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Intensive Nurses for Family Support toward Critically Ill Patients

A Thesis submitted in partial fulfillment of the requirements for MSC degree in critical care nursing.

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بسم الله الرحمن الرحيم

الآيـــــة

قال تعالى:

﴿وَقُلِ اعْمَلُوا فَسَيَرَى اللَّهُ عَمَلَكُمْ وَرَسُولُهُ﴾

صدق الله العظيم

(سورة التوبة : الآية 105)

Dedication

I dedicate this research to my parents who have played a Great role in my education till I reach this level.

To my brother and sisters

To supervisor Dr. Higazi Mohammed

To my collage and all nurses

Acknowledgement

First we deeply thank Allah.

It is difficult to acknowledge properly those who have helped me in the preparation of this research. But I extremely great full to our supervisor: **Dr. Higazi Mohammed** for her great assistance and effective cooperation

I deep thanks and appreciations to everyone who directly or indirectly help me. And I send thank to all nurses in Omdurman military hospital.

Finally I express our deep appreciations to the nursing teachers in shandi university.

Abstract

During the past few decades the numbers of ICUs and beds has increased significantly, but so too has the demand for intensive care. Currently large, with increasing, numbers of critically ill patients require increase family's needs and consideration are an essential component of intensive care unit. The needs of intensive care patients family members are often neglected. Many nurses do not realize that meeting the family needs in the intensive care sittings actually may improve outcome for their patients and enable the family members to cope and deal with the patient hospitalization period effectively. With this in mind, the present study aimed to address the needs of family members of intensive care unit patients

This descriptive hospital-based study was conducted in Omdurman Military Hospital, It aimed at assessing knowledge and performance of nurses regarding family support of critical ill patient in Intensive Care Unit (ICU).

The study covered 50 nurses. They constitute the available sample during the study period 2017-2018 Data were collected by a questionnaire designed for the study. Data were analyzing using the Statistical Packages for Social Sciences (SPSS).

The study showed that the nurses had good knowledge about family satisfaction and unrestricted visitation (52%), (40.3%)

The study showed that the half of study population (50%) had poor knowledge about nursing role about family support.

The study showed that the nurses had poor knowledge about how to communication of family (58%).

The study concluded the nurse's staff of critical care unit that is good about attitude and poor about knowledge. The study recommended that there is providing training programs for the nurses staff how to assess family needs and communication of family.

مستخلص البحث

خلال العقود القليلة الماضية، ازدادت أعداد وحدات العناية المركزة والأسرة بشكل كبير، ولكن أيضا زاد الطلب على العناية المركزة، ومع ازدياد عدد المرضى المصابين بأمراض خطيرة تزداد احتياجات الاسره والتي هي عنصر اساسي في وحده العنايه المكثفه.غالبا ما يتم اهمال احتياجات افراد اسره مريضي العنايه المكثفه.ولا يدرك العديد من الممرضين والممرضات ان تلبية احتياجات الاسره في جلسات العنايه المكثفه قد يؤدي بالفعل الي تحسين نتائج مرضاهم وتمكين افراد الاسره من التعامل مع فترة دخول المريض الي المستشفي بشكل فعال.

تهدف الدراسه الحاليه الي تلبية احتياجات افراد الاسره من مرضي وحدة العنايه المركزه. وقد أجريت هذه الدراسة الوصفية المستندة في مستشفى أم درمان العسكري، وهي تهدف إلى تقييم معرفة الممرضين و الممرضات بشأن احتياجات اسر المرضي والتعامل معهم. وشملت الدراسه 50 ممرض وممرضة ، وهي تشكل العينة المتاحة خلال فترة الدراسة-2017.-2018 تم جمع البيانات من خلال استبيان صمم وفق مرجعية للدراسة. تم تحليل البيانات باستخدام الحزم الإحصائية للعلوم الاجتماعية.

اظهرت الدراسه ان الممرضين والممرضات لديهم معرفه جيده حول ارضاء اسرة مريض العنايه المكثفه وعدم تقييد زياراتهم (52)،(40,3%) بالترتيب.

اظهرت الدراسه ان نصف سكان الدراسه(50%) لديهم معرفه ضعيفه حول دور التمريض في دعم الاسره.

اظهرت الدراسه ان الممرضين والممرضات لديهم معرفه ضعيفه حول كيفية التواصل مع الاسره (58%)

وخلصت الدراسة إلى أن الممرضين والممرضات من وحدة الرعاية الحرجة لديهم معلومات ضعيفه عن دعم الاسره وتلبية احتياجاتها بينما لديهم سلوك جيد. وأوصت الدراسة الى توفير برامج تدريبية للممرضين والممرضات عن تقييم احتياجات اسرة المرضي والتواصل معهم.

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List of abbreviation

ICU	Intensive Care Unit
PICU	Pediatric intensive care unit
PT	Patient
FPR	Family presence at resuscitation

Chapter One

Introduction

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Introduction

1.1 Introduction

Families of critically ill patients experience emotional challenges that are manifested differently by each family system, often producing disruptions in the family systems work and recreational, social and emotional life routines. Family respond to and perceive the hospitalization of a critically ill family member as a crises and exhibit crisis – like behaviors that include initial confusion, shock ember may experience other feelings ranging from anxiety and anger to sadness resignation. Initially, many families, feeling extremely vulnerable and powerless, and anxious to obtain information on the family members condition while also exhibiting hovering behavior around the patient and the nursing care area. During the initial phase of any crisis, the family system seeks to regain its homeostatic balance and return to previous levels of functioning. It is during this phase of the crisis that the family system may be more amenable to support, recommendations, and directions from critical care nurse.

How family cope with the critical care hospitalization of a loved one depends on the family unique balance of strengths and limitations, including patterns of communication, problem-solving skills, degree of cohesion within the family, interfacing with the external word, and conflict resolution abilities. Families with a good balance of these skills are able to confront a member s medical crisis in a less stressful manner, whereas other families require more assistance from critical nursing care staff and others in their environment to handle the stress. The literature identifies important needs of family members during this time, which include obtaining information, honesty, caring, assess to the patient and support.

Intensive care unit CU) nurses role is complex. Monitoring, adjusting interventions and medications, and collecting subsequent information are some of the procedures needed to be handled. ICU nurse works in an area of high technology and critical changes vital functions.

