on patients' needs only, (4) a lack of knowledge about family needs identified in the literature, and (5) a lack of understanding

of the importance of family needs related to patient outcomes.

2.5 STRATEGIES TO MEET FAMILY NEEDS

The strategies of meeting family needs are based on the initial understanding of common family needs at different stages during the crisis. In addition, provision of information, emotional support, involvement of family in patient's care and a positive nurse's attitude towards family members in the ICU have been shown as effective strategies to meet family needs (Hammond, 1995; Hupcey, 1998; Hughes, 2004; Johansson, 2005).

2.5.1 Family needs at different stages during the crisis

Jamerson (1996) has described a four-stage process a family may go through when a relative is admitted to an ICU. (1) Hovering: is the initial stage as the family gets to know about the admission. Confusion, shock, stress, and uncertainty characterise family members' feelings at this stage. At this stage, providing the family with information about the patient's condition and orienting the family members to the ICU environment and routines are essential. (2) Information seeking: is the active process of gathering information about the patient. The sources of information such as message boards, booklets or relative websites may help a family to collect information related to the patient's condition. (3) Tracking: tracking is the process of observing, analysing, and evaluating the patient's care as well as the

environment and caregivers. (4) Garnering of resources is the final stage experienced by family members. The garnering of resources is the acquisition of what family members perceive as needs for themselves or their family members, such as rest, nutrition, personal space or privacy and support from other family members, friends, etc.

2.5.2 Information providing

The need of family members for information has been identified as one of the most important family needs in the ICU (Molter, 1979; Norris & Grove, 1986; Davis-Martin, 1994; Lee, 1999; Agard, 2006). In an ICU environment, the important role information plays in helping relatives to cope, to reduce fear of the environment, and to promote communication of information is fundamental to the coping process (Hughes, 2005). However, Bowman (2000) pointed out that in a crisis situation, due to the fact that a person's level of arousal and stress increases, family members may have great difficulty processing and retaining information. As a result, nurses should understand these circumstances and constantly provide the family with adequate information regarding the patient's condition and treatment while also effectively answering questions from families in order to decrease the stress level of the family (Wilkinson, 1995),

2.5.3 Emotional support

Emotional support provided by the ICU staff is essential for meeting family members' needs, because most of the family members are stressed and hopeless either due to the life-threatening situation of the patients or due to them having been told by the doctor that there is little hope for the patient's survival. The life-threatening event will have occurred suddenly and without warning and preparation, and family members will experience powerlessness at being unable to help the patient and at having no choice other than to rely on the ICU staff. As a result, ICU nurses should definitely understand the situation and the feelings family members encounter at such times, and should support them emotionally by explaining the patient's disease or condition and treatment, as well as by encouraging them to come close and touch the patient, and to visit the patient frequently. Hupcey (1998) indicated that family members must be supported and comforted emotionally so that they will be able to be there and support patient.

2.5.4 Involvement of the family member

It is crucial and essential for a nurse to understand the importance of the involvement of the family members in patient care which will contribute to the patient's recovery and outcome, and also that this is one of the strategies towards meeting family members' own needs.

From the patient' viewpoints, all the ICU staff around them are strangers. The patient will not know what has happened to him/her and in some cases, patients cannot talk due to their illness. As a result, patients may feel stressed and anxious. This is the time when they most need support from family members. Studies (Plowright, 1998; Price, 2004; Williams, 2005) showed that the family provided vital sources of emotional support to patients, and that the presence of relatives at the bedside appeared to have a positive psychological effect, reducing the patient's anxiety and calming the patient through the period of ICU stay. Undoubtedly, a patient's recovery and outcome would be affected positively if family members could provide the patient with support by being involved in the patient's care.

On the other hand, the involvement of family members in a patient's care is a way of meeting the families' needs. Hammond (1995) explained that families could benefit emotionally from participation in patients' care during a crisis. While families participated in care, family members witnessed the treatment and nursing care given to the patient, and they were also able to give some physical care directly to their loved one. As a result, they felt less anxious and isolated because they felt that they were contributing and doing something for their loved one (Johansson 2005).

O'Malley (1991); Fox (2005) reported that family members are likely to be less

stressed when their needs are being met, and will therefore be in a better position to support the patient, thereby facilitating the recovery process. However, a conflict relationship between families and nurses can contribute to increased family stress and can impede family members' ability to provide social support to the patient, which could impact negatively on the patient's recovery process.

2.6 THEORETICAL FRAMEWORK

The Bowen's Family Systems Theory (1978) will be adopted as the theoretical framework that the research will follow.

The family as a fundamental unit forms our societies. Each family is comprised of each individual family member, and, as a holistic unit, every family member links to each other, not only by the tie of blood, but also by the specific function and emotion (Bowen, 1978). Bowen's Family Systems Theory is a theory of human behaviour that views the family as an emotional unit and uses systems thinking to describe the complex interactions in the unit (Kerr, 1988:31). According to Bowen (1978), the family is an emotional system which means that family members are emotionally interdependent and function in reciprocal relationships with one another. Family members are profoundly affected by each other's thoughts, feelings and actions. As a result, a change in one family member affects all other family members (Wright &

Leahey, 1994).

A family is a holistic unit and always tries to maintain its homeostasis. However, if the stressor is greater than the degree to which the family can cope with and adjust to by themselves, symptoms of dysfunction then occur in the family. ICU admission as a critical stressor could trigger a feeling of anxiety among family members which might spread infectiously among them, and, as anxiety goes up, the level of stress becomes higher. Eventually, one or more members feel overwhelmed or out of control. According to Bowen (1978:199) when the family's internal resource of coping is not available or exhausted, the family needs external resources to assist them in order to overcome the difficult situation.

Figure 1 below created by the researcher in order to apply Bowen's theory in the study. In this figure, the event of admission to the ICU produces anxiety, and increases the tension of family members, because each family member is linked to others, not only by blood, but also by emotion and specific family function and role. For instance, if the patient is the only one who earns an income for the whole family, this means that once s/he is admitted to the ICU, there will be no one to support the family financially, and, as a result, the homeostasis of the family is disrupted.

Furthermore, the ICU environment and threatening equipment such as ventilators and monitors makes families distressed. Family members cannot restore the balance by themselves; they experience powerlessness at being unable to help the patient and having no choice other than to rely on the healthcare professionals (Johansson, 2005).

ICU nurses as external resources could reduce family anxiety and stress by providing family members with emotional support and information, as well as encouraging family participation in the patient's care. On the other hand, the nurse provides nursing care, medical treatment, emotional and physical support to the patient.

By supporting both family members and patients in the ICU environment, the nurse would restore the homeostasis between the family members and the patient. Williams (2005) reported that when family stress is reduced, families could better support their relatives while concurrently meeting their own needs.

Therefore, an ICU nurse who is a stranger, outside the family unit, should consider that it is not only the patient who, as part of the large family unit, needs to be cared for by providing nursing and medical treatment, but the rest of the family. They also need to be supported by means of emotional

reassurance, by being encouraged and by having their needs met at the same time, so keeping their balance as a whole unit.

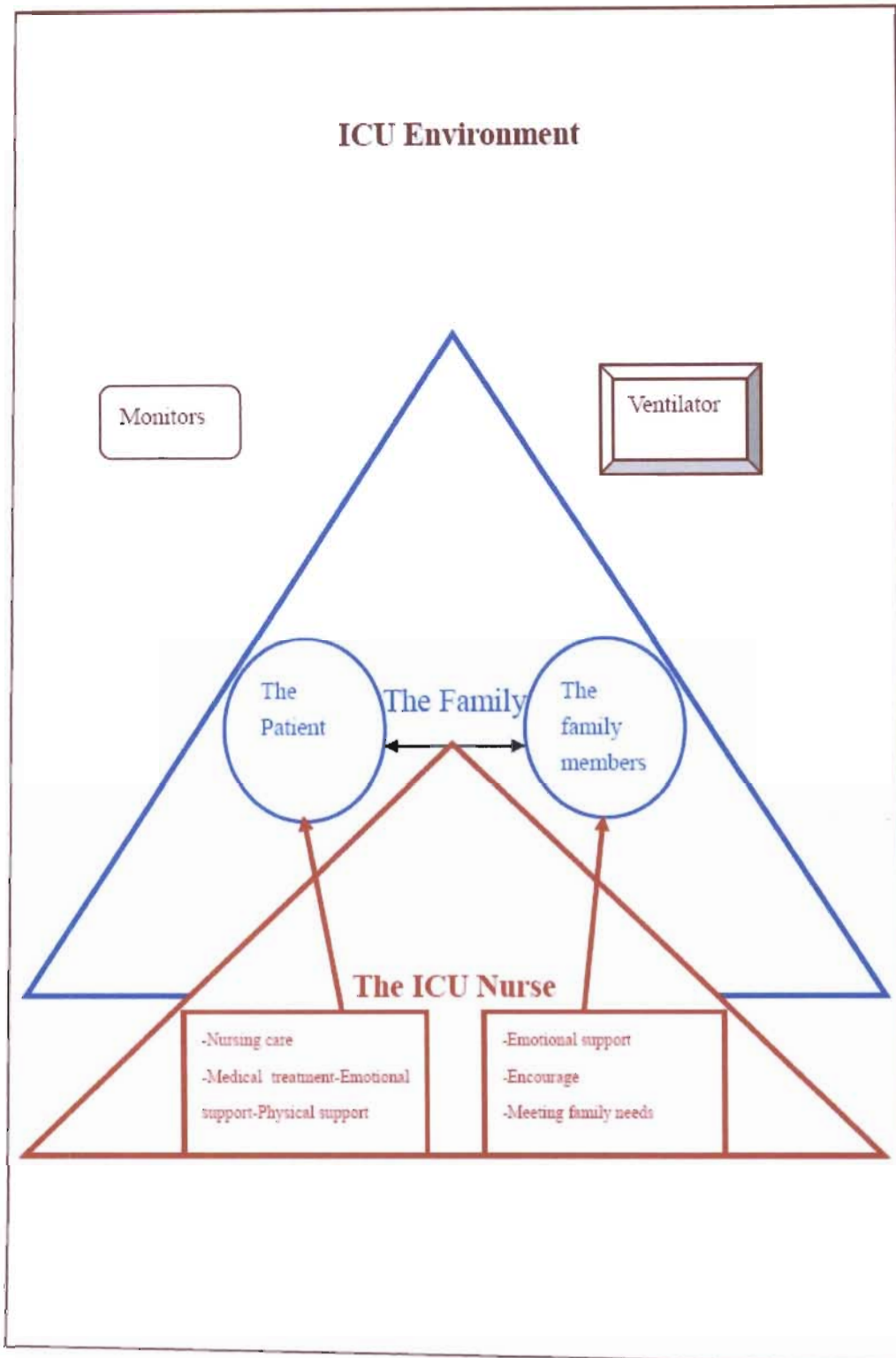


Figure 1: Modified from Bowen's Family Systems Theory. ICU nurse keeps the family's homeostasis by supporting the patient and the family members as a whole.

(Adapted from Bowen 1978: 199)

2.7 Conclusion

The chapter has presented an overview of literature covering the experiences and needs of families from both the families' and nurses' perspectives including the attitude of nurses towards family needs. The challenges faced by nurses in meeting these needs including suggested strategies by various authors are also covered. From this literature it appears that there is some paucity in literature that compares the perspectives of both the families and nurses in relation to family needs and meeting them. The theoretical framework underpinning this study has been presented and will guide the discussion of this study in subsequent chapters.

Chapter Three

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, a description is made of the research methodology which includes design, setting, population, sample and sampling, data collection process and data analysis. Data collection instruments including issues of reliability and validity and ethical considerations of the study are also discussed.

3.2 RESEARCH DESIGN

In this study a non-experimental descriptive survey design with a quantitative approach is used to explore the ICU patients' family members' needs from both the families' and nurses' perspectives.

3.2.1 Quantitative research

According to Polit & Beck (2004:729), quantitative research is the investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design. Quantitative research is based on numeric information that results from some type of formal measurement which is analysed through statistic procedures

(Polit & Beck 2004:16). A quantitative approach is selected because the nature of this study is to establish the specific family needs which are based on families' and nurses' perspectives by using a questionnaire as the survey tool for data collection. Subsequently, the results from families and nurses will be compared numerically.

3.2.2 Descriptive research

Descriptive research seeks to describe phenomena in real life situations (Bums & Grove 2001: 24). According to Polit and Beck, (2004:192) the purpose of descriptive research is to observe, describe, and document aspects of a situation as it naturally occurs. In this study, results will be described according to their real situation, for example, frequency, percentages. Final findings also need to be described, based on results. The researcher would thus be able to describe the relationship between variables, discern possible new findings and compare these to already existing data and make possible recommendations for current ICU management, practice, education as well as future studies.

3.3 SETTING

Two adult Intensive Care Units in two hospitals were selected for the study. These hospitals are located in Durban, in KwaZulu-Natal province, one of the nine provinces in South Africa. One of the hospitals has been operating at a

tertiary level until recently when it was downgraded to regional level though it still accommodates tertiary level patient load. Two tertiary hospitals (one was provincial, another one is the central and tertiary care referral hospital) where were located in central Durban, South Africa were selected. These hospitals were chosen because of their accessibility to the researcher, and also because both the two hospitals have ICUs. The two hospitals were government hospitals.

The provincial hospital has a bed status of 650, with about 2000 out- patients a day. It provides a tertiary service for the entire province of KwaZulu- Natal with a population of approximately 5 million. The provincial hospital has about 15 beds in a surgical-medical ICU and about 52 registered nurses permanently work in the ICU

(<http://www.kznhealth.gov.za/kingedwardhospital.htm>).

