

KNOWLEDGE, PERCEPTIONS AND EXPERIENCES OF NURSES TOWARDS FAMILY CENTRED CARE IN ADULT INTENSIVE CARE UNITS

Andile Ngcobo

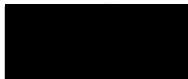
Dissertation submission in fulfillment of the requirement for the Degree in Masters of
Technology in Nursing in the Faculty of Health Sciences at the Durban University of
Technology

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2016

DECLARATION

I, Andile Ngcobo certify that this work is my own. This work has not been submitted before for any qualification to this university (Durban University of Technology) or any other University.



Signature of Student

20/11/2017

Date

Approved for final submission



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ABSTRACT

Aim and objectives: To explore and describe the knowledge, perceptions and experiences of nurses towards family centered care in adult ICUs.

Background: Promoting quality patient care and family satisfaction is a current trend in health care systems. In addition, the identification of family needs has been used as a means to measure quality patient care in intensive care units (ICUs). Evidence shows that family centred care (FCC) is an essential approach to promote quality patient care through the recognition of family needs. Admission to an ICU creates increased stress levels for the patient and family members, thus nurses' knowledge, skills and experiences are crucial during this time of a family crisis. Nurses in ICU are in the best position as critical bedside nurses to assess and evaluate strategies that can be used to minimise and prevent stressors that are caused by the critical illnesses and the ICU environment.

Design: An exploratory descriptive qualitative design was used.

Method: The study was conducted in a district and academic tertiary public hospital based in KwaZulu Natal. This hospital provides health care services to a diverse and cross cultural population. Two ICUs were used for data collection, namely, a surgical and a medical ICU. Nine nurses were purposively recruited from the two adult intensive care units. Data was collected using in-depth interviews with the assistance of an interview guide and audio recording. Qualitative content analysis was used to analyse the data.

Results: Findings of this study indicated that nurses have an accurate and correct knowledge on the concept of FCC, thus identifying and recognising their roles and responsibilities with respect to the components that enhance FCC. However their perceptions towards facilitating family involvement in nursing care activities as part of FCC, revealed discrepancies due to mentioned factors that cause a hindrance in family involvement. Participants' experiences has been shown to be positive in relation to family presence in ICUs, however findings indicated that participants restricted family visitation in adult ICUs is based on the existing policy pertaining to

family visitation in ICUs. Consequently, nurses noted the great contribution a family makes towards patients' well being in an ICU.

Conclusion: The study findings showed that nurses in the selected ICUs require skills and training on the strategies that can be used to enhance and promote active family involvement in relation to nursing care activities in adult ICUs.

Relevance to clinical practice: Training and further research for nurses has been proposed so as to better equip and encourage nurses with the necessary knowledge and skills required to improve family nursing in adult ICUs. In addition, the ICU environment including management, infrastructure and policy development can be adopted to allow such changes. Hence, nurses would need guidelines to be able to practice evidence based practices.

Key words: Family centered care, family, patients, critical care nurses, ICU.

DEDICATION

To my family this has been a long journey full of challenges but filled with joy at the end, I dedicate this to all of you for the endless support and love that you have provided for me during this time.

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Accomplishing this project has been overwhelming because of the challenges encountered along the way, however the support and love from the following people contributed greatly to my successful outcome.

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LIST OF ACRONYMS

Acronym	Full word
ICU	Intensive Care Units
FCC	Family Centred Care

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

This chapter provides background information and an overview of the study. Problem statement, purpose of the study, research question, significance of the study and operational definitions are presented. The outline of other chapters has been included at the end of this chapter.

The aim of this study is to explore and describe the knowledge, perceptions and experiences of nurses towards family centred care (FCC) in adult intensive care units (ICUs). To assess and meet family needs in ICUs is essential and crucial since family members are an integral aspect of a patient and thus, they provide support to the patient. This subsequently predisposes the family to experience increased levels of anxiety because of the patient's admission to ICU. Meeting family needs in an ICU is part of nurses' roles since nursing care is consistent. Hence, nurses interact a lot with family members because they spend most of their on duty time at the patient's bedside (Gill, Bagshaw, McKenzie, Oxland, Oswell, Boulton, Nivel, Potestio, Shklarov, Marlett, Stelfox and Critical care strategic clinical network 2016: 1-16; Frivold, Dale and Slettebø 2015: 232-240; Kodali, Stametz, Clarke, Bengier, Sun, Layon and Darer 2015: 961-967).

Frivold, Dale and Slettebø (2015: 232-240) and Høgshaug, Fagermoen and Lerdal (2012: 263-8); Hashim and Hassin 2012b: 103-111); Hashim and Hassin (2012a: 12-23); Al-Mutair, Plummer, Clerehan and O'Brien (2013a: 135-144) identified needs that are important for family members in an ICU, including support, comfort, information, proximity to the patient and reassurance. However if these needs are not met, anxiety and stress escalates to levels that may be detrimental to the patient's recovery and the family's well-being, and can affect the family members capacity to cope in an ICU (Carlson, Spain, Muhtadie, McDade-Montez and Macia 2015: 557-561). Family satisfaction can be achieved by encouraging family involvement in patient care, thus meeting these needs requires their presence. FCC is an approach that enhances, promotes and encourages family satisfaction in ICUs (Al-Mutair, Plummer, O'Brien and Clerehan 2013c: 1805-1817; Schwarzkopt,

Behrend, Skupin, Westermann, Riedemann, Pfeifer, Gunther, Witte, Reinhart and Hartog 2013:1071-1079; Cypress 2012: 53-64).