So she/he must develop separate skills. Not only do the professionals in these units face situations of serious illness, but they also come into contact with the uncertainty and anxiety of family members.

Nurses need to be aware of family members needs and expectations so that effective support strategies can be implemented and family satisfaction can be maximized.

Little is known about how families perceive the role of the critical care nurse as it relates to family members. Given the complex role of the ICU nurse investigating how relative perceive there role is urgent. The admission of a critically ill patient into an intensive care unit is a stress full even for both patients and families. Because of fact that critical illness often occurs without warning, families may feel vulnerable and helpless with no clear of knowledge of what to expect from nurses, additionally, the critical care sitting has been regarded as a major stressor because of the complex nurse of patient health problems that require an extensive use of highly technical environment. as a result of this patients families often experience stress, shock, disbelief, anxiety and depression in a critical care sitting.

The role of nurses in the critical care setting is very important in the provision of support and information to these families in order to cope effectively with the stress associated with critical illness. So, nurses need to be aware of family members needs and expectation in order to implement strategies to maximize family satisfaction. Family satisfaction can be achieved by supportive interventions that focus on decreasing feeling of isolation, strengthen coping efforts, and enhance adjustment to illness.

For this reason, nurse should act as mediators and interpret information that help patient family understand what physicians say and relevance of that information for patient prognosis and decision about treatment. Additionally, nurses need to provide effective and immediate psychological support and education to the family because the latter has little control over the patients condition during the first few days of hospitalization.

1.2 General Objective

To study assessment intensive nurses knowledge and attitude for family support toward critically ill patient.

1.3 Specific objective

1. To assess nurses knowledge regard perception of ICU nurse regarding the psychological need to family.
2. To Final association between selective demographic data and knowledge.

1.4 Justification

Family support of critical patient in ICU essential responsibility of ICU nurse resulting in increase stress of staff and family.

The study was conduct to assess knowledge, awareness, attitude regarding family support, the purpose of the present study was improve the level of knowledge, nurses in military Omdurman hospital need to recheck information and knowledge about family support and how to communication with family in ICU.

In military Omdurman hospital not clear guidance and evidence base practical regard family support

Chapter Two

Literature Review

Chapter Two

Literature Review

2.1 Background:

Perception of family need of critically ill patients have been addressed in several research studies. Conducted a study in order to explore nurse perceptions of the needs of family members of critically ill patients. Results suggested that the most important needs of family members can be met with assurance, proximity, information, support, and comfort.(1)

Any illness severe enough to necessitate admission to a critical care unit is life threatening and can precipitate severe anxiety within a family system. because of the sudden onset of critical illness, anxiety experienced within the family system cannot be prevented. fear of death, uncertain outcome, emotional turmoil, financial concerns, role changes, disruption of routines, and unfamiliar hospital environments are a few sources of anxiety for family members.(3)

Specialized assessment and intervention for family are needed because anxiety may interfere with the family ability to receive and comprehend information, maintain pattern of adequate family functioning, use effecting coping skills, and provide positive support for each other and patient. The family remains the most important social context to consider when determining intervention to positively influence patient outcomes.(2)

2.2 Family Coping

Having a loved one in an ICU is stressful for family members. the literature identifies a variety of stress factors, as well as factors that do not correlate with family stress or anxiety.

The use of mechanical ventilation was not found to be predictive of stress or anxiety for family members; objective acuity scores remained constant

whether or not the patient was on a ventilator.[3] Stress levels do not seem to lessen with longer ICU stays.

Families of ICU patients have a variety of needs: stress level rise when these are not met. High on the list is the need to maintain hope; to have questions answered honestly, in terms families can understand; to be notified promptly of any changes in the patient status; and to be allowed to visit the patient any time. Families also require assurance that there loved one is receiving quality care. The definition of hope may extend past the absence of death and include hope for a pain-free and dignified death or hope for more time or quality time together.[5]

Environmental amenities were found to be low on the list of family needs.

The transfer from the ICU to the floor induces stress on the patient and family. Written information provided to families may ease the transition out of the ICU.

Families find it frustrating and confusing to deal with a host of health care providers in the ICU. Family satisfaction increase if more than tow ICU physicians care for the patient or if the patient has a different nurse from one day to the next. Nurses need more training in assessing stress levels and anticipating family needs.[2]

Factor associated with the highest stress for parents of neonatal and pediatric patients include disruption of normal interactions with the child, changes in the child behavior or emotions, parents inability to comfort the child, having a child undergo painful procedures, and changes in the child s appearance. Parents experience stress long after there children are discharged. Tow pediatric studies found that parents stress related symptoms persist as a long as 6 months post discharge. A neonatal study showed that mother of high risk, very low birth weight infants experienced psychological distress even when the child reached 2 years of age.

It is now known that families of critically ill patients of all ages may develop anxiety, depression, and posttraumatic stress syndrome. One intervention study has shown that prospective diaries with review and follow up may improve communication and goal sitting and provide comfort. In a study of parents of children in the PICU, no relationship was found between incidence of posttraumatic stress disorder in the parent and severity of illness.[10]

2.3 Staff Stress Related To Family Interactions:

The literature reviewed for these guidelines included articles representing the perspectives of physicians, nurses, support staff, and families. Survey results, qualitative grounded theory, and opinion pieces described how particular institutions handled staff stress.[8]

Poor communication is a major source of stress for staff. one study showed that nursing stress increases when nurses do not have enough information about a case to answer questions from the family and also when communication is poor between the physician and family.[7]

In a patient centered environment, multi professional care is norm. With many people involved in and concerned about the patient care, it is important to establish clear lines of communication, both among various members of the health care team and between the team and the family.

Educating families on how the ICU works with respect to visiting hours, when rounds occur, and when and how the physician can be reached can also reduce friction. it is useful to identify a family spokesperson and family member who will be making decisions on the patients behalf as soon as a patient is admitted to the ICU.