The central and tertiary care referral hospital in Durban is the first hospital in South Africa to adopt a public/private partnership in the delivery of its services with about 850 beds in total, and 60 beds in different ICUs, and around 135 ICU nurses (<http://www.kznhealth.gov.za/IALCHhospital.htm>.)

3.4 POPULATION

The population can be described as all the elements that meet the criteria for

inclusion in the study (Burns & Groves, 2001). The entire set of individuals (or objects) having some common characteristics; sometimes called the universe (Polit & Beck, 2003). In this study, the target population consists of all registered nurses working in ICUs and ICU patients' family members over the period of October to November 2008 in eThekweni District Durban, South Africa.

3.5 SAMPLE AND SAMPLING PROCEDURES

A sample is a subset of the population that is selected for a particular investigation. Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2003). It is a representation of the population (Burns & Grove, 2001).

In this study, the number of family members was calculated according to the number of patients admitted to the two ICUs during the given time as the ratio of 1 patient: 2 family members, this statistical data was given by the ICUs from the two hospitals. The average rate of ICU bed occupancy in the Regional hospital is about 70% (11 out of 15 beds) over the past 2 years while the figure is 75% (45 out of 60 beds) in the Tertiary hospital. Statistical data showed that the average number of ICU patient admissions monthly at the Regional hospital is about 50, and has been 150 per month in the Tertiary hospital since January 2008.

A non-probability convenience sample was used for this study. Convenience sampling, also called accidental sampling, is a selection of the most readily available persons as participants in a study (Polit & Beck, 2003). The method of convenience sampling has been chosen for this study, because it is convenient for the researcher to collect data, and also because of limited time. The sample was collected from the adult medical and surgical ICU.

Sample size: Fifty (50) ICU nurses with 25 nurses from each hospital were selected. The study also included 50 family members with 25 family members from each hospital. Family members were requested to select one member of the family that the researcher could give the questionnaire to fill in. All the respondents were selected purposively

3.6 SELECTION CRITERIA FOR PARTICIPANTS

3.6.1 ICU nurses were selected according to the following criteria:

- were critical care nurses who were either trained or experienced
- working in an ICU
- had worked in an ICU for at least 6 months

3.6.2 ICU patient family members were selected as follows:

- were related to the patient either by blood or marriage
- whose loved one had been in the ICU for at least 2 days

- were 18 years or older for consent
- participated on a voluntary basis

3.7 DATA COLLECTION INSTRUMENTS

This study adopted the Critical Care Family Need Inventory (CCFNI) (Molter, 1979) (Appendix: 1) as the instrument for data collection.

In the CCFNI, 45 need items were listed, and every need item was ranked by a four-point Likert-scale in the format (1) not important, (2) slightly important, (3) important, (4) very important.

The 46th need item as "other needs" was added by the researcher in order to allow participants to express other needs that are not mentioned among the 45 need items.

Participants were asked to choose the most appropriate single answer from each item. In this study, family members and nurses used the same CCFNI, and an isiZulu (Appendix: 2) version of CCFNI was available for participants to choose. The isiZulu version of CCFNI was translated by a qualified staff member and was reviewed by the research supervisor and senior nursing managers in the two target hospitals. The research supervisor is an experienced ICU nurse and speaks isiZulu as her first language.

3.7.1 Measures for ensuring reliability and validity of the instrument

An instrument's reliability is the consistency with which it measures the target attribute, reliability also concerns a measure's accuracy (Polit & Beck, 2003). Furthermore Polit & Hungler 1997:297 define reliability as "the degree of consistency or dependability with which the instrument measures attitudes it is supposed to measure". The reliability of an instrument can be assessed in different ways, according to Polit & Beck (2003), although three key aspects are stability, internal consistency, and equivalence.

Validity can be defined as "the degree to which an instrument measures what it is intended to measure" (Brink 1996:168).

The Critical Care Family Need Inventory (CCFNI) has been adopted by many studies (Leske 1991; Wilkinson, 1995; Burr, 1998; Lee I 1999; Maxwell 2007) in different countries, and its reliability and validity have been tested repeatedly ($R=0.79-0.88$). However, in the context of South Africa, no study using CCFNI was found in the literature review.

When considering the reliability of the instrument, the researcher chose to use the test-retest reliability technique. Test-retest reliability is described as the assessment of the stability of an instrument by correlating the scores obtained on repeated administrations (Polit & Beck, 2003:734). All participants were

told that they would be asked to repeat the same questionnaire again after one week, in order for the researcher to determine whether the questionnaire was suitable for use before the major research took place.

The results from the two administrations of the same questionnaire to family member groups and nurse groups were calculated for reliability (r). The family group indicated $r=75\%$, and the nurse group $r=83\%$.

In order to measure the validity of the instrument, content validity was tested matching objectives of the study and the conceptual framework with the items in the instruments. A pilot study was also conducted as described below.

3.7.2 Pilot Study

Bless and Smith (2000: 55) define a pilot study as a small study conducted prior to a large piece of research to determine whether the methodology, sampling, instrument and analysis are adequate and appropriate. The purpose of conducting a pilot study for this research was to see whether the participants understood the questions, or experienced any difficulties when responding to these questions, as well as whether these questions really reflected the truth between what the researcher planned to measure and what the real family members' needs in adult ICUs are according to families' and nurses' viewpoints. The CCFNI was developed by Molter (1979), and had

been used by number of researchers in Western and European countries. However, in the context of South Africa, the utilisation of CCFNI was not found in the literature review yet South Africa differs from these countries culturally and economically.

A pilot study was conducted in a third hospital which was also located in Durban, but was not one of the two target hospitals before the major study took place. This hospital is also a public hospital operating at regional level and has the same type of ICU as target hospitals. Five ICU nurses who worked for this hospital and five family members were selected by the same criteria as the major study. All these participants had met the criteria for selection. Questionnaires were given out for completion, and ten completed questionnaires were collected by the researcher. All participants had been told that they could ask the researcher for explanations. All participants were observed for such instances, however, no questions were asked by participants throughout the process. The duration for completion of the questionnaire by all participants was 25 to 35 minutes.

The researcher asked all participants from the group of family members after their completion about their experience of the questionnaire and whether they found it easy to understand and also, if it matched their needs, or some of their needs. All participants acknowledged the value of the questionnaire and

it appeared that they had no difficulties in completing it. Similarly, feedback from the nurse group showed that they experienced no difficulty in understanding these questions, and found the questionnaire to be suitable for use in the study from their perspective. Both nurses and family members reflected that the questionnaire was suitable for the research to identify and describe the family needs in adult ICUs from family members' and nurses' perspectives.

The researcher also gave the same questionnaire to three ICU senior nurse specialists and to the research supervisor to assess for content and face validity of the instrument. The recommendations from them showed that the questionnaire included family needs in the ICU comprehensively, and should be suitable for use to measure family needs in the local hospitals. Furthermore, the instrument was in accordance with the purpose of the research, however, due to language barriers, an isiZulu version of the questionnaire should be available for participants as an option.

In conclusion, the researcher tried to ensure that the instrument used in this study was valid, by testing its content and face validity, and measuring its reliability by Test-retest reliability. The results from both family members and nurses involved in this pilot study showed that the instrument was valid. Recommendations from three ICU senior nurse specialists and the research

supervisor also confirmed its validity by assessment for content and face validity. Test-retest reliability revealed the family member group as $r=75\%$, and the nurse group as $r=83\%$. This pilot study showed the similar reliability of the CCFNI compared to previous studies by Leske (1991), Burr (1998), Lee (1999), Maxwell (2007) in which the reliability of the CCFNI ranged from 0.79 to 0.88. As a result, the researcher believes that the validity and reliability of the CCFNI is adequate, and that it was suitable for the researcher to use in the local hospitals in order to carry out this research.

3.8 DATA COLLECTION PROCESS

Appointments were made with the respective managers of each ICU. Charge nurses had made arrangements with these family members who their loved one was admitted over two days. Each family assigned one member to fill in the questionnaire. An introduction and explanation to both family members and nurses about the research was effected verbally, and the potential risks and benefits, confidentiality, anonymity, withdrawal, self-determination as well as voluntary participation were emphasised. A consent form (Appendix: 3) was signed by participants on a voluntary basis with IsiZulu version (Appendix 4) provided for the understanding of those who could not understand English. Data was collected in the ICU waiting area for family members (one family member per ICU patient), a private room was used to provide families with privacy, and the door was closed and labelled during the period of data

collection. Data collection for families mainly took place during visiting time based on different hospital policies. Tea-times and lunch breaks were used for nurses to complete the questionnaires. In order to protect participants' confidentiality, a box was made available for participants to drop completed questionnaires into. The researcher remained at a distance from participants while they were filling in the questionnaire, so that they could fill in the questionnaire independently. However, the researcher ensured his availability to answer questions from participants regarding the questionnaire.

3.9 DATA MANAGEMENT

Data was safeguarded after collection with only the researcher and the research supervisor being able to access it. This data will be kept with the supervisor for five years from completion of the study.

3.10 DATA ANALYSIS

Statistical procedures were used with the assistance of a statistician. The Statistical Package for the Social Sciences (SPSS Version: 15.0) computer program was used to analyse data. Data analysis was organised in two sections:

Section A: presented and described the biographic information of participants for both family members and nurses. Demographic data was presented in

frequency tables and percentages.

- Family members (Appendix: 5) and IsiZulu version (appendix 6)
- Nurses (Appendix: 7) and IsiZulu version (Appendix 8)

Section B: Described and compared the data regarding the CCFNI from families' and nurses' responses. Data was analysed in 3 parts:

Part 1: In the family group, data was analysed by obtaining the mean from each item of the 45 need items, data was then described and presented as a ranking which was established by comparing the 45 mean scores in order of the highest mean to the lowest mean of items. The Confidence Interval (CI) was set up at 95% in order to establish a range of values for the population means as well as the probability of being right –the estimate is made with a certain degree of confidence (Polit & Beck, 2003:479). The 45 need items were divided into five categories which were based on Leske's categorization (1991). The five domains are needs for (1) support, (2) information, (3) reassurance, (4) closeness, and (5) comfort. The average mean scores for each category were also calculated and compared.

Part 2: In the nurse group, data analysis, description and presentation from the nurses' perspectives was undertaken by the same method as mentioned for the family group.

Part 3: Described and compared the differences in perceived family needs between the family and nurse groups. Firstly, the mean scores of the 45 need items obtained from the two groups in Parts 1 and 2 were compared by use one sample t-test which was used to compare the means of each item between the family and nurse groups, in order to obtain the significance values (p value) for each of the 45 need items. The researcher was then able to compare the significance values which were obtained from the one sample t-test for each need item between the two groups, and to find the possible differences in perceived family needs from nurses' and families' perspectives. The significance level was set at 0.05, and the researcher only considered items of which the p value was less than 0.05 as significantly different. If the p value was more than or equal to 0.05, this meant that there was no significant difference between the family and nurse groups towards this need item.

3.11 ETHICAL CONSIDERATIONS

The study made all efforts to meet the ethical requirements for research as discussed below:

3.11.1 Permission for the study

Ethics approval (Appendix 9) was obtained from the University of

KwaZulu-Natal Research Ethics Committee. Permission was further sought from the KwaZulu-Natal Department of Health (Appendix 10) and from the relevant target hospitals (Appendix 11 and 12) to conduct the study.

3.11.2 Informed Consent

Informed consent is an ethical principle that requires researchers to obtain the voluntary participation of subjects, after informing them of possible risks and benefits (Polit & Beck, 2003). In this study, An English (appendix 3) and an isiZulu version of informed consent form (Appendix: 4) were made available for participants to ensure that the participants understood the information given well enough to give informed consent.

3.11.3 Potential risks and benefits

There were no potential physical or psychological risks to participants. However, it could disturb or upset participants, particularly family members, because they were stressed and worried about their loved ones in the ICU.

The researcher carefully selected the families to avoid those whose relatives were dying. The researcher, however, has sufficient training in Mental Health Nursing to allow him to identify any of the participants who were perhaps experiencing any psychological stress in completing the questionnaire and would have been able to refer them to appropriate support services. It was explained to participants that their participation would potentially contribute to,

and improve the nursing practice in terms of helping family members to cope with the difficult period of ICU admission. For ICU nurses, participation in the study might be somewhat stressful due to their time already being occupied by work. As a result, tea-time or the lunch breaks were used as suitable times for them to participate, instead of disrupting routine.

3.11.4 Confidentiality

Participants were assured that the information that they imparted would be accessible to the researcher and supervisor only, and that the information would only be used for the purpose of this research.

3.11.5 Anonymity

Participants were assured that there was no need to write their names on the questionnaires.

3.11.6 Withdrawal

Participants were informed that they could refuse to participate, or could withdraw from the research at any stage if they did not feel comfortable. Refusal of participation by the family would not affect any patient's care and treatment in the ICU.

3.11.7 Self-determination

Participants had the right to decide voluntarily whether to participate in the study, without risking any penalty or prejudicial treatment. This also meant that people had the right to ask questions, to refuse to give information, to ask for clarification, or to terminate their participation (Polit & Beck 2003: 147).

3.12 Conclusion

The methodology of the study was presented in this chapter to direct the subsequent chapters including issues of reliability and validity. The main ethical issues around research were considered and applied to the study.