Family members assist nurses and doctors to better understand the patient as a person rather than merely as a patient, therefore, becoming surrogate spokespeople and decision makers. Furthermore patients are treated as part of the family unit as opposed to being an isolated individual as was the case decades ago (Giannini, Garrouste-Orgeas and Latour 2014: 730-733). Researchers in the field, state that involving family members in patient care helps with the patient's care plan and treatment to be individualised. Because the patient is usually unresponsive, the family unit can provide valuable information which can enhance patient care. The family has extra knowledge of patient's needs, preferences and wishes which they can share with the health care team, especially the nursing staff.

Family members become effective patient supporters because of the following factors: they shared a common pattern of communication with the patient before hospitalisation, their contact with the patient is constant, cultural background and values are the same as the patient and lastly, family members are aware and have pre-existing knowledge about the patient's illness prior to ICU admission (Akroute and Bondas 2016: 67-80; Wilson, Kaur, Gallo De Moraes, Pickering, Gajic and Herasevich 2015: 1317-1323; Kodali *et al.* 2015: 961-967; Al-Mutair *et al.* 2013a: 135-144). A study conducted by Wilson *et al.* (2015: 1317-1323); Au, de Ordons, Soo, Guienguere and Stelfox (2017: 132-136) revealed that involving family members in the transfer of information of the patient, has shown less deterioration of the patient's health and increased levels of patient and family satisfaction, thus reducing anxiety levels.

Ultimately, information that is given by family members promotes patient recovery in the ICU and thus, greater rehabilitation (Karlsson, Bergbom and Forsberg 2012: 6-15). Family members can not only be a source of information for the patient, but also support the patient's emotional, psychological and physical status. Patients' experiences in the ICU with their family's presence has been reported to give the patient a moment of warmth and a sense of safety and security, thus hope and love is being instilled. Nevertheless, family members cannot provide support to the patient on their own, therefore, informational and emotional support given to them by nurses

and doctors is of utmost importance because it reduces stress levels as they learn more about the patient's condition and progress (Al-Mutair *et al.* 2013c: 1805-1817; Loghmani, Borhani and Abbaszadeh 2014: 67-82; Carlson *et al.* 2015: 557-561; Kumari and Das 2015: 337-340).

FCC has received major recognition related to the positive benefits. Conversely, supporting this approach means that policy development and nurses' training should be enhanced and encouraged. This will assist in adequately involving family members, especially in the decision making process (Al-Mutair *et al.* 2013a: 135-144; American Academy of Pediatrics Committee on Hospital Care 2012: 394-404). Cypress (2012: 53-64); Soh, Davidson, Leslie, Di Giacomo and Soh (2012: 856-865); Al-Mutair *et al.* (2013a: 135-144); Hashim and Hussin (2012b: 103-111); Jakimowicz and Perry (2015: 1499-1517) indicated that guidelines should be established that can be used to support evidence based practices. This requires the investigation of nurses' perceptions, experiences and knowledge, including beliefs and attitudes, which will determine the meaning and outcomes of the family members presence to those nurses. In order to implement FCC adequately and successfully, nurses require education and training, thereby empowering them with the knowledge and skills to enhance FCC.

1.2 Background

Promoting quality patient care and family satisfaction is the current trend and priority in health care systems globally, especially ICUs. This includes the identification of family needs as a means to measure quality patient care in ICUs (Carlson *et al.* 2015: 557-561; Di Bernardo, Grignoli, Marazia, Andreotti, Perren and Malacrida 2015: 866-870). Evidence shows that FCC is an essential approach to the promotion of quality patient care through the recognition of family needs (Wiegand, Grant, Cheon and Gergis 2013: 60-8).

FCC is an approach that encourages partnership or collaboration in the health care system. Hence, patients, family members and nurses are involved in this partnership (Kuo, Houtrow, Arango, Kuhlthau, Simmons and Neff 2012: 297-305). This partnership or collaboration promotes and encourages patient and family participation in shared decision making and patient care. The patient's and family's

belief systems, cultural background and needs are incorporated in this approach. Consequently, the patient and family's well-being is promoted and maintained (Kodali *et al.* 2015: 961-967). According to Shirazi, Sharif, Rakhshan, Pishva and Jahanpoui (2015: 207-216) the implementation of FCC has benefits and challenges as everyone involved learns along the way. Core principles of FCC include respect, share information, incorporate family and patient needs when formulating policies, provide support for patient and family, enhance and encourage patients and families to use their own coping mechanisms, encourage family involvement in patient care, and recognise the family and patient's diversity. This will ensure effective and efficient planning, delivery and monitoring of health services in the health care system (American Academy of Pediatrics Committee on Hospital Care 2012: 394-404; Kodali *et al.* 2015: 961-967 Al-Mutair *et al.* 2013a: 135-144).