Routine communication from the ICU physician, both with family representative and with the health care team, is indicated to clarify treatment goals and duties of various team members. Family representatives should be introduced to the care team, and the roles played by each team member should be clearly explained.[7]

The health care team includes the ICU physician, consulting physicians, nurses social worker, chaplain, and appropriate additional ancillary staff. For example, a respiratory therapist should be included in discussions with the family regarding ventilated patients. Involvement of clergy can help the staff understand different cultures and belief systems and thus prevent or relieve stress. A broadly inclusive multi professional team allows health care providers to take an organized approach to achieving common goals, which may also prevent or eliminate stress.[8]

Well planned routine care conferences are important to provide objective information, to share opinions, and to reach consensus on common goals. These conference may be held for the purpose of providing status report or for making a treatment decision. All team members should be invited to discuss the case from their perspective, which educates each member of the team. Collaborative care planning may resolve or defuse conflicts between the family and the team or within the team, thereby reducing staff stress.

In addition to care conference, ICU staff members need the opportunity to decompress and confront feeling about patients and their outcomes. An unexpected adverse event or medical error may trigger the need for a staff debriefing, And the resuscitation teem may require routine debriefings. A survey of pediatric nurses found that stress increases when the decision to continue treatment is against the nurses own values or when values or when a nurse feels powerless to effect a change. Nurses in such a position need an opportunity to work through these conflicts.[3]

One study demonstrated that stress increases when staff expectations for a good death are not met. Factor associated with perceptions of a good death include good rapport and support among team members, good communication timely anticipation of symptoms and adequate time to prepare for the patient's death, and good relationships with the patient and family. Training in grief counseling may be useful for nurses. Even when death is perceived as a good

death, the death of a patient may be extremely unsettling. The routine use of support groups has not been seen as effective in reducing staff stress. However, timely debriefing after a critical incident may be helpful, and the services of trained personnel such as psychologist, medical social workers, palliative care clinicians, or hospice grief counselors may be very beneficial.[4]

2.4 Cultural support of the family:

Culture is pattern of leaned beliefs shared values and behavior: it includes language styles of communication practices customs and views on roles and relationships the concept goes beyond race ethnic back ground and country of origin.

Among the factors that may affect disparities are lack of trust in the healthcare system and patient spiritual and cultural beliefs.

An effective relationship between families has five key patient and components:

Personal self-awareness knowledge of the patients and tartly cultural beliefs cultural assessment dynamic of difference and effective communication. Interpreter choice is important when dealing who speak a family language children and family members should not be placed in the difficult and sometimes embarrassing situation of interpreting as this may compromise the patients confidentiality.[6]

The complex nursing issues that arise in the ICU environment require a trained interpreter to communicate effectively.

Ethical principles applied to end of life care, such as autonomy, non-maleficence, beneficence, and the truth telling, should accommodate varying cultural perspectives.

This professional society has emphasized family centered, culturally sensitive and relevant ICU care. Difficulty arises when the values of the nurses are in conflict with those of the family.[10]

2.5 Spiritual and Religious Support:

Opinion pieces, historical reviews, and instrument design and validation studies were reviewed but excluded as references.

Four broad categories of articles informed these guidelines: healthcare provider surveys, patient surveys, outcome studies, and meta analyses of the impact of spirituality and religion on health.[6]

These authors concur that all members of the interdisciplinary team need to recognize the impact of spirituality on the patient \family ICU experience, especially with regard to matter of faith at the end of life. Failure to have appropriately trained personnel explore these issues may create barriers to a meaningful discussion of resuscitation status or the possibility of hospice care. The chaplaincy service carries the lead position in providing spiritual assessment and care, but all team members have a role in incorporating spirituality appropriate care to those patients and families who have disclosed preferences.[5]

2.6 Family Visitation:

With health care consumers more knowledgeable about their health, available care, and their health care rights, demand for access to hospitalized loved one is increasing. As the health care industry strive for a more " family friendly " environment of care, great efforts have been made to evaluate the need of patients and families as well as attitude and behaviors of nurses and other members of the health care team.[9]

Flexible open visitation policies and regular reports on patient status answer some of the significant needs of families with loved ones in the critical care unit.

2.7 Nurses attitudes toward visitation:

Some nurses allow more liberal family visitation privileges than the unit policy dictates, whereas others reduce family visiting time based on patient

anxiety. Still others base family visiting on the nurse schedule, restricting visit when the unit is busy.[5] Many nurses expressed a belief that patients need visitors; other felt the room was simply too small to allow for visitation and patient care at the same time.

Nurses attitudes notwithstanding, preponderance of the literature supports greater flexibility in ICU visitation policies. Descriptive study of the physiologic effects of visiting on mental status, intracranial pressure, heart rate, and ectopy demonstrated no physiologic rationale for restricting visiting. In fact in seven of 24 patients with neurologic injuries, family visit produced a significant positive effect, measured by decrease in intracranial pressure. One ethnographic study has demonstrated that family visiting may help the nurse to 'get to know' the patient and that family may be helpful in contributing to the care of the patient.[7]

2.8 Family Environment of Care:

Visitation policies become more flexible in the patient centered in ICU, the environment of care has a growing impact on families.[3]

Transmission of infection to patient generally occurs through two routes: airborne and direct contact. The design of the physical environment affects both transmission routes.[7]

The health insurance portability and accountability act created new incentives for redesigning patient care area to enhance privacy. With increased family access to the critical care environment through open visiting, privacy become a family issue as well. Several articles examine the health insurance portability and accountability acts impact on the structure of new facilities.[2]

As more is learned about the effects of the environment of care on patients and families, efforts will increase to include families in the design process for new hospital facilities. new facilities not only will be more comforting to patients and families but also will be more energy efficient and

more ergonomic and will provide for greater patient\family control of the environment.[8]

2.9 Family Presence on Rounds:

One opinion publication reported both pro and con opinions on parental presence on rounds in a NICU. Pros included improving respectful information to parents, family sharing of patient condition \like \dislikes with the health care team, efficiency of time spent with parents, and decreased parental anxiety. Cons included perception of not having enough time to answer parental question during rounds, one argued against inclusion of patients on medical and nursing round, one argued against inclusion of patients and on discussed both the pro and cons of patient inclusion.[6]

Recognizing that the topic of family presence in rounds is the least studied of any section within this document, these authors concur that family participation in rounds is beneficial. In our collective experience the burden imposed by the challenges related to privacy and teaching of the resident teams is outweighed by the greater benefit of improving bidirectional communication families and health care team.[10]

2.10 Family Presence at Resuscitation:

In family presence at resuscitation (FPR) a limited number of family members, usually one, are present in the resuscitation procedures.