Chapter Four

DATA ANALYSIS AND DESCRIPTION OF FINDINGS

4.1 INTRODUCTION

The purpose of this research was to describe and compare the needs of families of critically ill patients from the families' and nurses' perspectives in two hospital adult ICUs in Durban, South Africa. A total of 100 (100%) out of 100 completed questionnaires were collected from the two proposed hospitals. The two hospitals and all participants met the criteria as spelt out in chapter three. Two weeks were spent collecting data from the two hospitals.

Data analysis was organised in two sections:

Section A: presents and describes the demographic information for participants, both family members and nurses who were involved in this study.

Section B: describes and compares the data regarding the CCFNI from family members' and nurses' responses.

4.2 Section A: Participants' demographic information

Demographic information refers to the participants' personal information. For participants who were in the family members' group, the demographic information included age, gender, race, marital status, educational level,

religious background, relationship with the patient, previous ICU visiting history as well as the length of stay of the patient in the ICU. Similarly, the personal information for the nurse group required the nurses' age, gender, race, marital status, religious background, nursing educational qualification, work title, type of ICU training (ICU trained or experienced), and the length of ICU working experience.

The data in section A was analysed by the Statistical Package for the Social Sciences (SPSS, Version 15.0) and was presented in frequency tables and percentages.

4.2.1 The demographics for the families

4.2.1.1 Gender of family member participants

There were 52% (n=26) males and 48% (n=24) females among the family members as reflected in Table 4.1.

Table 4.1: Gender of family member participants (N = 50)

Gender	n	%
Male	26	52%
Female	24	48%
Total	50	100%

4.2.1.2 Age of family member participants

The ages ranged from 18 to 58 years. The majority of the participants, 74% (n=37) were aged between 18 and 38 years; 22% (n=11) were in the age

category between 39 and 48 years and 4% (n=2) were between 49 and 58 years old. See figure 4.1 below.

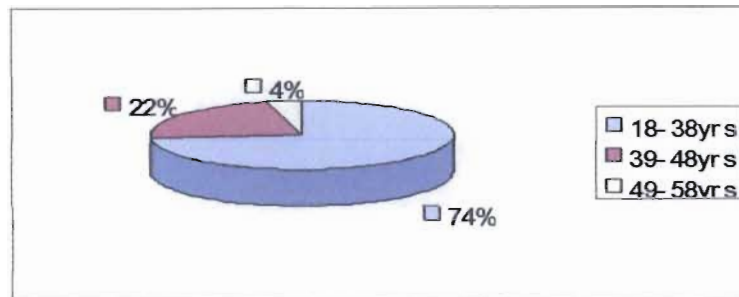


Figure 4.1: Age of family member participants (N = 50)

4.2.1.3 Cultural groups of family member participants

According to figure 4.2, three cultural groups were observed among the entire family members in this study. 64% (n=32) of the participants were African, 32% (n=16) were Indian and 4% (n=2) were White.

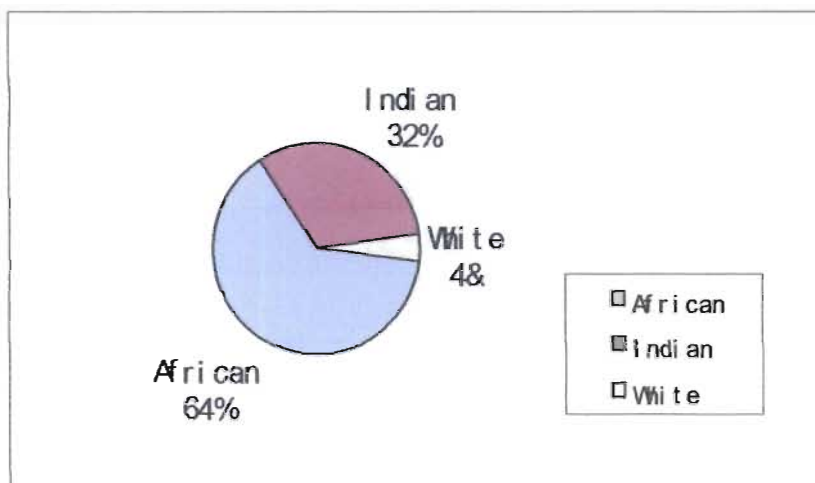


Figure 4.2: Cultural groups of family member participants (N = 50)

4.2.1.4 Marital status of family member participants

In response, 52% (n=26) were married; 44% (n=22) were single; 2% (n=1) was divorced and 2% (n=1) was widowed. See table 4.2 below.

Table 4.2: Marital status of family member participants (N = 50)

Marital status	n	%
Single	22	44%
Married	26	52%
Divorced	1	2%
Widowed	1	2%
Total	50	100%

4.2.1.5 Religion of family member participants

Of the participants, most 82% (n=41) were Christians, while 16% (n=8) were Hindu and 2% (n=1) belonged to other religious groups. See Figure 4.3 below.

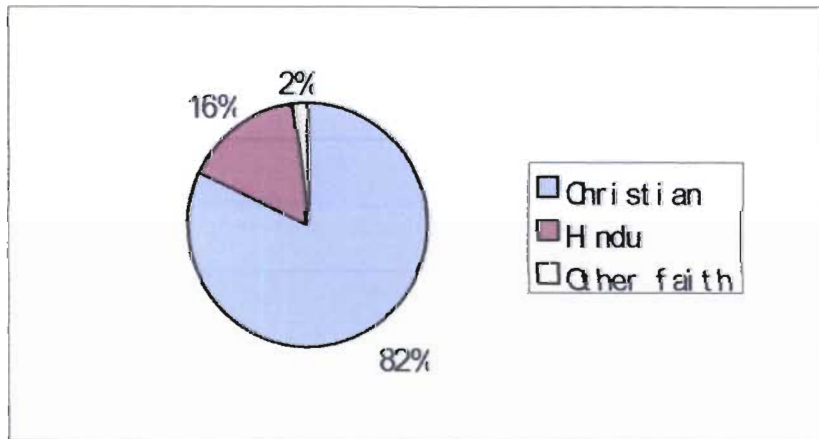


Figure 4.3: Religion of family member participants (N = 50)

4.2.1.6 Education of family member participants

Five educational levels were reported by participants. Thirty-four percent (n=17) were matriculants; 26% (n=13) had received college education, 22% (n=11) were educated up to secondary school level; 14% (n=7) held a University degree; 4% (n=2) had attended primary school. See figure 4.4 below.

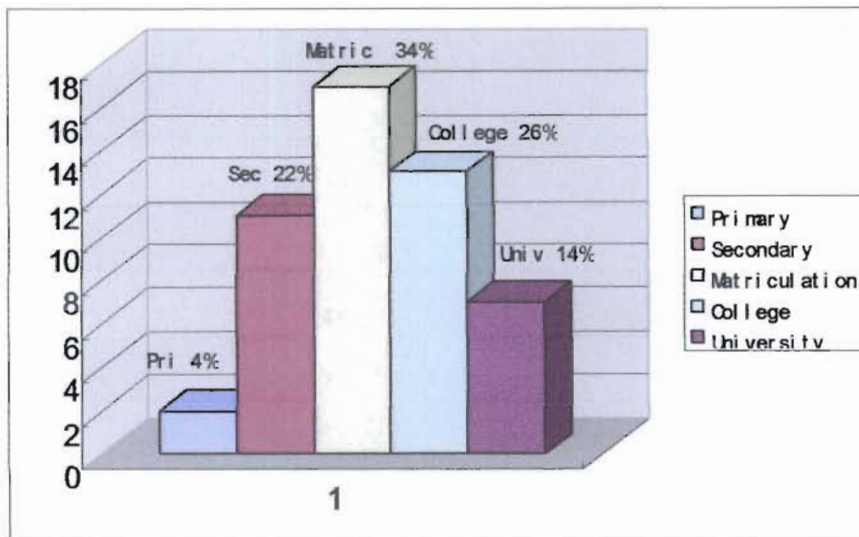


Figure 4.4: Education of family member participants (N = 50)

4.2.1.7 Relationship with patient

Four kinds of relationships namely spouse, sibling, parent, and child were found among the participants and patients in this research. Forty percent of the participants (n=20) went to the ICU to visit their brothers or sisters, 36% (n=18) visited their mothers or fathers, 16% (n=8) visited wives or husbands and 8% (n=4) visited their children. See table 4.3 below.

Table 4.3: Relationship with patient (N = 50)

Relationship with patient	n	%
Spouse	8	16%
Sibling	20	40%
Parent	18	36%
Child (>18 years old)	4	8%
Total	50	100%

4.2.1.8 Previous ICU visiting experience

According to table 4.4 below seventy-four percent (n=37) of the participants revealed that they had never visited any ICU previously, while 26% (n=13) said that they had had ICU visiting experience before.

Table 4.4: Previous ICU visiting experience (N = 50)

ICU visiting experience	N	%
Yes	13	26%
No	37	74%
Total	50	100%

4.2.1.9 Days of the patient has been in ICU

Seventy-two percent (n=36) of the participants reported that the patients had been in the ICU for 2 days; 22% (n=11) said for 3 days, while 6% (n=3) reported that their loved ones had been in the ICU for more than 3 days. See figure 4.5 below.

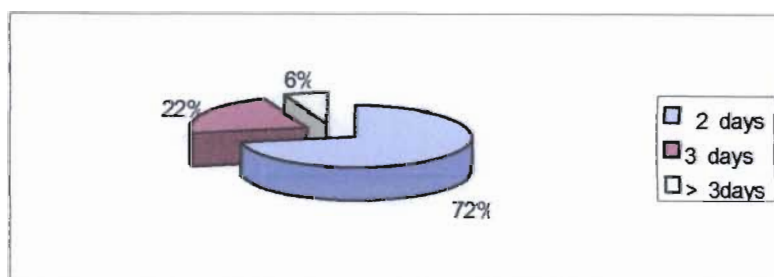


Figure 4.5: Days of the patient has been in ICU (N = 50)

4.2.2 The demographics for the Nurses

Demographics of nurse participants are presented separately from that of families hereunder.

4.2.2.1 Gender of nurse participants

According to figure 4.6 below, of the participants, most nurses 82% (n=41) were females and 18% (n=9) were males.

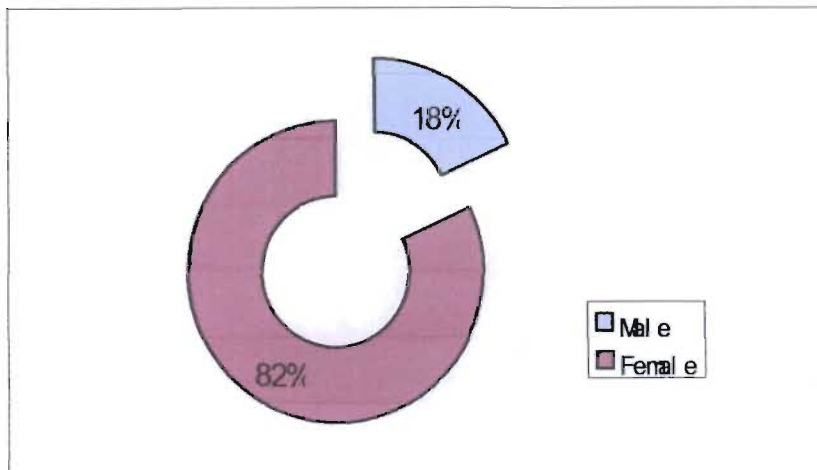


Figure 4.6: Gender of nurse participants (N = 50)

4.2.2.2 Age of nurse participants

Most of the participants, 84% (n=42) were aged between 18 and 38 years; 16% (n=8) were between 39 and 48 years old and no participant older than 49 years of age was found in this study. See figure 4.7 below.

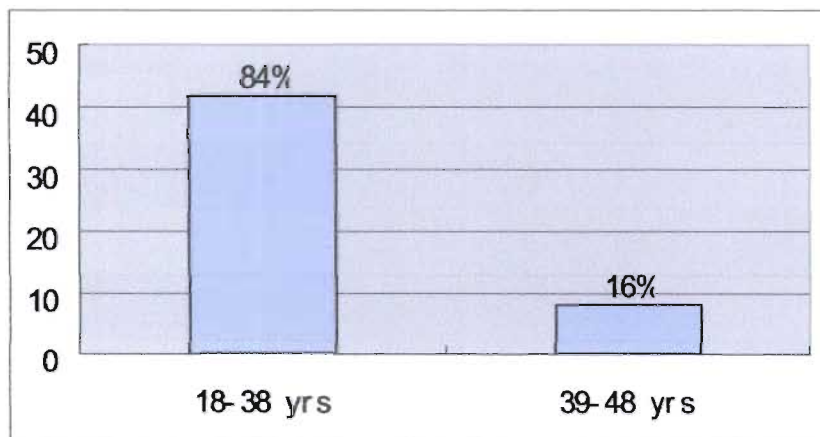


Figure 4.7: Age of nurse participants (N = 50)

4.2.2.3 Cultural groups of nurse participants

According to figure 4.8 below, two cultural groups were observed among the

nurse participants in this study. Africans constituted 86% (n=43) and Indians 14% (n=7).