The history of FCC began in neonate, paediatric and maternal units in the late 20th century and early 21st century. The aim was to promote patient and family satisfaction through identifying their needs. These needs included developmental and psychosocial needs. Consequently, FCC can be implemented in any health care setting. Family involvement promotes patient and family satisfaction and ultimately reduces signs and symptoms of anxiety and depression (Kuo *et al.* 2012: 297-305; Gill *et al.* 2016: 1-16; Akroute and Bondas 2016: 67-80). According to Akroute and Bondas (2016: 67-80); Wilson *et al.* (2015: 1317-1323); Al-Mutair *et al.* (2013a: 135-144); Gill *et al.* (2016: 1-16), family members of patients admitted into ICUs become the patients' advocates, spokespeople and surrogate decision makers. It is difficult for patients in ICUs to perform such duties, since they are non responsive nor capable of making their own decisions. This is due to being intubated, ventilated and sedated.

Nurses are the key members of the health care team and are therefore in a good position to promote FCC (Frivold, Dale and Slattebø 2015: 232-240; Akroute and Bondas 2016: 67-80). Nurses require skills and support in order to promote quality patient care such as implementing FCC (Knutsson, Enskär and Golsäter 2017: 9-17; Huffines, Johnson, Smitz Naranjo, Lissauer, Fisher, D'Angelo Howes, Punnulla, Ralls and Smith 2013: 56-59). Nurses have a professional obligation to care for the patient, while the family acts as their advocate (Wiegand *et al.* 2013: 60-8). However, McLaughlin (2013: 20-25) and Rippin, Zimring, Samuels and Denham (2015: 80-98)

point out that nurses demonstrate that it can be very stressful and challenging to deal with the family while caring for an unstable and critically ill patient. Nurses in ICUs need effective communication skills in order to be able to interact with family members, thereby providing the necessary care for the patient. Conveying information to the family from the doctors was noted as one of the most important roles for nurses in ICUs since doctors are busy and are not always available when family members come to visit the patient (Slatore, Ganzini, Press, Osborne, Chesnutt and Mularski 2012: 410-418; Milutinovic, Golubovic, Brkic and Prokes 2012: 171-180). According to Wilson *et al.* (2015: 1317-1323); Kumari and Das (2015: 337-340); Jakimowicz and Perry (2015: 1499-1517); Rippin *et al.* (2015: 80-98); Moretz and Abraham (2012: 106-109) nurses need to have a good understanding of each family involved with each patient as this will promote partnership and enhance FCC, thus reducing stress levels. Nurses should identify and assess the needs of the family as accurately as possible without having preconceived ideas. Consequently, more research needs to be conducted in order to determine the nurses' role with respect to assessing and meeting family needs in ICUs, thereby providing holistic nursing care.

1.3 Problem statement

The ICU environment is complex and technological, thereby producing a feeling of uncertainty. Usually patients admitted to the ICU are critical, unresponsive and unstable. This creates an atmosphere where the outcome is unknown and unpredictable, therefore, stress levels are increased not only for the patient but the family as well. Unsettled and unresolved stress levels can be persistent and detrimental to the patient and family. Stressors in the ICU can be the result of the patient's admission to the ICU, disease process, social issues and also the fact that the ICU is perceived as a place in a hospital that is considered to have high mortality and morbidity rates. Berman, Snyder and Frandsen (2016: 1003) indicated that stress can be experienced at the conscious, subconscious or unconscious level. The abovementioned authors further stated that individuals respond differently to stress depending on their perceptions to the event that caused the stress. In addition, the activation of the sympathetic and neuro-endocrine systems of the body leads to the physiological signs and symptoms. Some of these signs and symptoms may include:

increased blood pressure, increased heart rate, sweating, fear and anxiety. Berman, Snyder and Frandsen 2016: 1003).

Nurses in ICU have a responsibility and duty to care for the patient and family. This is accomplished by implementing strategies and interventions to promote health and wellness. Such strategies can enhance family and patient support systems and coping mechanisms (Smeltzer, Bare, Hinkle and Cheever 2010: 103). Maintaining such duties may be difficult for nurses since they are caring for unstable and critical patients. Research indicates that family needs in the ICU have been rated and ranked differently by family members and nurses (Wilson *et al.* 2015: 1317-1323; Khalaila 2014: 37-44; au *et al.* 2017: 132-136; Akroute and Bondas 2016: 67-80), thus, more research needs to be conducted in order to determine the nurses' role with respect to assessing and meeting families needs in ICUs.

There is little published research regarding the knowledge, perceptions and experiences of nurses towards FCC in South African adult ICUs. The researcher's personal experience is that nurses do not encourage effective family experiences in surgical and medical adult ICUs, even though it is an element of evidence based practice. Therefore, this study explores and describes the nurses' knowledge, perceptions and experiences towards FCC in adult ICUs. Hence, evidence has shown that family involvement in the ICU produces positive benefits, including nurses', patients' and families satisfaction. Furthermore, South Africa is a diverse and multi-cultural country where nurses are seen as caring professionals who need to be skilled and knowledgeable in all aspects of nursing in order to provide quality patient care. Thus, the researcher believes that the findings and recommendations from the current study will be helpful to enhance good and friendly nursing care practices for the patient and family, which in turn will promote holistic nursing care. Jakimowicz and Perry (2015: 1499-1517) indicated that nursing as a profession, brings satisfaction, gratification and a sense of achievement to those that chose it as a profession. Hence, this results from providing support and help to those in need through delivering compassionate care.

1.4 Purpose of the study

The purpose of the study is to explore and describe the knowledge, perceptions and experiences of nurses towards family centred care in adult ICUs, thus findings and recommendations can further enhance family friendly nursing in adult ICUs.