Family today are exercising their right to be present during resuscitation the same way they once did to have fathers present in the delivery room.

Seventy –five percent or more of families surveyed wanted the option of being present in the resuscitation room [6]. A similar percentage of patients, asked if they wanted their family present, answered yes. Of families who experienced FPR, >75% felt that the experience was positive and helped in their grieving process and said they would repeat the experience >60% felt that their dying relative.

Survey data indicate that health care professionals vary in their opinions of FPR; nurses tend to support it and physicians to oppose it. Mc Clenathan et al.found that approximately 60% of nurse support FPR, compare with 30% of physicians.[5]

Other pertinent findings in these surveys were that experienced nurse were more likely to support FPR than inexperience staff and special trained staff member too offer the family the option of entering the resuscitation room with permission of the staff. This liaison should explain beforehand what the family may see, stay with the family in the resuscitation room, escort the family out of the room when requested by the family or when an invasive procedure is needed, and support the family after the resuscitation is over, whatever the outcome. A study of ICU and emergency department nurses reported that few hospitals have policies in place for FPR, but most hospitals have allowed families to be present and have had families request to be present.[4]

Chapter three

Methodology

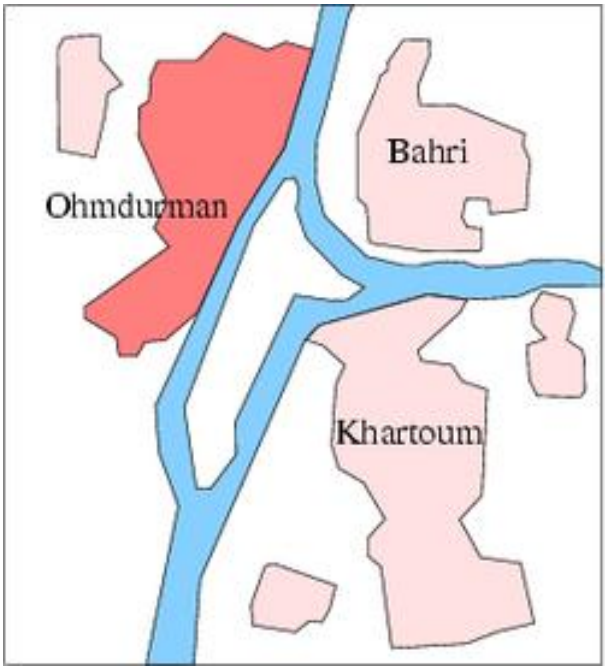
CHAPTER Three

Methodology

3.1The Study Design:

This descriptive study was carried out Omdurman Military Hospital in Khartoum.

3.2 The Study Area:



The study was conducted in Omdurman Military Hospital, capital of Sudan. Omdurman (standard Arabic Umm Durmānأم درمان) is the largest city in Sudan and Khartoum State, lying on the western banks of the River Nile, opposite the capital, Khartoum. Omdurman has a population of 2,395,159 (2008) and is the national center of commerce with Khartoum and Khartoum North. Furthermore, being a highly dense city, small private clinics that are scattered throughout the city are a common sight, especially close to Hay Alshohada. Some notable hospitals include:

1. Omdurman Teaching Hospital, the biggest public hospital with an emergency center.
2. Omdurman Military Hospital (*AlsilahAltiby*)

3. Omdurman Maternity Hospital (*Aldayat Hospital*), a public hospital specializing in labor,
4. Blue Nile Hospital, a private hospital
5. Asia Hospital, a private hospital
6. [[*Atigany Almahy* Hospital]], a public historical hospital specializing in psychological and mental health

3.3 Department of Omdurman Military Hospital:

Omdurman Military Hospital contains (trauma room. hot area, cold area. outpatient clinic, dressing room, triage, medicine word, surgical words, VIP wards, intensive care unit, theater, laboratory, blood bank, pharmacy, x-ray, CT–scan, 3ambulance, engineering, diet therapy, kitchen and management department.

3.4 Study Population:

The sample of this study included All currently working nursing staff at Omdurman Military Hospital including (50) nurses.

3.5 Sample Size:

Sample size consisted of (50) nurses.

3.6 Data Collection tools:

Data was collected using a well-structured questionnaire contains two forms demographic data and knowledge assessment for interviewing the respondents. The questionnaire contained information that covered the variables under study.

3.7 Data Processing and Analysis:

The data were checked, verified and analyzed using the Statistical Packages for Social Sciences (SPSS).

3.8 Scoring system:

Majority of the questionnaire question contain 5 answer if the nurse answered more than 3 = good 3 = fair less than 3 = poor

3.9 Data Analysis:

For the purposes of this study, the data were coded, processed and transferred to computer coding. The descriptive analytical method was adopted which includes percentage, means, frequency distribution, tables and figures. SPSS was applied to determine the relationship between the independent variables and dependent variables

3.10 Ethical Considerations:

The researcher took permission from the hospital of the study with an official letter from the Faculty of Nursing Sciences to the director of the hospital with the agreement of the target population, every individual observed once. Verbal consent from the interviewed persons was also taken after explaining the study and its objectives to them. Confidentiality was given consideration and the information is used for the research purpose only.