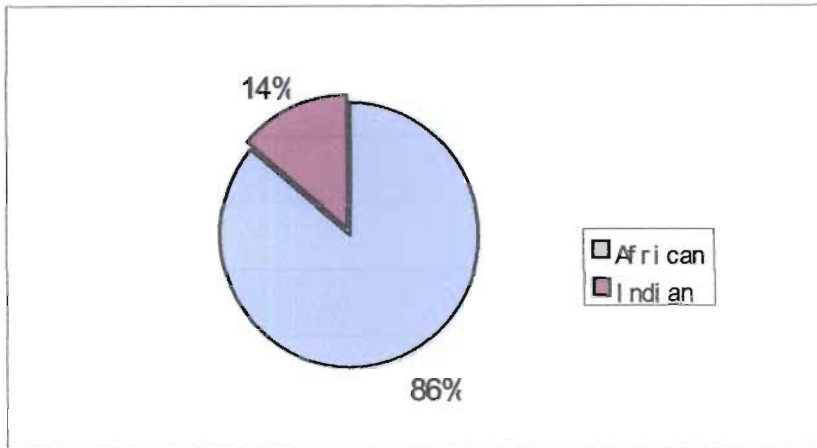


Figure 4.8: Cultural groups of nurse participants (N = 50)

4.2.2.4 Marital status of nurse participants

Fifty-two percent (n=26) of the nurse participants were married, while 46% (n=23) reported that they were single and 2% (n=1) was divorced. See figure 4.9 below.

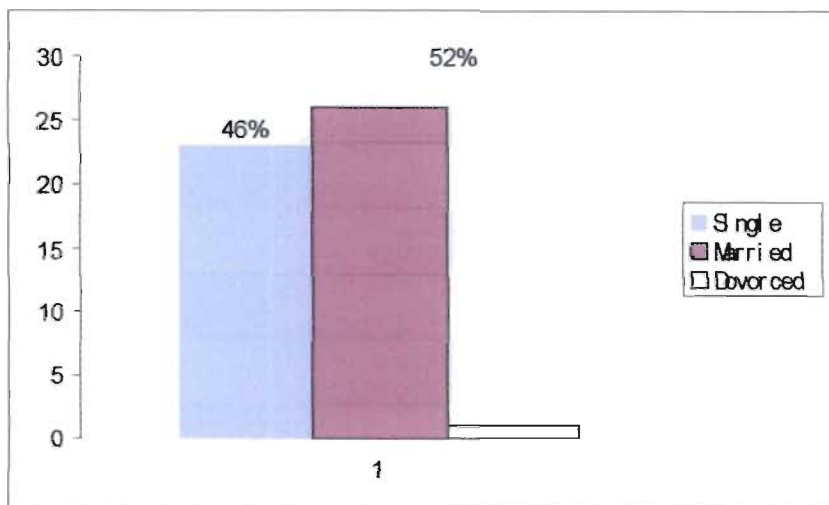


Figure 4.9: Marital status of nurse participants (N = 50)

4.2.2.5 Religion of nurse participants

According to figure 4.10, most nurses, 92% (n=46) were Christians, 6% (n=3) were Hindu, and 2% (n=1) belonged to other faiths.

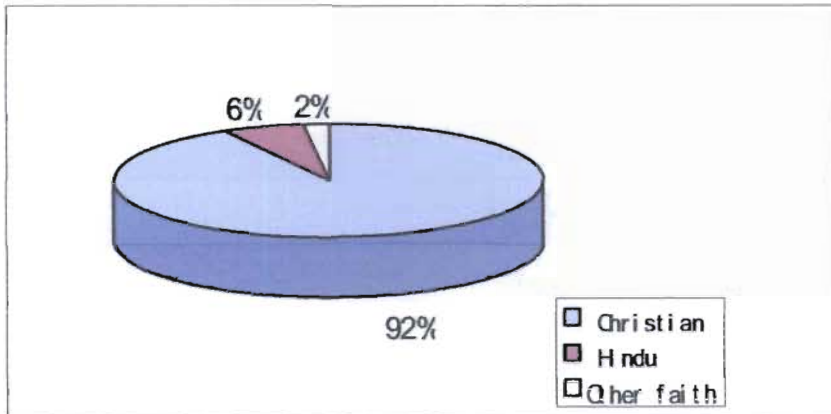


Figure 4.10: Religion of nurse participants (N = 50)

4.2.2.6 Nursing educational level

The majority of the participants, 88% (n=44) had a diploma in Nursing Science while 12% (n=6) possessed a degree in Nursing Science. See figure 4.11.

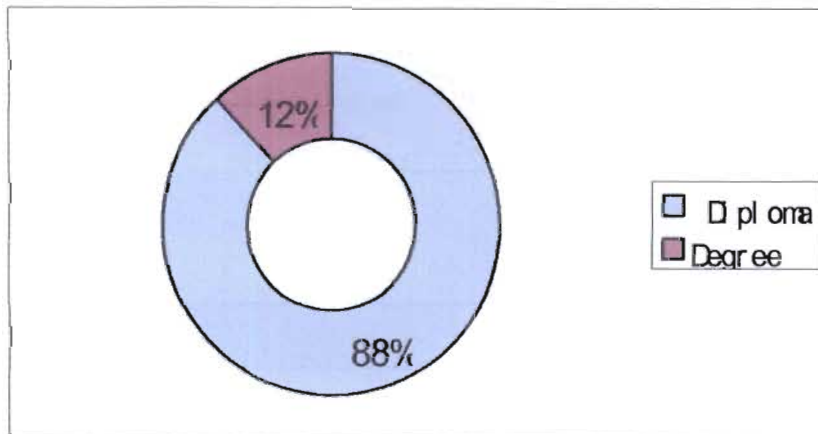


Figure 4.11: Nursing educational level (N = 50)

4.2.2.7 Work title of nurse participants

According to table 4.5, all of the participants, 100% (n=50) were working as Professional Nurses.

Table 4.5: Work title of nurse participants (N = 50)

Work title	n	%
Professional Nurse	50	100%
Total	50	100%

4.2.2.8 Type of ICU training of nurse participants

Two types of ICU training for nurses, namely ICU trained and ICU experienced nurses were represented in this study. Sixty-two percent of the participants (n=31) were ICU experienced while 38% (n=19) of them were ICU trained. See table 4.12 below.

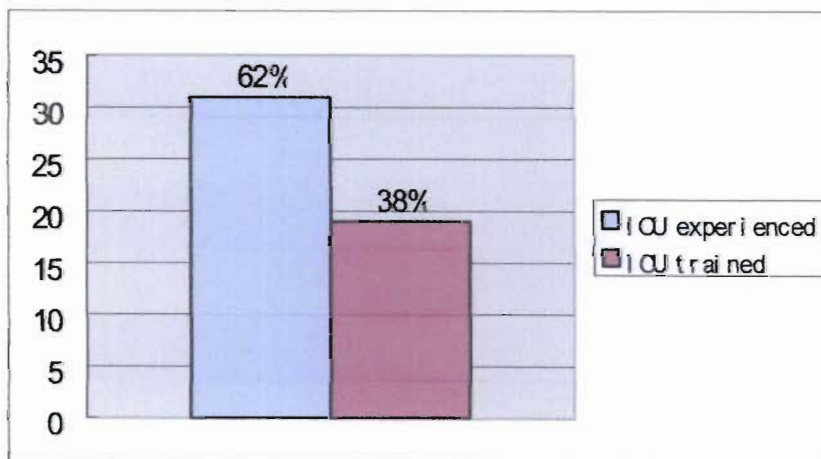


Figure 4.12: Type of ICU training of nurse participants (N = 50)

4.2.2.9 ICU training experience of nurse participants

Forty-four percent (n=22) of the participants had 1 to 5 years of ICU nursing experience, 32% (n=16) of them had 6 to 10 years nursing experience in an ICU, 16% (n=8) of the participants had more than 10 years ICU nursing working experience, while 8% (n=4) of them had the least number of years

nursing experience in an ICU (6 to 11 months). See figure 4.13 below.

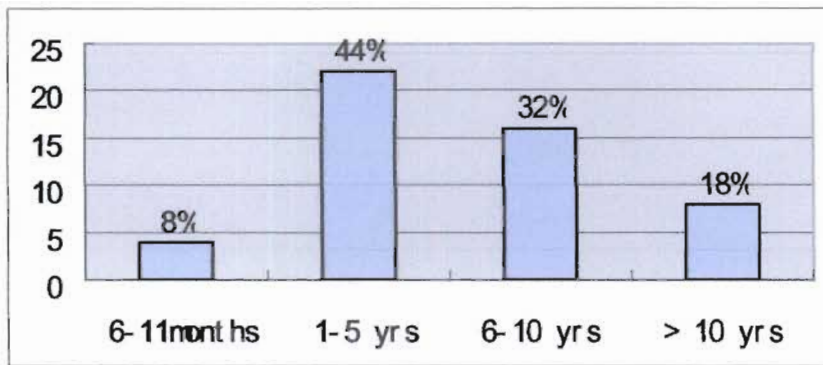


Figure 4.13: ICU training experience of nurse participants (N = 50)

4.3 Section B: Describes and compares the data regarding the CCFNI from family members' and nurses' choice.

Data in section B was analysed in 3 parts:

Part 1 (4.3.1): Data in the family group was analysed by calculating the mean from each item of the 45 need items. Data was described and presented as the ranking which was established by comparing the 45 mean scores in the order of the highest mean to the lowest mean of items. The average mean scores of each needs category under the five domains were also calculated and compared.

Part 2 (4.3.2): In the nurse group, data analysis, description and presentation from the nurses' perspectives was the same as mentioned in Part 1.

Part 3 (4.3.3): Describes and compares the differences in perceived family needs between the family group and the nurse group. The first 10 family needs from the two groups were compared by their respective rankings. The mean scores of the 45 need items from the two groups were also compared by one sample t-test, and by comparing significance values. Items were considered as significant when $p < 0.05$. In addition, the significantly different and similar need items between the two groups are presented separately. Finally, the average means of each category of needs under the five domains between the two groups were compared.

4.3.1 Family needs from family members' perspectives

Table 4.6 illustrates the rank of 45 family need items from family members' perspectives, the means for each of these need items were calculated, and then ranked in order of importance. The confidence interval was set up at 95%.

The mean scores for 45 need items ranged from 3.96 to 1.48. More than half, 24 (53.3%) of the 45 items were rated as important, or very important (mean score > 3). 48 (96%) participants chose the need 'to be assured that the best care possible is being giving to the patient' as the most important need

(mean=3.96). The need 'to be alone at any time' was rated as the least important need (mean=1.48) and was selected by 1 (2%) participant.

Forty-five need items were divided into five domains using Leske's (1991) categorisation. The five domains are (1) support, (2) information, (3) reassurance, (4) closeness, and (5) comfort. See table 4.6 below.

Table 4.6: The mean score of the 45 need items from family members' perspectives

Need item	Mean of importance N(n=50)	95% CI*
1.To be assured that the best care possible is being given to the patient R	3.96	(3.9, 4.0)
2. To know exactly what is being done for the patient I	3.94	(3.8, 4.0)
3.To know the expected outcome R	3.82	(3.7, 3.9)
4.To feel there is hope R	3.80	(3.6, 3.9)
5.To have questions answered honestly R	3.80	(3.6, 3.9)
6.To receive information about the patient at least once a day CL	3.76	(3.6, 3.8)
7.To know why things were done for the patient I	3.76	(3.6, 3.8)
8.To feel that hospital personnel care about the patient R	3.70	(3.5, 3.9)
9.To see the patient frequently CL	3.66	(3.5, 3.8)
10.To have explanations of the environment before going into the ICU for the first time S	3.52	(3.3, 3.7)
11.To visit at any time CL	3.50	(3.2, 3.7)
12.To know how the patient is being treated medically I	3.32	(3.1, 3.5)
13.To have explanations given that are understandable R	3.30	(3.1, 3.5)
14.To be told about transfer plans while they are being made CL	3.28	3.1, 3.4)
15.To help with the patient's physical care I	3.22	(3.0, 3.4)
16.To have directions as to what to do at the bedside S	3.22	(3.0, 3.4)
17.To have a specific person to call at the hospital when unable to visit I	3.20	(2.9, 3.5)
18.To be called at home about changes in the patient's condition CL	3.18	(2.9, 3.5)
19.To have visiting hours start on time CL	3.08	(2.9, 3.2)
20.To be told about someone to help with family problems S	3.08	(2.9, 3.2)
21.To be told about other people that could help with problems S	3.02	(2.8, 3.2)
22.To have friends nearby for support S	3.02	(2.8, 3.2)
23.To know specific facts concerning the patient's progress R	3.02	(2.8, 3.2)
24.To have another person with you when visiting the ICU S	3.02	(2.7, 3.3)
25.To have visiting hours changed for specific conditions CL	2.98	(2.7, 3.2)
26.To talk about possibility of the patient's death S	2.88	(2.6, 3.2)
27.To have someone to help with financial problems S	2.82	2.6, 3.0)
28.To have someone be concerned with your health S	2.80	(2.5, 3.0)
29.To talk about feelings about what has happened S	2.70	(2.4, 3.0)
30.To have a pastor visit S	2.68	(2.4, 2.9)
31.To be told about religious services S	2.68	(2.4, 2.9)
32.To talk to a doctor every day I	2.62	(2.3, 2.9)
33.To have the waiting room near the patient CL	2.58	(2.3, 2.8)
34.To have a toilet near the waiting room CM	2.52	(2.2, 2.8)
35.To know which staff members could give which type of information I	2.50	2.2, 2.7)
36.To feel accepted by the hospital staff CM	2.50	(2.2, 2.7)
37.To talk to the nurse in-charge every day CL	2.28	(2.0, 2.6)
38.To have a telephone near the waiting room CM	2.20	(1.9, 2.5)
39.To be assured it is all right to leave the hospital for a while CM	2.14	(1.9, 2.4)
40.To have a place to be alone while in the hospital S	2.08	(1.8, 2.3)
41.To know about the type of staff members taking care of the patient I	2.06	(1.7, 2.3)
42.To have comfortable furniture in the waiting room CM	2.00	(1.7, 2.2)
43.To feel it is all right to cry S	1.84	(1.6, 2.1)
44.To have good food available in the hospital CM	1.82	(1.5, 2.1)
45.To be alone at any time CM	1.48	(1.2, 1.7)

R: Reassurance, I: Information, S: Support, CL: Closeness, CM: comfort

*CI=confidence interval

Figure 4.14 illustrates the Mean scores for the five categories of needs ranged from 3.63 to 2.15. The reassurance category (mean=3.63) was rated as the

most important. It was followed by closeness (mean=3.14), information (mean=3.08), support (mean=2.72) and comfort (mean=2.15). There was no new need identified by participants in terms of the 46th question which was added by the researcher in order to allow participants to express other needs not mentioned among the 45 need items.