1.5 Research question

What are the knowledge, perceptions and experiences of nurses towards family centred care in adult ICUs?

1.6 Significance of the study

The South African health care system has been reconstructed and decentralised to promote quality patient care, thus ensuring easy access to everyone. Consequently family members have also been included in patient care. Despite the improvement, the public health care system is still facing many challenges (Matlakala and Botha 2016: 49-57). Evidence has shown that the family plays a crucial and active role in the care of a patient that is admitted to the ICU (Kuo *et al.* 2012: 297-305; March and Bosch 2013: 53-75). Since the ICU environment is so complex and technological family members need guidance, encouragement and support (Frivold, Dale and Slettebø 2015: 232-240). FCC in adult ICUs can be promoted and implemented with the collaboration of nurses, patients and the patients' family as partners (Al-Mutair *et al.* 2013c: 1805-1817; Schnell, Abadie, Toullic, Chaize, Souppart, Poncet, Schlemmer and Azoulay 2013: 1873-1874; American Academy of Pediatrics Committee on Hospital Care 2012: 394-404).

FCC is an approach that has been internationally recognised, but there is still some confusion and challenges associated with its implementation as an evidence based practice (Knutsson, Enskär and Golsäter 2017: 9-17; Kuo *et al.* 2012 297-305; Rippin *et al.* 2015: 80-98). These challenges include staff shortages, lack of resources, lack of training and knowledge from nurses and management, lack of time to interact with the family and implement the ideas. Nurses have demonstrated that they have knowledge but they do not put it into practice due to time constraints. With additional motivation, an attitude change from nurses and the necessary training, FCC can go a long way (Kuo *et al.* 2012: 297-305; Knutsson, Enskär and

Golsäter 2017: 9-17; Matlakala, Bezuidenhout and Botha 2014: 1-7; Rippin *et al.* 2015: 80-98; Moretz and Abraham 2012: 106-109; Loghmani, Borhani and Abbaszadeh 2014: 67-82)

Allowing the family of critically ill patients into ICUs to become involved in care is the crucial element in providing holistic care as an important aspect of FCC (Knutsson, Enskär and Golsäter 2017: 9-17). Holistic care can be practiced effectively if nurses have the necessary knowledge and skills to deal with different cultures (Pera and van Tonder 2012: 168). In FCC, nurses do not only concentrate on the physical health of patients, but include the cultural, psychological, religious and spiritual aspects of a patient because it can influence the decision making process (Akroute and Bondas 2016: 67-80; Al-Mutair *et al.* 2013a: 135-144; Al-Mutair, Plummer, O'Brien and Clerehan 2014: 254-8; Cypress 2012: 53-64). As South Africa is a diverse country, if quality patient care becomes a priority in health care systems, nurses will need to improve their knowledge and competencies regarding cultural awareness (Pera and van Tonder 2012: 176).

South Africa is a developing country and therefore, a lack of resources and the HIV/AIDS pandemic has lead to prolonged ICU stays, which is a problem that impacts negatively on the health care delivery system (Matlakala, Benzuidenhout and Botha 2014: 1-7). Related to this, some of the benefits of FCC that have been reported include reduced hospital stays and readmissions, reduced anxiety and increased staff confidence in providing patient care (Kodali *et al.* 2015: 961-967). Furthermore, Uys and Klopper (2013: 1-4); Matlakala and Botha (2016: 49-57) stated that the nursing profession has been suffering as there is a high turnover of nursing staff and staff shortages in Gauteng province alone. This situation can be alleviated to some extent by allowing the family to play more of a formally accepted role in the hospital setting and at home using the FCC approach, thereby providing continuity of care. However, according McAdam, Fontaine, White, Dracup and Puntillo (2012: 386-393) a family cannot be used as replacements of nurses and take full responsibility for providing nursing care, but they can be partners in providing patient care.

Research indicates that families needs in an ICU have been rated and ranked differently by family members and nurses (Wilson *et al.* 2015: 1317-1323; Khalaila

2014: 37-44; au *et al.* 2017: 132-136; Akroute and Bondas 2016: 67-80), therefore, more research needs to be conducted in order to determine the nurses' role with respect to assessing and meeting families needs in ICUs. This study will explore and describe nurses' knowledge, perceptions and experiences towards FCC in adult ICUs. Findings from this study will assist nurses to provide quality patient care that is more dignified and caring. The researcher believes that the findings from the current study will be helpful in developing strategies and guidelines to enhance good nursing care practices for the patient and family, which in turn will promote holistic nursing care.

1.7 Operational definitions

Intensive care units (ICUs) are the specialised units in the hospital which have specialised and advance equipment and highly trained health care team. Patients that are admitted in these units are in a critical and life threatening condition which requires constant and close monitoring (Gibson, Plowright, Collins, Dawson, Evans, Gibb, Lynch, Mitchell, Page and Sturmeay 2012: 213-218). In this study ICU refers to a hospital setting where critical, unstable and unresponsive patients are admitted for emergency treatment and monitoring. This environment requires experiences, knowledge and skills to promote quality patient care.

Family centred care (FCC) is the approach that allows the interaction between the healthcare team, the patient and the patient's family. The patient's family participates and gets involved in the patient's care in ICU when patients are unable to make their own decisions. Family centred care also recognises the needs and the roles the patient's family plays in their well-being. This includes family involvement in policy development, implementation and monitoring (American Academy of Pediatrics Committee on Hospital Care 2012: 394-404). For the purpose of this study, FCC is the approach that allows and involves family members to be an active part of the health care team. This includes the involvement in all aspects of the patient care plan.