Chapter Four

Result

Chapter Four

Result

4.1 Result

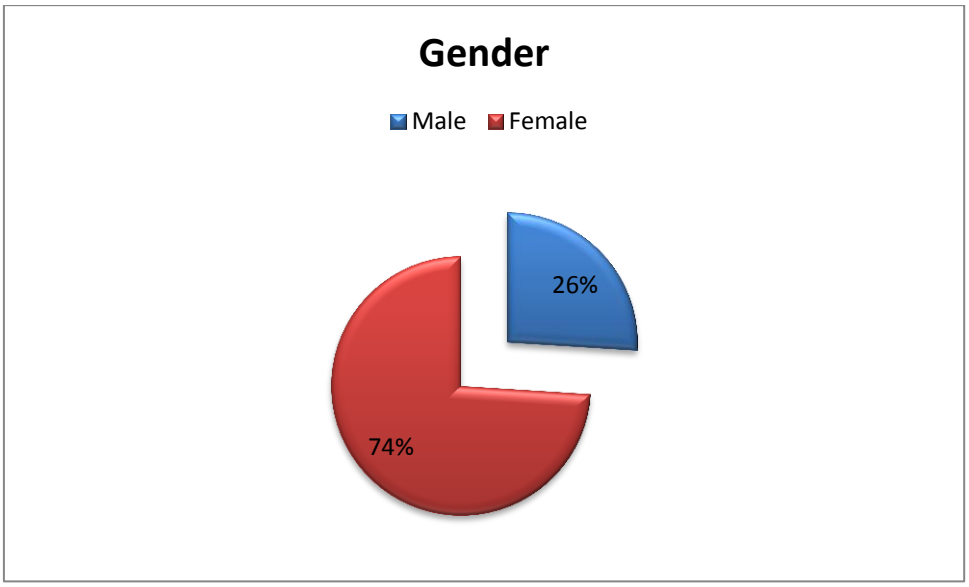


Figure No (4.1) distribution of study group according to their gender (n=50)

Showed that most of study population is female (74%), male is (26%).

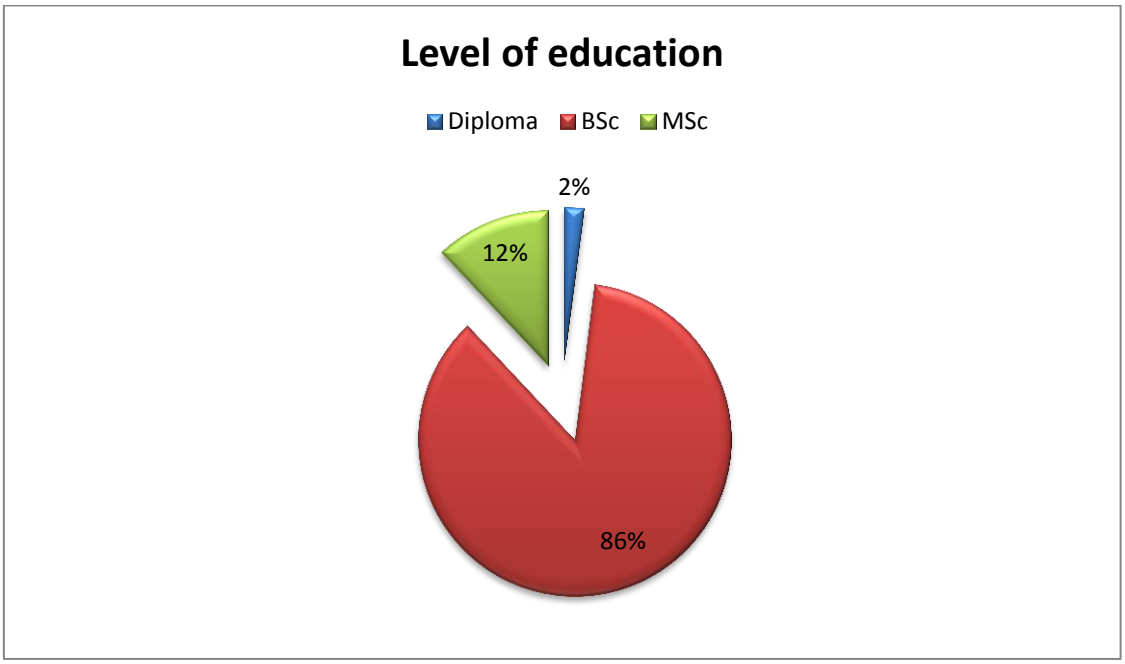


Figure No (4.2) distribution of study group according to their level of education (n=50)

Showed that most study population is bachelors (86%). master (12%),diploma (2%).

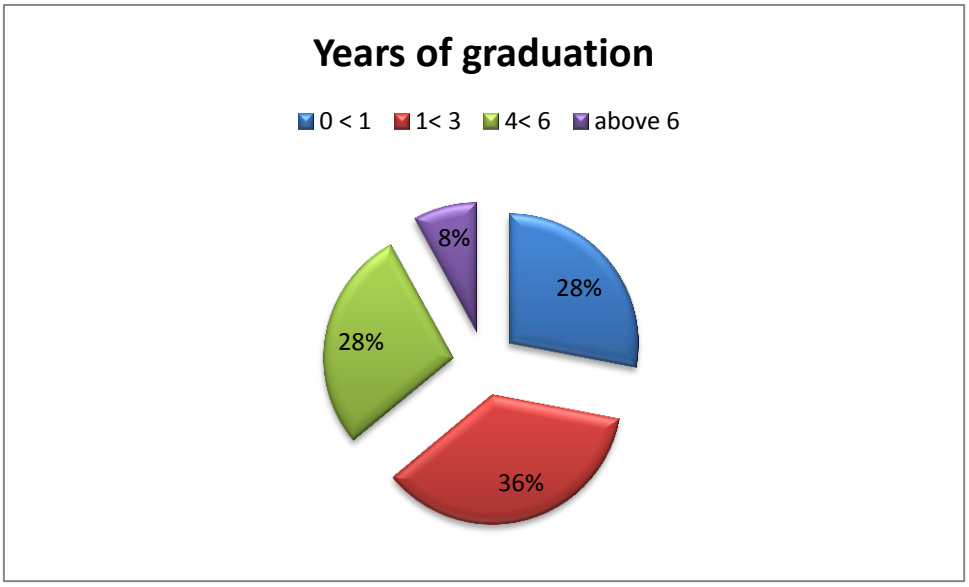


Figure No (4.3) distribution of study group according to their years of graduation (n=50)

Showed that 36% of nurses ranged between 1- 3, 28%ranged between 0 -1, 28% ranged between 4 – 6, 8% more than 6 years.