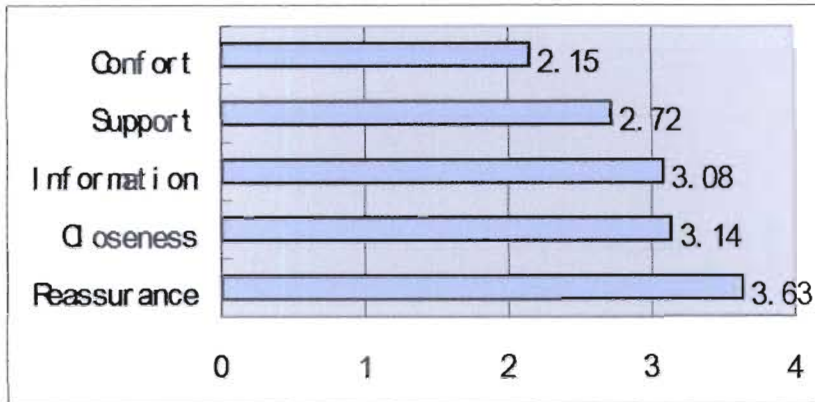


Figure 4.14: Mean scores of the five need categories from family group

4.3.2 Family needs from nurses' perspectives

Family needs from the nurses' perspectives have been illustrated in Table 4.7. 45 family need items were ranked in the order of importance which was based on the calculated means for each need item independently. The confidence interval was set up at 95%

The mean scores for 45 need items ranged from 3.70 to 1.36 and less than half, 17 (37.8%) of the 45 items were rated as important, or very important (mean score > 3). Seventy percent (n=35) of the participants chose the need 'to have questions answered honestly' as the most important need (mean=3.70). The need 'to visit at any time' was seen as the least important

need (mean=1.36) by the nurse group.

Table 4.7: The mean scores of the 45 need items from nurses' perspective

Need item	Mean of importance N=50	CI 95% ,
1.To have questions answered honestly R	3.70	(3.6, 3.8)
2.To be assured that the best care possible is being given to the patient R	3.54	(3.4, 3.7)
3.To receive information about the patient at least once a day CL	3.42	(3.2, 3.6)
4.To be called at home about changes in the patient's condition CL	3.40	(3.2, 3.5)
5.To have explanations of the environment before going into the ICU for the 1 st time S	3.38	(3.2, 3.5)
6.To have someone be concerned with your health S	3.38	(3.2, 3.5)
7.To have explanations given that are understandable R	3.36	(3.1, 3.5)
8.To feel that hospital personnel care about the patient R	3.36	(3.1, 3.5)
9.To be told about someone to help with family problems S	3.36	(3.1, 3.5)
10.To have visiting hours start on time CL	3.34	(3.1, 3.5)
11.To be told about other people that could help with problems S	3.30	(3.0, 3.5)
12.To be told about transfer plans while they are being made CL	3.28	(3.0, 3.4)
13.To know the expected outcome I	3.16	(2.9, 3.4)
14.To have friends nearby for support S	3.14	(2.9, 3.3)
15.To have another person with you when visiting the ICU S	3.08	(2.8, 3.3)
16. To have directions as to what to do at the bedside S	3.06	(2.8, 3.2)
17.To know exactly what is being done for the patient I	3.04	(2.9, 3.2)
18.To talk about possibility of the patient's death S	2.98	(2.7, 3.2)
19.To know why things were done for the patient I	2.96	(2.7, 3.2)
20.To have visiting hours changed for specific conditions CL	2.94	(2.6, 3.2)
21.To feel there is hope R	2.88	(2.7, 3.1)
22.To feel accepted by the hospital staff CM	2.84	(2.6, 3.1)
23.To talk about feelings about what has happened S	2.76	(2.6, 3.0)
24.To have a toilet near the waiting room CM	2.72	(2.5, 2.9)
25.To be told about religious services S	2.58	(2.3, 2.8)
26.To have a pastor visit S	2.58	(2.3, 2.8)
27.To know specific facts concerning the patient's progress R	2.54	(2.2, 2.8)
28.To know how the patient is being treated medically I	2.50	(2.2, 2.7)
29.To know which staff members could give which type of information I	2.42	(2.1, 2.7)
30.To feel it is all right to cry S	2.40	(2.1, 2.6)
31.To have comfortable furniture in the waiting room CM	2.36	(2.1, 2.6)
32.To have the waiting room near the patient CL	2.30	(2.0, 2.5)
33.To have a place to be alone while in the hospital S	2.30	(2.0, 2.5)
34.To have a specific person to call at the hospital when unable to visit I	2.26	(1.9, 2.5)
35.To be assured it is all right to leave the hospital for a while CM	2.24	(1.9, 2.5)
36.To have someone to help with financial problems S	2.24	(1.9, 2.5)
37.To know about the type of staff members taking care of the patient I	2.14	(1.8, 2.4)
38.To see the patient frequently CL	2.10	(1.8, 2.3)
39.To have a telephone near the waiting room CM	1.96	(1.7, 2.2)
40.To help with the patient's physical care I	1.96	(1.7, 2.2)
41.To talk to a doctor every day I	1.74	(1.5, 2.0)
42.To have good food available in the hospital CM	1.64	(1.4, 1.9)
43.To talk to the nurse in-charge every day CL	1.60	(1.3, 1.9)
44.To be alone at any time S	1.42	(1.2, 1.6)
45.To visit at any time CL	1.36	(1.2, 1.5)

R: Reassurance, **I:** Information, **S:** Support, **CL:** Closeness, **CM:** comfort

*CI=confidence interval

Figure 4.15 illustrates the Mean scores of the five categories of needs ranged from 3.22 to 2.29, the reassurance category (mean=3.22) was ranked as the most important. It was followed by support (mean=2.80), closeness (mean=2.64), information (mean=2.38) and comfort (mean=2.29). No new need was identified by participants in respect of the 46th question which was added by the researcher in order to discover any need that was unlisted in the CCFNI.

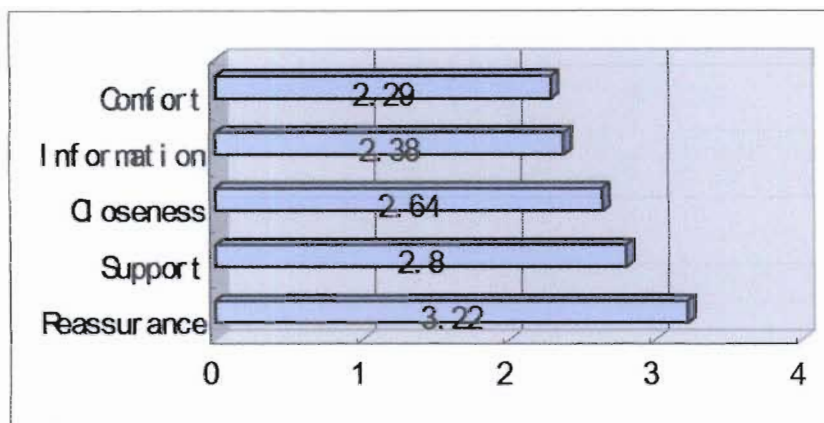


Figure 4.15: Mean scores of the five need categories from the nurse group

4.3.3 Comparison of the differences in perceived family needs between the family member group and the nurse group

In this part, the researcher intended to compare the first 10 needs of families in the ICU from families' and nurses' perspectives. This comparison was made based on the results from the table 4.6 and 4.7.

Table 4.8 indicates that families and nurses were in agreement with 5 of the first 10 most important needs for families in the ICU. These needs were (1) to be assured that the best care possible is being given to the patient, (2) to have questions answered honestly, (3) to receive information about the patient at least once a day, (4) to feel that hospital personnel care about the patient,

and (5) to have explanations of the environment before going to the ICU for the first time.

Table 4.8: The comparison of the top 10 family needs between the family and the nurse group

Family group's rankings	Nurse group's rankings
1.To be assured that the best care possible is being given to the patient*	1.To have questions answered honestly*
2.To know exactly what is being done for the patient	2.To be assured that the best care possible is being given to the patient*
3.To know the expected outcome	3.To receive information about the patient at least once a day*
4.To feel there is hope	4.To be called at home about changes in the patient's condition
5.To have questions answered honestly*	5. To have explanations of the environment before going to the ICU for the first time*
6.To receive information about the patient at least once a day*	6.To have someone be concerned with your health
7.To know why things were done for the patient	7.To have explanations given that are understandable
8.To feel that hospital personnel care about the patient*	8. To feel that hospital personnel care about the patient*
9.To see the patient frequently	9.To be told about someone to help with family problems
10.To have explanations of the environment before going to the ICU for the first time*	10.To have visiting hours start on time

*Need item which was selected by both the family and the nurse group

As in Table 4.9, 45 family need items were presented from family and nurse groups by using one sample *t*-test to compare the means of each need item between the two groups. The significance level was set up at $p=0.05$.

Twenty-four (53%) of the 45 items showed a significant difference ($p < 0.05$) between the two groups, whereas 21 (47%) of the 45 need items showed no significant difference between the family and the nurse groups ($p > 0.05$).

Table 4.9: Comparison of the differences in perceived family needs between family members' and nurses' perspectives.

Need item	Families N=50 Mean	Nurses N=50 Mean	t	p
1. To be assured that the best care possible is being giving to the patient	3.96	3.54	15.003	0.000*
2. To know exactly what is being done for the patient	3.94	3.04	26.528	0.000*
3. To know the expected outcome	3.82	3.16	12.025	0.000*
4. To feel there is hope	3.80	2.88	14.400	0.000*
5. To have question answered honestly	3.80	3.70	1.750	0.086
6. To receive information about the patient at least once a day	3.76	3.42	5.573	0.000*
7. To know why things were done for the patient	3.76	2.96	13.112	0.000*
8. To feel that hospital personnel care about the patient	3.70	3.36	3.548	0.001*
9. To see the patient frequently	3.66	2.10	21.237	0.000*
10. To have explanations of the environment before going into the ICU for the 1 st time	3.52	3.38	1.462	0.150
11. To visit at any time	3.50	1.36	19.841	0.000*
12. To know how the patient is being treated medically	3.32	2.50	7.553	0.000*
13. To have explanations given that are understandable	3.30	3.36	-0.656	0.515
14. To be told about transfer plans while they are being made	3.28	3.28	0.000	1.000
15. To help with the patient's physical care	3.22	1.96	12.579	0.000*
16. To have directions as to what to do at the bedside	3.22	3.06	1.667	0.102
17. To have a specific person to call at the hospital when unable to visit	3.20	2.26	6.716	0.000*
18. To be called at home about changes in the patient's condition	3.18	3.40	-1.462	0.150
19. To have visiting hour start on time	3.08	3.34	-2.645	0.011*
20. To be told about someone to help with family problem	3.08	3.36	-2.544	0.014*
21. To be told about other people that could help with problems	3.02	3.30	-2.490	0.016*
22. To have friends nearby for support	3.02	3.14	-1.144	0.258
23. To know specific facts concerning the patient's progress	3.02	2.52	4.413	0.000*
24. To have another person with you when visiting the ICU	3.02	3.08	-0.476	0.363
25. To have visiting hour changed for specific condition	2.98	2.94	0.317	0.753
26. To talk about possibility of the patient's death	2.88	2.98	-0.720	0.475
27. To have someone to help with financial problem	2.82	2.42	5.125	0.000*
28. To have someone be concerned with your health	2.80	3.38	-5.241	0.000*
29. To talk about feelings about what has happened	2.70	2.76	-0.467	0.643
30. To have a pastor visit	2.68	2.58	0.774	0.443
31. To be told about religious services	2.68	2.58	0.765	0.453
32. To talk to doctor every day	1.84	2.40	-4.055	0.000*
33. To have the waiting room near the patient	2.58	2.30	2.186	0.034*
34. To have a toilet near the waiting room	2.52	2.72	-1.519	0.135
35. To know which staff members could give what type of information	2.50	2.42	0.607	0.546
36. To feel accepted by the hospital staff	2.50	2.48	-2.644	0.011*
37. To talk to the in charge nurse every day	2.28	1.60	4.577	0.000*
38. To have a telephone near the waiting room	2.20	1.96	1.878	0.066
39. To be assured it is alright to have the hospital for while	2.14	2.24	-0.714	0.478
40. To have a place to be along while in the hospital	2.08	2.30	-1.648	0.106
41. To talk to a doctor every day	2.06	2.14	-0.605	0.548
42. To have comfortable furniture in the waiting room	2.00	2.36	-2.817	0.007*
43. To feel it is alright to cry	1.84	2.40	-4.055	0.000*
44. To have good food available in the hospital	1.82	1.64	1.219	0.229
45. To be alone at any time	1.48	1.42	0.556	0.580

* P < 0.05

Based on Table 4.10, the 24 significantly different need items between the two groups are highlighted in Table 4.10. The 24 significantly different need items in Table 4.10 were arranged by comparing the results of significant-value which was obtained from one sample *t*-test for each item of the 45 items between the family and nurse group. As mentioned in the methodology chapter, the researcher considered and selected those items the *p*-value of which was less than or equal to 0.05 as significantly different items (24 items). Because there were 17 items of which the *p*-value was 0.000 among the 24 items, in order to distinguish the 17 items, the researcher then compared the results of *t*-test descent for these 17 items.