Family means any person who plays an important part in the patient's life. It does not necessary mean that they have to be blood related. It could be any one the

patient prefers to be involved in their care. For the purpose of this study, family members refers to anyone that is close to the patient, including friends. This is because patients that are admitted in ICUs are usually unresponsive due to an illness or trauma, thus their physical and psychological status requires anyone that is close and knows the patient.

A Registered nurse is a person that has completed nursing training and education. Nurses that have completed their training in South Africa, practice under the scope of the South African Nursing Council Regulation 2598 of the 30th of November 1984 (South African Nursing Council, 2005). For the purpose of this study, registered nurses refer to nurses that have registered with SANC and practice under the abovementioned scope of practice, which includes implementing the acts and procedures that can be effectively executed based on scientific evidence which is physical, psychological, social, educational, chemical and technologically that is related to health care practices. These registered nurses are required to have been working in these selected ICUs for more than three months to be able to take full responsibility for the patient without direct supervision from the shift leader. The term 'nurse' will be used in this study for nurses working in the surgical and medical ICUs that meet the inclusion criteria.

Knowledge is the information and skills that one acquire from training or experience. For the purpose of this study, knowledge refers to nurses' understanding and background information in relation to the concept of FCC and the implementation thereof in adult ICUs.

Perceptions refers to the use of your senses in order to recognise the world around you. In this study it refers to the ideas, understanding and belief systems associated with nurses, patients and family members, with regards to family involvement in ICUs.

Experiences are the process of acquiring knowledge or skills during participation in a certain situation. For the purpose of this study it refers to nurses' knowledge or skills in relation to the concept of FCC in adult ICUs that are gained whilst working in an ICU with family members of patients admitted in ICUs.

1.8. Conclusion

This chapter focused on the introduction and background of the study. The problem statement, purpose of the study, the research question and the significance of the study was discussed as well as the definitions for operational terms. The following chapter will introduce and discuss the research methodology and design.

1.9. The layout of the chapters

1.9.1. Chapter1 – Introduction and background to the study

This chapter described the introduction, background and significance of this study. The research question, problem statement and the purpose of the study were presented.

1.9.2. Chapter 2 – Methodology and design

In this chapter, the researcher explained the methodology and design used to describe the processes that was involved in obtaining the findings. This chapter focused on the research design, research setting, study population, sampling process, data collection, data analysis and ethical considerations.

1.9.3. Chapter 3 – Presentation of findings

Interviews were conducted during data collection, thus findings will be illustrated in this chapter. The researcher used qualitative content analysis. Three themes and five sub-themes emerged from data analysis.

1.9.4. Chapter 4 – Discussion of findings

In this chapter the findings were discussed with literature to support the findings.

1.9.5. Chapter 5 – Recommendations and limitations

Recommendations and limitations arising from the findings were presented in this chapter.

CHAPTER 2 : METHODOLOGY AND DESIGN

2.1. Introduction

This research study explores and describes the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs. Discussion of the methodology and research design will be presented in this chapter. The chapter will also focus on the research setting, study population, sampling process, data collection, data analysis and ethical consideration.

A literature review for a research study is discussed under the conceptual phase of the scientific research process, hence, it is phase 1. However, in this study, Chapter 2 discusses the research methodology and design, which falls under phase 2 (Botma, Greef, Mulaudzi and Wright 2010: 38). The same authors also state that for a qualitative study, literature control can be done at a later stage after data collection and analysis to support the findings that emerged from data analysis.

In contrast, Creswell (2014: 61-62) states that a literature review in qualitative studies or research can be done in three placements, which includes: the first form can be covered in the introduction section, where the researcher indicates available studies that have been previously done on the topic, thus addressing a gap or a problem. The second placement for a literature review can be inserted in a separate section on its own as a chapter, where the researcher uses a model. Lastly, the abovementioned author states that a literature review can be used as literature control in the chapter that discusses the study findings, where the researcher uses relevant literature to equate and find differences in relation to themes that emerged, thus the literature is used inductively (Creswell 2014: 61-62). However, in this study, the literature control was inserted in chapter 4 with the discussion on the findings or themes that emerged from the data.

2.2. Research design

Qualitative research is a systematic and subjective research approach which focuses on human life experiences. Individual perceptions are put together in order to make meaning of life experiences. Qualitative research allows the researcher to gain the

richness and in-depth knowledge about the phenomenon under study. Exploratory descriptive research aims to observe, describe and demonstrate the phenomenon as naturally as it happens (Burns and Grove 2009:51- 359; Polit and Beck 2012: 226). Therefore, a qualitative exploratory descriptive research design was used in this study, as the researcher sought to explore and describe knowledge, perceptions and experiences of nurses towards family centre care in adult intensive care units.

2.2.1. Exploratory research

This type of research identifies important aspects on the phenomenon and processes involved (Polit and Beck 2012: 18). Exploratory research is performed when little is known about the topic. Thus, it also focuses on the full nature of the phenomenon and other related factors. This is done to achieve full understanding and meaning of the phenomenon, thereby contributing towards new information on the phenomenon under study (Polit and Beck 2012: 18). According to Polit and Beck (2010:22) research may start in an area of interest to the researcher. In this study, the researcher selected this method to gain new insights, on the nurses' knowledge, perceptions and experiences towards FCC in the selected adult ICUs. Hence, there was little available literature on the topic or related topics that were studied in South Africa, at a district level.