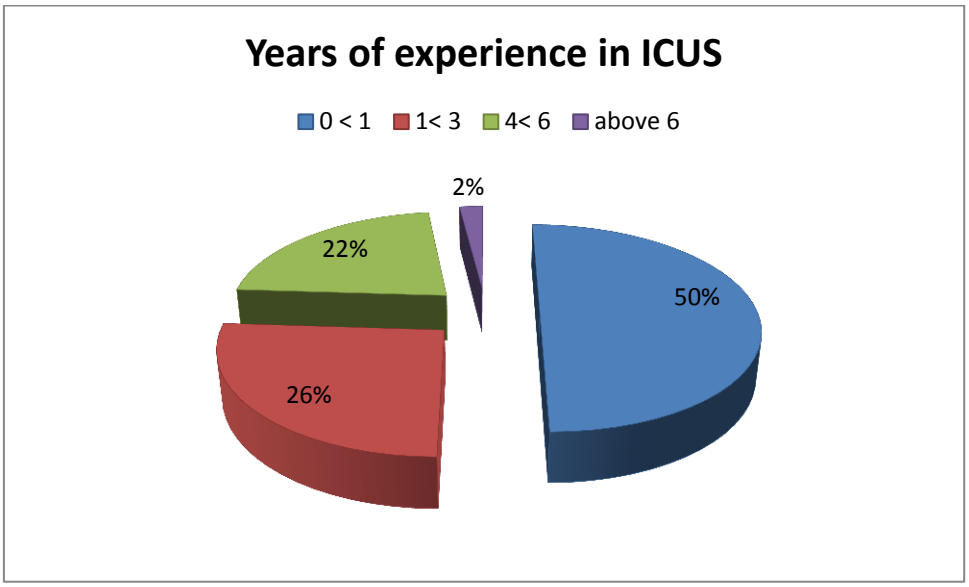


Figure No (4.4) distribution of study group according to their level of experience (n=50)

Showed that 50% of nurses ranged between 0 -1, 26% between 1 - 3 years, 22 % ranged between 4 – 6 years, 2% above 6 years.

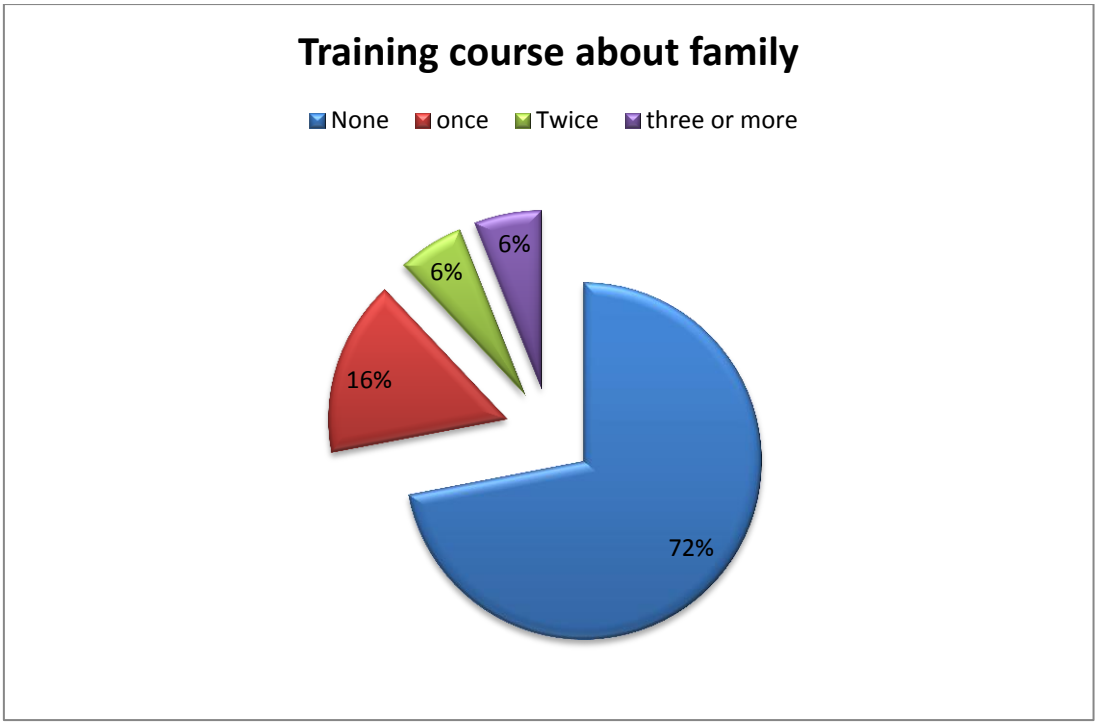


Figure No (4.5) distribution of study group according to their training course about family (n=50)

Showed that 72% of nurses not course, 16% once course, 6 % twice course or more than.

Table no (4.1) distribution according of study group to their knowledge about intervention of family member (n=50)

Study group knowledge regarding intervention of family member

ITEMS	Frequency	Percent
Good knowledge	11	22.0
Sufficient knowledge	10	20.0
Poor knowledge	29	58.0
Total	50	100%

Showed that 22% good knowledge, 20% had Sufficient knowledge. 58% had poor knowledge.

Table no (4.2) distribution according of study group to their knowledge about intervention of family need (n=50)

Study group knowledge regarding families need

ITEMS	Frequency	Percent
Good knowledge	21	42.0
sufficient knowledge	7	14.0
Poor knowledge	22	44.0
Total	50	100%

Showed that 22% good knowledge, 20% had sufficient knowledge. 58% had poor knowledge.

Table no (4.3) distribution according of study group to their knowledge about beneficial for family member (n=50)

Study group knowledge regarding interventions beneficial for family member

ITEMS	Frequency	Percent
Good knowledge	16	32.0
sufficient knowledge	13	26.0
Poor knowledge	21	42.0
Total	50	100%

Showed that 16% good knowledge, 26% had Sufficient knowledge. 42% had poor knowledge.

Table no (4.4) distribution according of study group to their knowledge about family of critical ill need (n=50)

Family of the critically ill need to psychological support because may be high risk for posttraumatic stress disorder related to

ITEMS	Frequency	Percent
Good knowledge	19	38.0
sufficient knowledge	9	18.0
Poor knowledge	22	44.0
Total	50	100%

Showed that 38% good knowledge, 18% had Sufficient knowledge. 44% had poor knowledge.

Table no (4.5) distribution according of study group to their knowledge about important of family meeting (n=50)

Study group knowledge regarding important of family meeting

ITEMS	Frequency	Percent
Good knowledge	16	32.0
sufficient knowledge	12	24.0
Poor knowledge	22	44.0
Total	50	100%

Showed that 32% good knowledge, 24% had Sufficient knowledge. 44% had poor knowledge.