Table 4.10 reveals that the need “to know exactly what is being done for the patient” was the most significantly different need item between the two groups. Other obvious differences regarding “the need to see patient frequently”, “visiting at any time”, also existed between the two groups. Families claimed that hope is very important for their loved ones as well for themselves; however this need seem to be ignored by nurses somehow. Nurses did not perceive involving family members in patient care as important, like “helping patients with physical care”. Nurses tended to be concerned about family members’ health status, and perceived family affairs as important, whereas families paid more attention to patients’ treatment, quality of care, progress, and expected outcome rather than taking care of themselves. Although both

groups treated the waiting room environment as a less important need, nurses still showed more concern than family members regarding having comfortable furniture in the waiting room and visiting patients on time, as well as the understanding that family members needed to express their emotions such as crying and feeling accepted by the hospital. More family members thought talking to a doctor every day, and having a specific person to call at the hospital when they were unable to visit were more important than nurses did, despite more nurses advocating that families should receive information about the patient at least once a day.

Table 4.10: The 24 significantly different need items between the family and the nurse groups

Need item	Family R*	Nurse R	t-test	p*
1.To know exactly what is being done for the patient	2	17	26.528	0.000
2.To see the patient frequently	9	38	21.237	0.000
3.To visit at any time	11	45	19.841	0.000
4.To be assured that the best care possible is being given to the patient	1	2	15.003	0.000
5.To feel there is hope	4	21	14.400	0.000
6.To know why things were done for the patient	7	19	13.112	0.000
7.To help with the patient's physical care	15	40	12.579	0.000
8.To know the expected outcome	3	13	12.025	0.000
9.To know how the patient is being treated medically	12	28	7.553	0.000
10.To have a specific person to call at the hospital when unable to visit	17	34	6.716	0.000
11.To receive information about the patient at least once a day	6	3	5.573	0.000
12.To have someone to help with financial problems	27	36	5.125	0.000
13.To talk to the charge nurse every day	37	43	4.577	0.000
14.To know specific facts concerning the patient's progress	23	27	4.413	0.000
15.To feel it is all right to cry	43	30	- 4.055	0.000
16.To talk to a doctor every day	32	41	- 4.055	0.000
17.To have someone to be concerned about your health	28	6	- 5.241	0.000
18.To feel that hospital personnel care about the patient	8	8	3.548	0.001
19.To have comfortable furniture in the waiting room	42	31	- 2.817	0.007
20.To feel accepted by the hospital staff	36	22	- 2.644	0.011
21.To have visiting hours start on time	19	10	- 2.645	0.011
22.To be told about someone to help with family problems	20	9	- 2.544	0.014
23.To be told about other people that could help with problems	21	11	- 2.490	0.016
24.To have a waiting room near the patient	33	32	2.186	0.034

*R: rankings; *P < 0.05

Twenty-one (47%) needs among the 45 need items were similar ($p > 0.05$) in differing degrees in the family and the nurse group. Table 4.11 presents the 21 similar need items from the two groups. The researcher used the same method as when analysing the 24 significantly different needs.

In the 21 similar need items, both groups agreed that questions should be answered honestly, the ICU environment should be explained before the first visit, and explanations should be delivered in a manner which families could understand. The two groups were similar in expressing the need for information of transfer plans, directions at the bedside, friends for support, expression of feelings, and flexible visitation when patients' conditions

changed.

Dramatically, both groups made similar choices in categorising information about hospital personnel as a less important need, such as the type of staff taking care of patients, and which staff could give which type of information. Results also showed that the two groups did not perceive the need for waiting room facilities such as telephones and toilets as important. Finally, the two groups agreed that the need to be alone at any time was the least important need.

Table 4.11: The 21 need items that were similar in the family and the nurse group.

Need item	family R*	Nurse R	t-test	p*
1.To be told about transfer plans while they are being made	14	12	0.000	1.000
2.To have visiting hours changed for specific conditions	25	20	0.317	0.753
3.To talk about feelings about what has happened	29	23	- 0.467	0.643
4.To be alone at any time	45	44	0.556	0.580
5.To know about the type of staff members taking care of the patient	41	37	- 0.650	0.548
6.To know which staff members could give which type of information	35	29	0.607	0.546
7.To have explanations given that are understandable	13	7	- 0.656	0.515
8.To be assured it is all right to leave the hospital for while	39	35	- 0.714	0.478
9.To talk about the possibility of the patient's death	26	18	- 0.720	0.475
10.To be told about religious services	31	25	0.765	0.453
11.To have a pastor visit	30	26	0.774	0.443
12.To have another person with you when visiting the ICU	24	15	- 0.476	0.363
13.To have friends nearby for support	22	14	- 1.144	0.258
14.To have good food available in the hospital	44	42	1.219	0.229
15.To have explanations of the environment before going into the ICU for the first time	10	5	1.462	0.150
16.To be called at home about changes in the patient's condition	18	4	- 1.463	0.150
17.To have a toilet near the waiting room	34	24	- 1.519	0.135
18.To have a place to be alone while in the hospital	40	35	- 1.648	0.106
19.To have directions as to what to do at the bedside	16	16	1.667	0.102
20.To have questions answered honestly	5	1	1.750	0.086
21.To have a telephone near the waiting room	38	39	1.878	0.066

*R: rankings; *P >0.05

Figure 4.16 demonstrates that the need for reassurance was chosen by participants in both the family and the nurse group as the most important

needs category among the 5 domains.

Family members want to know what is being done for their loved ones, and want to feel that the hospital staff care about their loved ones, and to be assured that the best possible care is being given. Meanwhile, families wish to retain hope for their loved one's recovery, as well as for themselves, by demanding that questions be answered honestly, and that they be informed of the patient's progress and expected outcome. Similarly, nurses perceived that it is their responsibility to answer questions honestly for families in a way which they can understand, and to assure families about the quality of care, and the positive attitude of the ICU staff towards the patient. However, nurses still have some different views regarding a couple of the needs when compared to the family group under this category, such as the need 'to feel there is hope' and 'to know specific facts concerning the patient's progress.

The second category of needs was rated as 'closeness' by the family group, whereas 'support' was selected by the nurse group. Families desired to be close to, to support and encourage their loved ones by visiting them frequently and at any time possible, particularly when the patients' conditions change. If family members were not at the hospital, they wished to be called from home. Nurses agreed that families should be called and should be allowed to visit patients freely when patients' conditions change, however they were against

visiting frequent patient visits and visits which took place at any time. Nurses perceived that the needs for the support of family members such as concern with family members' health and having someone to help with family problems were more important than visiting patients frequently and at any time.

The need for 'information' was rated by families as the third most important category, while the need for 'closeness' was perceived as the third most important category of needs for families from the nurses' perspectives. Families considered that information about how and why their loved ones were treated was important for them; and they were also willing to be instructed and to help with patients' physical care. Trying to obtain information about someone at the hospital, and someone who could call there when they could not visit was also important to families. Results from the nurse group showed that nurses admitted that information-giving is one of the most important needs for families; however they did not perceive the need for information to be as important as the families did.

The choices for the fourth category of needs still differed between the two groups. The families saw 'support' as important, but the nurses believed that 'information' was more appropriate. Family and nurse groups agreed again on the need for 'comfort' as the lowest priority category of family needs in the five domains. These needs included having toilets, telephones and comfortable

furniture in the waiting room and good food in the hospital. In conclusion, the two categories of needs, 'reassurance' and 'comfort' were agreed upon by the two groups as being ranked as the first and the fifth family needs in order of priority. The rest of the three categories of needs, namely the need for 'closeness', 'information' and 'support' were ranked differently by the two groups.

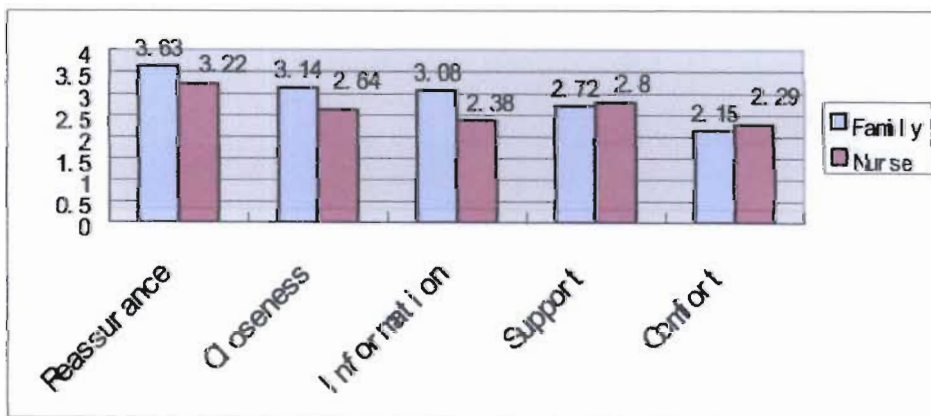


Figure 4.16: Comparison of the five categories of family needs from the family and nurse groups

4.4 CONCLUSION

In this chapter, the findings were presented according to objectives, for example, demographics, families' and nurses' perspectives of family needs and a comparison of the perspectives of the two groups/categories of participants was effected. Differences and similarities were identified in some aspects. Chapter Five will present and discuss the findings in detail, in the context of the conceptual framework and the existing literature.

Chapter Five

SUMMARY AND DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

In this chapter, the summary and discussion of the findings of the study is presented. Recommendations and the limitations of this study are also discussed, and finally a conclusion is detailed.

The purpose of this study was to describe and compare the needs of families of critically ill patients in two adult ICUs from both the families' and the nurses' perspectives. The objectives of the study were:

- 1) To describe the family members' needs from the families' perspectives
- 2) To describe the family members' needs from the nurses' points of view
- 3) To describe and compare the differences in perceived family needs in the ICU from the families' and nurses' perspectives

The summary and discussion of the findings was based on the three objectives of the study, and also on the results of data analysis from the participants of the family and nurse groups towards the demographic information and the CCFNI as discussed in Chapter Four.

5.2 FINDINGS

The findings were divided into three parts:

Part 1 (5.2.1): Participants' demographic information

Part 2 (5.2.2): Family members' needs from families' perspectives

(5.2.3): Family member's needs from nurses' points of view

Part 3 (5.2.4): Comparison of the differences in perceived family needs as indicated by the family and the nurse groups.

5.2.1 Participants' demographic information

The study sample consisted of 50 family members of critically ill patients and 50 ICU nurses.

Among the 50 family members, males accounted for 52 % (n=26), females constituted 48% (n=24), and most of these, (74%; n=37) were between the ages of 18 and 38 years. 64% (n=32) of the participants were African in terms of cultural group, followed by 32% (n=16) Indian participants and 4% (n=2) White participants. More than half of the participants were married and were Christians. The level of education of family members was reported as follows: matriculants 34% (n=17), primary and secondary education 26% (n=13), college education 26% (n=13), university education 14% (n=7). In categorizing their relationship with the patients, 40% (n=20) indicated that they were siblings of patients, followed by parents (36%; n=18), spouses (16%;

n=8;) and children (8%; n=4;). Among the 50 participants, 74% (n=37) had no previous experience of visiting ICUs, whereas 26% (n=13) admitted to having some previous ICU visiting experience. When data was collected, 72% (n=36) of the participants reported that their loved ones had been in the ICU for 2 days, and 28% (n=14) of the participants reported that those whom they visited had been in the ICU for 3 or more than 3 days.

In the nurse group, the majority of the participants were females (82%; n=41). Most participants (84%; n=42) were aged between 18 and 38 years. In the cultural groups, Africans constituted 86% (n=43) and Indians 14% (n=7). More than half of the nurses were married. Most participants (86%; n=43) were Christians. All of the participants (n=50) were working as professional nurses, either ICU experienced (62%; n=31) or ICU trained (38%; n=19). 88% (n=44) participants indicated that they possessed a diploma in nursing, while the remaining 12% (n=6) had earned a degree in nursing. The results indicated that 44% (n=22) nurses had between 1 and 5 years ICU working experience, followed by nurses (32%; n=16) who held between 6 and 10 years experience in an ICU, and nurses (16%; n=8) who had been working in an ICU for more than 10 years. Only 8% (n=4) of the nurses had been working in an ICU for less than 1 year. Therefore experience should have taught the nurses on how to treat families of critically ill patients and give convincing data on family needs.

5.2.2 Family members' needs from families' perspectives

The family group identified that 24 (53.3%) of the 45 need items were rated as important or very important (mean > 3), and 21 (46.7%) items were rated as slightly important or not important (mean <3) from the families' perspectives.

The need for reassurance (mean=3.63) such as the assurance of the best possible care for the patient, knowing what and why things were done for the patient, knowing the expected outcome, and feeling hope etc. have been rated as the first priority by family members. This was followed by the need for closeness (mean=3.14), information (mean=3.08), support (mean=2.72) and comfort (mean=2.15). Previous studies (Daley, 1984; Leske, 1986; Mendonca & Warren, 1998; Bijttebier, 2001; Lee & Lau, 2003; Hassan & Hweidi, 2004) have shown similar results to those of this study regarding family needs from families' perspectives.