2.2.2. Descriptive research

The aim of descriptive research is to allow the researcher to describe the phenomenon and find meaning. The researcher does this by using methods that will allow in-depth and description of variations, dimensions and the importance of the phenomenon (Polit and Beck 2012: 505). In this study, the researcher explored and described the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs, thus in-depth interviews were used. This allowed the researcher to provide accurate descriptions of the phenomenon under study by describing the participants' experiences through the use of responses and quotes.

2.3. Research setting

The study was conducted in an academic tertiary public hospital in KwaZulu Natal Province in Pietermaritzburg, in the uMgungundlovu district. This hospital provides health care services to a diverse and cross cultural population. However, the majority of the patients are Zulu speaking. Two intensive care units from this hospital were used, namely, a surgical and a medical ICU. The old surgical ICU was a 10 bedded unit of which a new surgical ICU was still in the process of opening during the proposal development period. Consequently, the new surgical ICU was then opened during the data collection period. This new surgical ICU is a 21 bedded unit of which only 11 beds that are in use. The size of the medical ICU is five beds.

The surgical ICU admits trauma cases. Medical ICU admits medical emergencies. The selected ICUs are allocated within the hospital premises, the medical ICU has no visitors' room. However the surgical ICU has one visitors' room, with chairs and one counselling room. The visitors' room is used by family members while waiting to see the patient and the counselling room for counselling family members. Family discussions are also held in these rooms. Family visitation in these selected ICUs are guided by the visiting policy. The visiting policy include visiting times from 15h00 to 16h00 and 19h00 to 19h30. These visiting times only permit close family members, such as parents, grandparents and spouses, but siblings under 12 years are not allowed. However the policy also states that the registered nurses in charge of the units can use their discretion for visitation if it is after the visiting times. The surgical ICU has 20 registered nurses who are permanently employed and 2 registered nurses who are working part time. In the medical ICU, 15 registered nurses are employed on a full time basis. Working shifts for the registered nurses in these ICUs include shifts from 07h00 to 19h00, 07h00 to 13h00, and then a night shift. The nurses are allocated to work day and night shifts alternating and rotating in the same month. Interviews were conducted according to scheduled times or convenient times with the participants.

2.4. Population

The population in a study is a group of individuals or objects that share the same characteristics (Polit and Beck 2010: 306). Registered nurses that work in ICUs were

the target population for this study. Participants that were involved in the research study met the inclusion criteria (See 2.5.1.).

2.5. Sampling process

According to Polit and Beck (2010: 307) sampling is the process of obtaining the specific subjects from the specific population in order to represent that population. A sample is a subset of or a portion from that specific population. Non probability purposive sampling was used in this study. According to Polit and Beck (2010: 312) this type of sampling is normally used by qualitative researchers when the aim is to obtain rich information about the phenomenon. Participants are also chosen because of their expertise in the field of the phenomenon under study. Registered nurses working in adult medical and surgical ICUs of one selected public hospital were the participants in the study. Registered nurses that met the inclusion criteria (See 2.5.1. below) participated in the study because of their knowledge and experiences in selected adult ICUs. Thus, the working experiences in adult ICUs for these registered nurses ranged from one year to more than ten years. A sample size is the specific number of subjects from the entire population. In qualitative research sample size is determined by the saturation of data (Polit and Beck 2010: 321). In this study, data became saturated after nine professional nurses were interviewed and there was no new information obtained from the interviews.

2.5.1. *The inclusion criterion*

- Registered nurses working in the medical and surgical adult ICUs of the selected hospital.
- Registered nurses that are permanently employed at the hospital.
- Participants should have worked in an adult ICU for more than three months because of orientation. Thereafter, nurses are fully accountable and responsible to care for a patient.

2.5.2. *The exclusion criterion*

- Registered nurses that are not working in the medical and surgical adult ICUs.
- Registered nurses that are only part time employees.

- Registered nurses that have not worked for more than three months in an ICU.

2.6. Pilot study

A pilot study was conducted to ensure trustworthiness of the data collection tool. In this study, in-depth interviews were conducted to test the interview questions. Pilot studies are used in a small scale trials (Polit and Beck 2012: 195). Therefore, two registered nurses were used for pilot testing, one was from unit A and the other was from unit B. The same medical and surgical ICUs were used in the pilot study were also used for the actual research study. According to Grove, Burns and Gray (2013: 343) a pilot study can be carried out in a familiar setting that will be used for the main study in order to identify problems which can be rectified before the main study. This is to verify the intervention or interview schedule is understandable and has adequate details to allow other researchers to replicate the work. The broad question was initially asked followed by the other questions that are listed below (2.6).

In addition participants' responses were probed to add to the richness of the information that was given. The outcome of the pilot study was that the interview guide was satisfactory and the participants had no problems with the questions. There were no changes made to the interview guide after the pilot study was conducted. Thus, ensuring the validity and reliability of the tool. The registered nurses taking part in the pilot study were not included in the main study. According to Grove, Burns and Gray (2013: 343) participants should be made aware of the requirements that are involved in a study. Ultimately, in this study, the participants that were involved were able to understand the requirements of the study before participating. This was completed by informing the participants about their rights, the study risks and the benefits involved. Thus, the letter of information and consent was given to participants of which participants were allowed to read the letter of information before signing the consent.