Table no (4.6) distribution according of study group to their knowledge about family satisfaction (n=50)

Family satisfaction of critically in pt has gained incased interest as important indicator to evaluate the quality of care in ICU, study group knowledge regarding nurse responsibility about pt for satisfaction

Items	Frequency	Percent
Good knowledge	26	52.0
sufficient knowledge	3	6.0
Poor knowledge	21	42.0
Total	50	100%

Showed that 52% good knowledge, 6% had Sufficient knowledge. 42% had poor knowledge.

Table no (4.7) distribution according of study group to their knowledge about unrestricted visitation of family (n=50)

Unrestricted visitation enhance pt and family satisfaction this especially true in ICU. Study group knowledge regarding cause to restrict visitation

Items	Frequency	Percent
Good knowledge	20	40.3
sufficient knowledge	10	20.0
Poor knowledge	20	39.7
Total	50	100%

Showed that 40% good knowledge, 20% had Sufficient knowledge. 40% had poor knowledge.

Table no (4.8) distribution according of study group to their knowledge about visitation policy of family (n=50)

Flexible visitation polices and regular reports on pt. status for needs of family with loved ones in ICU study group attitude regarding about visitation

Items	Frequency	Percent
Good knowledge	11	22.0
sufficient knowledge	17	34.0
Poor knowledge	22	44.0
Total	50	100%

Showed that 22% good knowledge, 34% had Sufficient knowledge. 44% had poor knowledge.

Table no (4.9) distribution according of study group to their knowledge about role of nurse (n=50)

Role of nurse about family support in critically ill patient

Items	Frequency	Percent
Good knowledge	19	38.0
sufficient knowledge	6	12.0
Poor knowledge	25	50.0
Total	50	100%

Showed that 38% good knowledge, 12% had sufficient knowledge. 50% had poor knowledge.

Table no (4.10) distribution according of study group to their knowledge about communication with family (n=50)

Study group knowledge regarding barrier affect communication between nurse and patient family

Items	Frequency	Percent
Good knowledge	14	28.0
sufficient knowledge	7	14.0
Poor knowledge	29	58.0
Total	50	100%

Showed that 28% good knowledge, 14% had sufficient knowledge. 58% had poor knowledge.

Table no (4.11) distribution according of study group to their knowledge about general family behavior need (n=50)

In general family behavior and culture is deference from person to person. Study group knowledge regarding to dealing about this

Items	Frequency	Percent
Good knowledge	15	30.0
sufficient knowledge	13	26.0
Poor knowledge	22	44.0
Total	50	100%

Showed that 30% good knowledge, 26% had Sufficient knowledge. 44% had poor knowledge.

Table no (4.12) distribution according of study group to their knowledge about family member misunderstand hospital policy (n=50)

The family members are misunderstand hospital policy.study group knowledge regarding help them

ITEMS	Frequency	Percent
Good knowledge	24	48.0
sufficient knowledge	5	10.0
Poor knowledge	21	42.0
Total	50	100%

Showed that 48% good knowledge, 10% had sufficient knowledge. 42% had poor knowledge.

Table no (4.13) **Level of education * study group knowledge regarding interventions beneficial for family member Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.227	.122	-1.617	.113(c)
Ordinal by Ordinal	**Spearman Correlation**	-.228	.122	-1.620	.112(c)
N of Valid Cases	50				

Table no (4.14) **Level of education * study group knowledge regarding important of family meeting Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.167	.140	-1.174	.246(c)
Ordinal by Ordinal	**Spearman Correlation**	-.162	.141	-1.136	.262(c)
N of Valid Cases	50				

Table no (4.15) **Level of education * Communication consisted of spiritual care, emotional support, participation, notification, consolation, study group knowledge regarding barrier affect communication between nurse and patient family Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.348	.122	-2.569	.013(c)
Ordinal by Ordinal	**Spearman Correlation**	-.347	.121	-2.563	.014(c)
N of Valid Cases	50				

Table no (4.16) **Years of experience in ICUS * study group knowledge regarding interventions beneficial for family member Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.022	.144	-.151	.881(c)
Ordinal by Ordinal	**Spearman Correlation**	-.051	.145	-.354	.725(c)
N of Valid Cases	50				

Table no (4.17) **Years of experience in ICUS * study group knowledge regarding important of family meeting Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.176	.144	-1.241	.221(c)
Ordinal by Ordinal	**Spearman Correlation**	-.147	.144	-1.031	.308(c)
N of Valid Cases	50				

Table no (4.18) **Years of experience in ICUS * Communication consisted of spiritual care, emotional support, participation, notification, consolation, study group knowledge regarding barrier affect communication between nurse and patient family Cross tabulation**

		Value	Asymp. Std. Error(a)	Approx. T(b)	p.value
Interval by Interval	**Pearson's R**	-.011	.141	-.073	.942(c)
Ordinal by Ordinal	**Spearman Correlation**	-.004	.142	-.031	.976(c)
N of Valid Cases	50				

Chapter Five

Discussion & Conclusion & Recommendation

Chapter Five

Discussion & Conclusion & Recommendation

5.1 Discussion:

The role of nurses in the critical care setting is very important in the provision of support and information to these families in order to cope effectively with the stress associated with critical illness.

The study showed that the three quarter of study population (74%) are female and more than one third (36%), the graduation between (1 – 3) years. According to level of education and experiences the study showed that the majority of study population (86%) had bachelors and half (50%) had experiences less than one years. these finding indicated that the study group where qualified and experts.so they will be able to translate knowledge into practice and improve quality of care.

The study showed that the most of study population (72%) not training course of family support.

The study showed that the nurses had poor knowledge about intervention of family member and intervention beneficial for family also family need and psychological support (58%), (42%) (44%) (44%).

These finding indicated that the study group not received training course causes poor knowledge related to not personal and time and equipment available, THE study recommended that there is providing complex training course and encourage and support that by workshop and role play.

The study showed that less than half (44%) had poor knowledge about family meeting. these finding indicated that the study group failed to meet family member, expectation with respect to some specific interventions that

follow: explaining patient prognoses, explaining equipment used with patients, preparing family members for their first visits.