5.2.3 Family members' needs from nurses' points of view

The mean scores of the 45 need items ranged from 3.70 to 1.36. Unlike the family group, less than half, 17 (37.8%) of the 45 need items were rated as important or very important (mean score > 3). 28 (62.2%) needs were selected as slightly important or not important (mean < 3).

Like the family group, the nurses rated the need for reassurance (mean=3.22)

as the most important need category and the one which should be met first. The second to fifth family need categories from the nurses' perspectives were needs for support (mean=2.80), closeness (mean=2.64), information (mean=2.38) and comfort (mean=2.29). Findings from relative studies (Leske, 1986; Hupcey, 1998; Al-Hassan & Hweidi, 2004; Fox-Wasylyshyn, 2006) show little difference when compared with this study in terms of the need for comfort which was always rated as an important need category by the nurses.

5.2.4 Comparison of the differences in perceived family needs in the family and nurse groups

When comparing the two groups, 24 (53%) of the 45 need items appeared significantly different ($p < 0.05$), whereas 21 (47%) items showed no significant differences ($p > 0.05$). These figures indicated that nurses were less accurate in half of their perceived family needs compared to family members' perceptions despite the two groups were in agreement with 5 of the first 10 most important needs.

Families and nurses agreed on rating the needs for assurance and comfort as the first and the last priority which should be dealt with and met. The two groups rated the other three need categories differently.

A significant difference in the perceptions of the need for visiting frequently

and at any time between the two groups has reflected the different perspectives toward the need for closeness. Nurses disagreed that families should visit patients frequently and at any time, while families desired to do so. Other studies (O'Malley, 1991; Simpson, 1996; Quinn, 1996; Chesla & Stannard, 1997; Plowright, 1998) also show similar findings regarding visitation, and indicate that this perception could be due to nurses' negative attitudes and practice habits. In addition to visiting, families were desperately concerned about their loved ones in the ICU, nurses, however, tended to focus on the need for support of families such as the family members' health, and someone who could help with family problems.

A difference also appeared in the need for information among the two groups. Families perceived that receiving information about the patients' treatment, progress and expected outcome was important to them, however nurses did not rate these need items regarding information as high as the families did. Results from previous studies (O'Malley, 1991; Kirchhoff, 1993; Simon, 1997) show that because lack of time, shortage of staff, lack of knowledge, as well as ineffective communication skills, nurses prefer to meet needs other than the need for information, despite the fact that nurses perceived information as an important need for families. However, the researcher found it difficult to explain that when families wanted to obtain information about patients' conditions and treatment etc, they tended not to be interested in 'talking to a

doctor every day' (mean=2.62, ranking at 32nd), or to know 'what type of staff were taking care of the patient' (mean=2.06, ranking at 41st) and 'which staff could provide which kind of information' (mean=2.50, ranking at 35th). Stricker, Niemann, Bugnon, Wurz, Rohrer and Rothen (2007) also identify communication with patients and relatives, process of information and decision making among important outcome parameters in intensive care, however, respondents in their study were least satisfied with communication with doctors and support during decision making supporting the current study. Unfortunately these authors further suggest that family members who consider information incomplete are at risk for developing post traumatic stress disorder or depression. Jones (2008), on the other hand, suggests a proactive communication strategy in the form of a 30-minute end-of life family conference with specific objectives, for example, acknowledgement and understanding of family emotions and identity, listening, eliciting questions from family members including handing over a written bereavement brochure. While many authors recommend several interventions to meet the needs of families, Brysiewicz & Chipps (2006) their systematic review of interventions, express concern about a culture-specific interpretation of the process and the content of a family information booklet in a South African context with such multiplicity of cultures.

In addition, in this study nurses tended to prevent families from being involved

in patients' care by discouraging them from helping with patients' physical care, although families were willing to do so. Related studies (Jacono, 1990; Hammond, 1995; Hupcey, 1998; Appleyard, 2000) explain that many nurses did not perceive families as having a care-giving role in the ICU, rather viewing them as visitors or supporters who watched and encouraged patients. Moreover, many nurses' practices were still guided by patient-centred approaches, and they did not recognise the importance of involving family members in patients' care in an ICU environment (Dunkel & Eisendrath, 1983; White & Tonkin, 1991).

In this study, the needs for support and comfort have been rated as less important needs from the families' perspectives. Previous studies (Forrester, 1990; Jacono, 1990; Leske, 1992; Lee & Lau, 2003) point out that family members' dominant concerns are for their loved ones, and that they have little time to think about their own needs such as physical condition or comfort. This could also be explained by Jamerson's 4 stage process theory (1996), in which, in an ICU environment, families always demonstrate closeness, seeking information about their loved ones as the first priority at the beginning of the 4 stages, looking for resources such as support, and taking care of themselves as less important and at the last stage in the process.

This study also found that the nurse group rated information and comfort as

less important needs for families. As mentioned earlier, the fact that nurses rated information as less important may be influenced by limited time, staff, knowledge and personal communication skills. However, the researcher could not explain why nurses perceive the need for comfort as less important for families, as relative studies (Leske, 1986; Hupcey, 1998; Al-Hassan & Hweidi, 2004; Fox-Wasylyshyn, 2006) show that nurses always perceive and deal with the need for comfort of families as their primary duty in an ICU environment.

In relation to the theoretical framework of this research, the findings show clearly that ICU nurses were willing to support family members emotionally, and tried to provide help for families regarding family problems. On the other hand, nurses also focused on patient care by delivering nursing care, medical treatment and physical support. However, findings revealed that ICU nurses had not been able to connect patient and family members as a whole unit when delivering care to them, and sometimes tried to limit the visitation and prevented family involvement with patients' physical care etc. As mentioned earlier, these actions and behaviours may be due to traditional practice guides or habits, and lack of relative training.

5.3 RECOMMENDATIONS

- ✧ This study was conducted using a quantitative approach; the sample size of 100 in two local hospitals might not be sufficient considering the nature of the topic. As a result, the findings obtained from this study may not be generalised. A larger number of samples and hospitals are suggested for further studies.

- ✧ Although the findings of this study have indicated the different perspectives towards family needs from family and nurse groups, due to the nature of quantitative research, the researcher could not go further towards detecting detailed reasons. Therefore, a qualitative approach is suggested for further research in order to reveal the reasons which caused the differences between the two groups.

- ✧ In this study, the questionnaire CCFNI was developed in the USA and some participants reported that certain items were similar to one another. The researcher suggests that future researchers modify the CCFNI, so that it is more appropriate to local participants and settings. This is supported by Striker et al, (2006) who suggests that cross-cultural adaptability is a key aspect of a questionnaire to be used for research projects especially if it has to be used for multicultural comparison as in this study some nurses were of a different culture.

- ✧ A recommendation for nursing management based on the findings of this study, is that local ICUs adopt a flexible visitation policy which allows families to visit their loved ones, according to their willingness and convenience. It is suggested that a written guideline for family members be provided which includes the contact number of the ICU and details of a specific person who families can approach and call when they unable to visit or have queries. Brochures could also be developed to explain ICU environment, treatment and procedures to familiarise families with this stressful environment.

- ✧ A further recommendation for nursing education is the introduction of specific in-service training programmes which develop skills around family needs at different stages of the patients' stay in ICU. It is suggested that strategies of meeting family needs and the concept of family-centred care be developed, as well as programmes which focus on improving nurses' communication skills. Nurse education might need to review their curricula to establish adequacy of the content on family support.

- ✧ In practice nurses should be take cognisance of their responsibility to the family considering the family as a unit. Consultation with the family cannot be over emphasized especially on end of life decisions. A

multidisciplinary approach would include discipline specialists like psychologists and social workers and clergyman to accommodate psychosocial support of the family as a unit especially under conditions of nurse shortage as is found nowadays.

5.4 LIMITATIONS OF THE STUDY

This is a non-experimental study; the sample size is small, and from only two hospitals among many hospitals in Durban. As a result, it may not be totally representative of the population.

In the study, the tool for collection of data is an inventory; this may be a limitation for participants who have other needs which extend beyond the inventory list. However provision was made in the tool as an adaptation to accommodate additional needs by adding an item on "other"

5.5 CONCLUSION

This study described and compared family needs in adult ICUs from families' and nurses' perspectives in two hospitals in Durban, South Africa. The participants' responses revealed that there were different perceptions of family needs between families and nurses. Nurses were accurate in perceiving 21 (47%) of the 45 families' need items compared to family members' perceived needs. Nursing management in both practice and education should

co-operate and improve in order to meet family needs, restore family homeostasis, and assist family members, as well as their loved ones in dealing with the difficult period of an ICU stay.

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Appendix 1

Critical Care Family Needs Inventory

Please choose one answer from each question in your own experience, do you think is important for FAMILY MEMBER,,,,,,

A not important **B** slightly important **C** important **D** very important

- 1: To know the expected outcome_____
- 2: To have question answered honestly _____
- 3: To be called at home about changes in the patient's condition_____
- 4: To be assured that the best care possible is being given to the patient_____
- 5: To know how the patient is being treated medically_____
- 6: To know specific facts concerning the patient's progress_____
- 7: To feel that the hospital personnel care about the patient_____
- 8: To receive information about the patient at least once a day_____
- 9: To have explanations given that are understandable_____
- 10: To talk to doctor every day_____
- 11: To feel there is hope_____
- 12: To know why things were done for the patient_____
- 13: To see the patient frequently_____
- 14: To know exactly what is being done for the patient_____
- 15: To talk to the in charge nurse every day_____
- 16: To have visiting hour changed for specific conditions_____
- 17: To be told about transfer plans while they are being made_____
- 18: To have visiting hour start on time_____
- 19: To have a toilet near the waiting room_____

A not important **B** slightly important **C** important **D** very important

- 20: To have friends nearby for support_____
- 21: To feel accepted by the hospital staff_____
- 22: To be told about other people that could help with problems_____
- 23: To have a telephone near the waiting room_____
- 24: To have directions as to what to do at the bedside_____
- 25: To know which staff members could give what type of information_____
- 26: To have a specific person to call at the hospital when unable to visit_____
- 27: To have explanations of the environment before going into the ICU for the 1st time__
- 28: To help with the patient's physical care_____
- 29: To have the waiting room near the patient_____
- 30: To visit at any time_____
- 31: To know about the types of staff members taking care of the patient_____
- 32: To have someone to help with financial problem_____
- 33: To be assured it is alright to have the hospital for while_____
- 34: To talk about feelings about what has happened_____
- 35: To talk about the possibility of the patient's death_____
- 36: To be told about someone to help with family problems_____
- 37: To have someone be concerned with your health_____
- 38: To have another person with you when visiting the ICU_____
- 39: To feel it is alright to cry_____
- 40: To have comfortable furniture in the waiting room_____

A not important **B** slightly important **C** important **D** very important

41: To have a place to be alone while in the hospital_____

42: To be told about religious services_____

43: To have a pastor visit_____

44: To be alone at any time_____

45: To have good food available in the hospital_____

46: Other
needs _____

THANK YOU VERY MUCH FOR YOUR TIME!

-

Appendix 2

Critical Care Family Needs Inventory

Sicela uphendule ngempendulo eyodwa kulemibuzo ngendlela obona ukuthi ibalulekile elungeni lomndeni wakho

A akubalulekile **B** kubaluleke kancane **C** kubalulekile **D** kubalulekile kakhulu

- 1: Ukwazi ngomphumela olindelwe_____
- 2: Ukuphendula imibuzo ngokwethembeka_____
- 3: Ukubizwa ekhaya ngoshintsho olwenzekile ngesimo sesiguli_____
- 4: Ukuqinisekisa ukuthi isiguli sithola ukunakekelwa okufanele_____
- 5: Ukwazi ukuthi isiguli sithola kanjani unyango lwaso _____
- 6: Ukwazi amaqiniso athize mayelana nokuqhubeka kwempilo yesiguli _____
- 7: Ukuqinisekisa ukuthi abasesibhedlela bayasinakekela isiguli_____
- 8: Ukuthola ulwazi ngesiguli okungenani kanye ngosuku_____
- 9: Ukuthola imibiko ezwakalayo ngesiguli_____
- 10: Ukukhuluma nodokotela nsukuzonike _____
- 11: Ukuthola ukuthi kunethemba lokusinda_____
- 12: Ukuthola ukuthi kwenziweni ukusiza isiguli_____
- 13: Ukubona isiguli njalo_____
- 14: Ukwazi kahle ukuthi yini eyenziwe ukwelapha isiguli_____
- 15: Ukukhuluma nomhlengikazi obhekelene nesiguli nsuku zonke_____
- 16: Ukuba izikhathi zokuvakashela isiguli zishitshwe ngezimo ezithile_____
- 17: Ukwaziswa umangabe kwenziwa izinhlelo zokudluliswa kwesiguli kwenye indawo
- 18: Ukuqikelela ukuthi izikhathi zokuvakasha ziqala ngesikhathi_____
- 19: Kube nendlu yangasese eduzane nendlu yokulindela_____

A akubaluekile B kubaluleke kancane C Kubalulekile D kubalulekile kakhulu

20: Ukuba nabangani abaseduze abangusizo esigulini_____

21: Ukuzizwa wamukelekile ngabasebenzi basesibhedlela_____

22: Ukutshelwa ngesimo sokugula ngabanye abantu abangasiza ezinkingeni zempilo yesiguli_____