2.7. Data collection

A descriptive exploratory qualitative method was used to explore and describe the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs. Semi-structured interviews were conducted and a digital voice recorder was used for

recording and transcribing the interviews. Field notes were also used. Semi-structured interviews allowed the researcher to predict what they want to know and ask (Polit and Beck 2012: 537). This can be done with the use of a set guide of questions that can be asked (Polit and Beck 2012: 537). In addition, semi-structured interviews allow the participants to give information freely and the researcher obtains all relevant information (Polit and Beck 2012: 537). Written notes were also taken during the interviews to ensure precision. Therefore face to face interviews were conducted with the registered nurses in the selected adult ICUs.

An interview guide (Appendix 6) was used as it had the broad question for discussion and other questions were used to gain greater understanding and information from the participants. The broad question was 'What are the nurses' knowledge, perceptions and experience towards family centred care in adult ICUs?'. Probing questions were used to gain more insight into the participants' experiences. Probing also gives the participants an opportunity to express themselves. In this way, they provide exclusive and in-depth information needed for the study (Polit and Beck: 2012: 310). The following questions were used to probe the participants in order to facilitate the meaning and understanding of the phenomenon under study:

- What are your roles with family centred care as the registered nurse in an adult intensive care unit (ICU)?
- Tell me, what do you know about family centre care and the implementation and practice of family centred care?
- What are your experiences during relatives' visitation and involvement as part of family centred care (FCC).
- What are your perspectives/views as the nurse in ICU with regards to family centred care in an adult ICU?
- How do you deal with family and patient diversity when implementing FCC?
- Describe if and how family is/are resource to the patient.

Interviews were scheduled for 20 minutes during scheduled or convenient times as identified by the participants. This was done to prevent disruption on the unit's normal routines. Interviews were conducted with nine participants as saturation of data was reached. There was no new information that came out during the final two interviews, hence the overall participants were nine. In qualitative research, data

saturation determines the sample size. This is achieved when there is no new information and redundancy is obtained from additional participants (Polit and Beck 2010: 321).

2.8. Data analysis

Analysing data is about getting the in-depth knowledge and richness of the information given. Analysis also promotes understanding the full meaning of the phenomenon under study. Data analysis starts when the data is collected, where the researcher listens, writes notes, reads and re-reads transcripts. Getting more and more involved with data, the researcher is able to identify and describe important responses. Participants' responses were organised into themes as they emerged. Relationships and connections of themes were identified (Streubert and Carpenter: 2011: 44-47).

Data collection and data analysis occurred simultaneously. The researcher listened to the audiotapes as well as reading the field notes to ensure accuracy. Interviews were transcribed manually by the researcher listening to the audio recording. All recordings were transcribed verbatim. The researcher spent more time listening to the transcriptions until themes and sub-themes emerged. Thus, qualitative content analysis was used to analyse the data from the transcripts. Polit and Beck (2012: 564) describe qualitative content analysis as the process of making small units from data and making codes, thus inserting coded data into similarities and differences based on the content they are presenting. Therefore, themes and sub-themes that emerged can be identified.

2.8.1. The process involved in qualitative content analysis

Bengtsson (2016: 8-14) identified four stages that can be used for analysing data when implementing qualitative content analysis. These stages include the decontextualisation, the recontextualisation, the categorisation and the compilation. The author further states that trustworthiness can be maintained by implementing each stage several times to ensure quality of the analysis. The stages of qualitative content analysis are described below according to the present study.

Stage 1: The decontextualisation

In the present study, the researcher read and re-read the transcripts until the researcher gained the meaning of the whole content. According to Bengtsson (2016: 8-14) reading the context several times gives a sense of wholeness and understanding. Concepts that appeared to be connected to the research aim and the research question were highlighted. This allowed the researcher to gain understanding and knowledge of the content before breaking it down into smaller meaning units. Bengtsson (2016: 8-14) describes meaning units as the units that are formulated and used by the researcher from the content, which gives insights or ideas to the researcher about the phenomenon under study. The researcher used sentences and phrases when formulating the meaning units with the aim of answering the research question. The researcher used different coloured pencils to highlight the meaning units from the original text. The same colours were used to highlight the concept that gave the same idea accordingly. The researcher then developed codes in relation to the meaning units that were identified earlier. Keeping in mind that these codes are still connected to the original context. Hence, the coding was repeated as the researcher was continuing to analyse the transcripts as new data emerged. As the researcher coded data, explanations, notes and headings were inserted on the side of the margin to prevent confusion and mixing up of concepts. Ultimately, the researcher wrote several headings to describe the important aspects in the context. Bengtsson (2016: 8-14) refers to this coding process as 'open coding'.

Stage 2: The recontextualisation

The researcher checked data that was highlighted by coloured pencils against data from the original context. This was done to ensure that important data was highlighted and appears as the meaning units that were identified previously. The researcher also checked if the study aims and research question was being answered by ensuring that the important aspects were included as meaning units. The researcher left some information unhighlighted as the researcher felt that it was not relevant to the study as it did not answer the research aims and the research question. According to Bengtsson (2016: 8-14) information that is not highlighted can be left unused if it does not tie up with the research aims or it does not answer the research question.