The study showed that the nurses had good knowledge about about family satisfaction and unrestricted visitation, but the poor knowledge about policy of visit.(52%), (40.3%) (44%). these finding indicated that the study group good family satisfaction to save and support this result increase high quality care and explanation and consultation about patient condition step by step, to enhance knowledge about policy visit recommended to clear guidelines and policy visit.

The study showed that the half of study population (50%) had poor knowledge about nursing role about family support.

The study showed that the nurses had poor knowledge about how to communication of family and general family behavior (58%), (44%).

These finding indicated that the study group poor communication related to family stress and different culture and hospital policy recommended to receive education to provide culturally competent care and understand body language.

The study showed that there is statistical not significance with there level of education and level of experience p value (0.113),(0.881), this refer to nurses knowledge about intervention of family member also is statistical not significance with there level of education and level of experience p value (0.246), (0.221) this refer to nurses knowledge about family meeting and is statistical significance with there level of education p value (0.013) this refer to nurses knowledge about communication with family member.

5.2 Conclusion:

This study is concluded the nurses had poor knowledge about intervention of family member in intensive care unit, and had poor knowledge about family meeting and family need, but the good knowledge about family satisfaction

Family support knowledge of ICU nursing staff could be improved by providing well-organized practical training.

5.3 Recommendations

Organization:

1- ICU staff and nurses receive training in how to assess family needs and family members stress and anxiety level.

2- ICU nurses receive education to provide culturally competent care.

3-Family support is provided by the multi professional team, including social workers, clergy, nursing, medicine, and parent support group.

4- Organization should have clear plan and protocol about deal with family and family visitation.

5.4 References

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Appendix

In The Name Of Allah

UNIVERSITY OF SHENDI

Questionnaire about nurses affect toward family support of critical ill patient

1. **Gender:**

Male [ ] Female [ ]

2. **Level of education:**

Diploma [ ] BSc [ ]

MSc [ ] PHD [ ]

3. **Years of graduation:**

0 > 1 [ ] 1 – 3 [ ]

4 – 6 [ ] above 6 [ ]

4. **Years of experience in ICUS:**

0 > 1 [ ] 1 – 3 [ ]

4 – 6 [ ] above 6 [ ]

5. **Training course about family:**

None [ ] once [ ]

Twice [ ] three or more [ ]

6. **Why provide intervention of family member:**

- Anger and dissatisfaction with care [ ]
- Noncompliance with the treatment regimen [ ]
- Unmitigated family anxiety may manifest itself in distrust of hospital staff [ ]
- Family appear to have a beneficial impact on the patient response to treatment [ ]

7. **What do families need:**

- To receive assurance reflecting a need to maintain or redefine hope about the pt outcome [ ]
- To remain near the patient reflecting a desire to link and maintain familial relationship [ ]

- To receive information reflecting the goal of understanding the patient condition [ ]
- To be comfortable reflecting a need to reduce stress [ ]

8. What interventions beneficial for family member:

- Intervention had positive effects on depression when the spouse was induced and in some case, on mortality. [ ]
- Among family members positive effects were found for caregiving burden depression and anxiety [ ]
- Family member in turn have strong influence on the pts psychological adjustment and management of illness [ ]
- Reduce concern for the family member and enhanced family support for the pt [ ]

9. Family of the critically ill need to psychological support because may be high risk for posttraumatic stress disorder related to:

- Unfamiliarity of the intensive care environment especially during 72h after ICU admission [ ]
- Fear of death or permanent disability [ ]
- Emotional conflict [ ]
- Financial concern [ ]

10. Family satisfaction of critically in pt has gained incased interest as important indicator to evaluate the quality of care in ICU, what is nurse responsibility about pt for satisfaction:

- Clear, understandable, honest information about pt condition [ ]
- Effective communication of the staff with the family of ICU patient [ ]
- Support, comfort, information, proximity, assurance, family needs assessment [ ]

11. What is important of family meeting

- Can improve patient outcome [ ]
- Reduce the stress of both families and nurse staff [ ]

- Develop trust in health care team [ ]
- Increase their satisfaction with hospital care and help them cope with stressful situation [ ]

12. Unrestrict visitation enhance pt and family satisfaction this especially true in ICU what's cause to restrict visitation:

- Hospital policies [ ]
- Increase risk of infection [ ]
- Disrupt patient comfort and nursing care [ ]
- Patient privacy [ ]

13. Flexible visitation polices and regular reports on pt status for needs of family with loved ones in ICU how attitude toward visitation

- Allow more liberal family visitation privileges than the unit policy dictates [ ]
- Reduce family visiting time based on patient anxiety [ ]
- Restricting visits when the unit is busy [ ]
- When expressed a belief that patients need visitors [ ]

14. Role of nurse about family support in critically ill patient.

- Nurse need to be aware of family member needs and expectation so that effective support strategies can be implemented and family satisfaction can be maximized [ ]
- Nurse should act as mediators and interpret information that help pt family understand what physicians say [ ]
- Nurse tend to underestimate the needs of family members, who want to have adequate information to feel accepted by the staff [ ]
- Nurse deliver intimate, personal care allowing them to develop trusting relationship with family and pt assess their needs, and observe the response that family members have to changing condition of the pt [ ]

15. **Communication consisted of spiritual care, emotional support, participation, notification, consolation, what is barrier affect communication between nurse and patient family:**
    - Highly technical equipment which is used in the treatment of patient [ ]
    - Managerial influence to a larg extent determined the type of interaction between nurse patient family [ ]
    - Shortag staff [ ]
    - Nurse multiple responsible [ ]
16. **In general family behavior and culture is deference from person to person how is dealing about this:**
    - Firstly trying to enders and behavior and culture [ ]
    - Be good observer during conversation pt family [ ]
    - When have conflicting question about pt treatment use delegation process with family member [ ]
    - Respect family culture as possible [ ]
17. **The family members are misunderstand hospital policy how help them:**
    - Initially explain family hospital policy as possible [ ]
    - Ensure this policy is important to treatment your patient [ ]
    - Encourage family members to adapt about current situation and policy [ ]
    - Tell family member clear policy in work is beneficial for pt outcome [ ]