23: Ukuba nocingo eduze kwendlu yokulindela abazobona iziguli_____

24: Ukutshelwa izinto okumele uzenze eceleni kombhede wesiguli_____

25: Ukwazi ukuthi yibaphi abasebenzi abangasiza ngaluphi uhlobo lwemininingwane_____

26: Ukuba momuthu othile wasesibhedlela ongashayela ucingo uma ungakwazi ukuvakasha_____

27: Ukuchazelwa kabanzi ngesimo sase ICU ngaphambi kokuya khona umangabe uqala ukuya khona_____

28: Ukusiza isiguli ngezidingo zokuthokomala_____

29: Ukuba nendlu yokulindela eseduze nesiguli_____

30: Ukuvakashela isiguli noma ngabe yisiphi isikhathi_____

31: Ukwazi ngezinhlobo zabasebenzi besibhedlela abanakekela isiguli_____

32: Ukuba nomuntu ozosiza ngezinkinga zezimali_____

33: Ukuqinisekisa ukuthi kufanele ukubasesibhedlela iskihashana_____

34: Ukukhuluma ngesimo sokugula okukuphethe_____

35: Ukukhuluma ngokuthi kungenzeka sishone isiguli_____

36: Ukutshelwa ngomuntu ozosiza ngezinkinga zommdeni_____

37: Ukuba nomuntu obhekene nokugula kwakho_____

38: Ukuhambisana nomunye umuntu uma uvakashale e-ICU_____

39: Ukuzizwa ukuthi kufanele ukhale umangabe kudingekile_____

A akubaluekile B kubaluleke kancane C Kubalulekile D kubalulekile kakhulu

40: Ukuhlala ngokunethezeka endlini yokulindela_____

41: Ukuba nendawo yokuba wedwa ngesithathi usesibhedlela_____

42: Ukutshelwa ngosizo lwezenkolo esibhedlela_____

43: Kube khona umfundisi ovakashoyo uma usesibhedlela_____

44: Ukuba wedwa yinoma ngasiphi Isikhathi uma uthanda_____

45: Ukuba nokudla okufanele esibhedlela_____

46: Ezinye izidingo uma
zikhona_____

NGIYABONGA NGESIKHATHI OSITHATHE UPHENDULA LEMIBUZO

Appendix 3

THE UNIVERSITY OF KWAZULU-NATAL

INFORMED CONSENT STATEMENT

INTRODUCTION

You are invited to participate in a research study on Family Members' Needs in Intensive Care Unit (ICU). With this research, we want to gain insights on families' needs in ICU from family perspective, also from ICU nurses' view as well. This research is part of the requirement for the degree of Master in nursing which the researcher currently studying for at the University of KwaZulu-Natal.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

The study consists of a questionnaire which we ask you to choose the most appropriate one answer from each question.

DURATION OF THE STUDY

Your participation requires about 20-30 minutes in total.

BENEFITS

Your participation would contribute directly to the research which as part of the Master degree in nursing. Furthermore your participation would contribute to the further research studies regarding Family Needs in ICU, and possible policy making, management development related to Family Needs in Durban, and South Africa as a whole.

DISCOMFORT

You may feel discomfort to fill in the questionnaire as you are concerning your loved one in ICU.

CONFIDENTIALITY

The study is anonymous, i.e. we will not be able to relate the data obtained to your name. Be assured that anonymity and confidentiality will be preserved- all of our analyses will focus on patterns in the data over many individuals, rather than on individuals themselves. Your name will not appear in any published documents, and no individual information about you will be passed on to any other party under any circumstances.

PARTICIPATION

Your participation in this study is voluntary; you can refuse to participate or withdraw from the study at anytime if you are not feeling comfortable.

PROJECT MEMBERS

The researcher. ZhiQiang Tao, Master of nursing in Critical Care Postgraduate student at the School of Nursing, University of KwaZulu-Natal Howard College. Phone: 0838724716

The research supervisor. Professor Busisiwe R Bhengu, the Head of the School of Nursing, University of KwaZulu-Natal Howard College. Phone: (031)2601432

CONSENT

I have read the above information. I agree to participate in this study. I understand that I can withdraw from the study at any time, should I so desire.

Participant's signature _____

Appendix 4

IMVUME YOKUZIBOPHEZELA

ISIBINGELELO

Uyamenywa ukuba yengxenywe yophenyo olubhekiswe kumalunga omndeni family members in Intensive Care Unit (ICU). Ngaloluphenyo sifuna ukuthola izidingo zeminoeni, kwaomndeni, kanye niakubahlengirazi base ICU.

ULWAZI NGALABO ABAZOBA YINGXENYE YALOLU PHENYO

Loluphenyo loqhukethwe yimimibuzo, kodwa kuyomele ukhethe impedule ehambisan nombuzo.

IBUDE BALOLU PHENYO

Ukuba yingxenywe yalolu phenyo kuyokuthatha imizuzu engamashumi amabili kuya kwamathathu.

UMVUZO

Ukubamba kwakho iqhaza kulolu phenyo kugabongeka ngoba luyingxenywe yezingu zenfundo ephakeme yabahlengi kazi. Ngaphezu kwalokho ukubamba kwakho iqhazo, kungaholela ekutheni kwenziwe nezingezimpenyo ezibhekene nezidingo zemibeni ese-ICU. Kwenziwe nemithetho ezohambelana nezidingo

zaleyo mindeni eThekwini, kanye nase Nigizmu yakana.

UKUNGAKHULULEKI

Kuyaziwa ukulhi ungazizwa umgakhululeki ukuphendula eminye imizo ebhekene nabathandiweyo bakho abase-ICU.

UKUPHETHWA NGEMFIHLO

Igama lakho liyoba yimfihlo. Ulwazi oyosinika lona, uyathenjiswa ukuthi angeke luhlanganiswe negama lakho. Uyathenjiswa futhi igama lekho liyoba imfitho nolwazi oyosinika lona luyongcinwa luginfihlo. Igama lakho ngeke libonakale emaphepleni. Ulwazi osinikeze lona angeke ludluliselwe kwenye inhlango noma ngaphandle kwczimo ezinjani.

UKUBA YINGXENYE

Ukuba yingxenye yakho kulolu phenyo, kungokuthanda kwakho, uma uthanda ukuyeka ungayeka noma yinini uma uzizwa ukuthi awusathandi nokuqubeka.

PROGECK MAUBERS

-Umphenyi: zhiQiang Tao, Master of nursing in Critical Care Postgraduate student at the School of Nursing, University of

KwaZulu-Natal Howard College. Phone: 0838724716

-Umluleki waloluphenyo: Isolwazi Busisiwe R. Bhengu, inhloko yesikole Sezonhlalakahle, UKZN Howard College. Inombolo (031) 2601432

UKUZIBOPHEZELA

Ngiyifundile futhi ngiyavuma ukumi kuyiqiniso konke okungaphezulo. Ngiyavuma ukube yingxenye yophenyo. Ngiya qonda ukuthi nginelungelo lokuhoxa noma inini uma ngifisa ukwenza njalo.

Participant's

signature_____

Appendix 5

Family member's Personal Information

- 1) Age: _____
- 2) Gender: _____
- 3) Race: _____
- 4) Marital status: (e.g. single, married, divorced, widowed etc) _____
- 5) Education level (e.g. Primary, Secondary, Matriculate, College, University etc.)
_____.
- 6) Religious background: (e.g. Christian, Catholic etc.): _____
- 7) Patient is your (e.g. father, mother, sister, son etc.): _____
- 8) Experience of visiting ICU: (whether you had visited ICU before)
Yes _____ No _____
- 9) How long your loved one has been in ICU since Admission (e.g. 2 days, 3 days)
_____.

Appendix 6

Family member's personal information

- 1) Iminyaka _____
- 2) Ubulili _____
- 3) Uhlanga _____
- 4) Isimo somshado: (uwedwa, ushadile, uhlukanisile, umfelokazi nokunye) _____
- 5) Ibanga lemfundo: (isikole esincane, isikole esikhulu, imfundo, ephakeme, nokunye) _____
- 6) Inkolo: (inkrestu, ikhatholika nokunye) _____
- 7) Isiguli: (ubaba, mama, sisi, bhuti nokunye) _____
- 8) Ulwazi loku vakasha: (wake wafika e ICU ngaphambili
Yebo _____ cha _____
- 9) Isikhalhi esingakanani use ICU, kusukela ufakiwe esibhedlela (isibonelo) isuku ezimbili, ezintathu _____

Appendix 7

Nurse's Personal Information

- 1) Age: _____
- 2) Gender: _____
- 3) Race: _____
- 4) Marital status: (e.g. single, married, divorced, widowed etc) _____
- 5) Religious background: (e.g. Christian, Catholic etc.): _____
- 6) Nursing Educational qualification (e.g. Certificate, Diploma, Degree etc.)
_____.
- 7) Work title: ENA __, Staff nurse __, PN __.
- 8) ICU trained _____, experienced _____
- 9) ICU work experience (e.g. 6 months, one year, ten years etc.)

Appendix 8

Nurse's personal information

- 1) Iminyaka_____
- 2) Ubulili_____
- 3) Uhlanga_____
- 4) Isimo somshado: (uwedwa, ushadile, uhlukanisile, umfelokazi nokunye)_____
- 5) Inkolo: (inkrestu, ikhatholika nokunye)_____
- 6) Iziqu zemfundo ka mhlengikazi: (isibonele, Isitifiketi, iziqu nikunye)_____
- 7) Uhlobo lomsebenzi: (umhlengikazi oqeqeshiwe nokunye)_____
- 8) Umhlengikazi oqeqeshiwe ukusebenza e ICU_____, onolwazi_____
Yebo_____ cha_____
- 9) Umhlengizazi oqeqeshwe (isibonelo) inyanga eziwu 6, inyanga eyodwa, iminyaka ewu 10 nokunye_____

Appendix 9



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

7 NOVEMBER 2008

MR. Z TAO (203520182)
SCHOOL OF NURSING

Dear Mr. Tao


ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0610/08M

I wish to confirm that ethical clearance has been approved for the following project:

"A comparative descriptive study of the perspectives of families and nurses regarding the needs of families in adult intensive care unit in two tertiary hospitals in eThekweni District"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully



MS. PHUMELELE XIMBA

cc. Supervisor (Prof. BR Bhengu)
cc. Mr. S Reddy



HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component

10 – 102 Natalia Building, 330 Langalibalele Street

Private Bag x9051

Pietermaritzburg

3200

Tel.: 033 – 395 2805

Fax.: 033 – 394 3782

Email.: hrkm@kznhealth.gov.za

www.kznhealth.gov.za

Reference: HRKM043-09

Enquiries: Mr X. Xaba

Telephone: 033-395 2805

15 April 2009

Dear Mr Z. Tao

Subject: Approval of Research

1. The research proposal titled **“A comparative descriptive study of the perspectives of families and nurses regarding the needs of families in adult intensive care unit in two tertiary hospitals in eThekweni District”** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Inkosi Albert Luthuli commercial and King Edward VIII hospitals.
2. You are requested to undertake the following:
 - a. Make the necessary arrangement with identified facility before commencing with your research project.
 - b. Provide an interim progress reports and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za.

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

Yours Sincerely

Dr. S.S.S. Buthelezi

Chairperson: Provincial Health Research Committee

KwaZulu-Natal Department of Health

Appendix 11

28-NOV-2008 10:59 FROM:IRLCH CEO 0312401005

TO:00312601543

P12/2



HEALTH
KwaZulu-Natal

INKOSI ALBERT LUTHULI CENTRAL HOSPITAL

Department: Nursing & Quality
800 Bellair Road, Mayville, 4091
Private Bag X03, Mayville, 4058
Tel: 031 - 240 1062/3
Fax: 031 - 240 1060

www.kzn.health.gov.za

Enquiries: Mrs P.P. Zungu
25 November 2008

Professor B.R. Bhengu
School of Nursing
Howard College Campus
Durban
4041

RE: LETTER OF SUPPORT FOR THE RESEARCH BY STUDENT ZHIQIANG TAO

Title of the research: A Comparative descriptive study of the perspectives of families and Nurses regarding the needs of families in adult Intensive Care Unit in two Tertiary Hospitals in Ethekwini District.

In responding to your request to seek support from the tertiary hospital, this has reference.

Permission is hereby granted in support for the research.

Regards,

Mrs. Zungu
Nursing & Quality Manager

uMnyango Wezempi, Departament van Gesondheid

FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE



HEALTH

KwaZulu-Natal

KING EDWARD VIII HOSPITAL
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Email.: rejoyce.khuzwayo@kznhealth.gov.za
www.kznhealth.gov.za

Enq.: Miss. R. Khuzwayo
Ref.: KE 2/7/1/ (26/2008)
Research Programming

5 December 2008

Mr. Z. Tao
School of Nursing
Westville Campus
UNIVERSITY OF KWAZULU- NATAL

Dear Mr. Tao

Request to conduct research at King Edward VIII Hospital

Protocol:- A Comparative Descriptive Study of the Perspectives of Families and Nurses Regarding the Needs of Families in Adult Intensive Care Unit in two Tertiary Hospitals 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 Directorate Managers
 - * Sign an indemnity form at Room 8, 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

DR. OSIBALO
MEDICAL MANAGER

SUPPORTED / NOT SUPPORTED

05/12/2008
DATE

APPROVED / NOT APPROVED

MR. M. BHEKISWAYO
CHIEF EXECUTIVE OFFICER

10/12/08
DATE