Stage 3: The categorisation

The meaning units that were identified previously were now reduced or condensed into manageable sentences and phrases. Hence, the researcher ensured that the condensed data still retained the true sense of the content. This information was organised and thereafter inserted into a table. However, the researcher ensured that the richness of the content is retained by repeating this stage. The data was condensed and then labelled with codes. Thus, the data was organised according to the similarities and differences based on their codes. The researcher then divided this data into three broad domains or themes, which was based on the questions that were used during the interviews. Thus the broad question was: What are the knowledge, perceptions and experiences of nurses towards family centred care in adult intensive care units?. In addition the researcher organised data into three broad main themes and five sub-themes. These themes and sub-themes described the participants' knowledge, perceptions and experiences towards family centred care in adult intensive care units. According to Bengtsson (2016: 8-14) each stage should be repeated to maintain quality of the analysis. Erlingsson and Brysiewicz (2013: 92-99) defined themes as 'a red thread of underlying meaning that ties the data together'

Stage 4: The compilation

According to Bengtsson (2016: 8-14), a researcher should always be aware of their own biases, objectivity, thus they need to remain as neutral as possible. The researcher presented the participants' responses by formulating themes and sub-themes. A table in chapter 3, table 3.1 was presented with the summary of themes and sub-themes. A reader can have a quick view of the participants' responses by looking at the table presenting themes and sub-themes (Bengtsson 2016: 8-14). In addition, the researcher retained the richness of the content by including the appropriate meaning units as participants' quotations. The research findings in the current study were supported by the relevant literature and arguments from previous studies. The trustworthiness of the research process and the results have been discussed below with the relevant concepts.

2.9. Trustworthiness

Analysis is accomplished by adhering to complex mental processes, critical thinking, and analysis. Qualitative researchers ensure high quality outcomes through trustworthiness. Maintaining trustworthiness in qualitative research is as important as ensuring validity and reliability in quantitative research. Lincoln and Guba developed a criteria to ensure trustworthiness in a qualitative study. These include: credibility, dependability, confirmability and transferability (Polit and Beck 2010: 492-493; Polit and Beck 2012: 584-585). The researcher applied these criteria to ensure trustworthiness in the study findings.

2.9.1. Lincoln and Guba's framework

The criteria by Lincoln and Guba to maintain and develop trustworthiness is described below (Polit and Beck 2010: 492-493; Polit and Beck 2012: 584-585).

2.9.1.1. Credibility

Refers to how the truth is presented during collection of data. This involves time spent doing data collection. This allows the researcher to gain an in-depth understanding of the culture, language and views of participants in the study. In addition, the researcher was exposed to some of the participants before when she used to work in one of the units, thus this also promoted prolonged engagement with participants of the study. However, the researcher was also able to identify her own biases and preconceived knowledge about the phenomenon under study to prevent influencing the outcomes of the study. To promote credibility, a researcher can use multiple references and methods, for instance, interviews and observations. This can also be used to build trust and rapport (Polit and Beck 2012: 584-585). According to Polit and Beck (2010:492) credibility has two aspects, namely; credibility is enhanced where the data collected is able to promote believability; and credibility must have strategies to present that data. In the current study, credibility was ensured by guaranteeing accuracy of the data that was collected by describing the research setting and maintaining the inclusion criteria.

The researcher also ensured that bias was avoided as the research setting was the researcher's previous area of employment. The researcher ensured that personal

emotions, knowledge and experiences were identified that might affect the studied phenomenon and thus integrated this understanding into the study. According to Burns and Grove (2009: 545) this allows the researcher to remain as neutral as possible. The researcher used an interview guide (Appendix 6) to gain more information about the phenomenon under study and to ensure that rich meanings of phenomenon were captured by allowing the participants to describe their knowledge, perceptions and experiences.

Credibility was also ensured by completing member checks. The researcher maintained this by participants' feedback. The researcher returned to the participants to check for the findings that came out of the interviews. The researcher was able to implement member checks with only five participants as the other four had left the research setting. However, the other participants were given an opportunity to check the themes and sub-themes that emerged from their experiences that they shared during the interviews. According to Polit and Beck (2012: 591) and Creswell (2014: 252) the researcher is supposed to inform the participants of the findings of the study. The researcher then discussed the interpretations and the conclusion in relation to the findings with the participants.

2.9.1.2. Dependability

This is defined as the stability of data that has been presented over time and over certain circumstances (Polit and Beck 2010:492). According to Polit and Beck (2012: 585) there is no dependability without credibility in a qualitative research. The same results should emerge even if the study was repeated using the same participants in the same setting, thus maintaining consistency of findings. In order to maintain dependability in research findings, it should be checked and audited by the external checks (Polit and Beck 2012: 594). The researcher and the participants form part of the research instruments to be checked for consistency in a qualitative study. The researcher in the current study ensured dependability by performing a pilot study using two participants that did not participate in the main research study. Findings, supporting data and recommendations were confirmed by the supervisor of this study to ensure dependability, thus confirmability.

2.9.1.3. Confirmability

Confirmability refers to data being neutral, where two or more independent people confirm the relevance of the data. The meaning should be the same as well. This emphasises that the information presented should not be biased or motivated. Data collected should represent the participants' information and data interpretation should not demonstrate the researcher's perceptions (Polit and Beck 2012: 585). To ensure confirmability, the researcher used a digital voice recorder to retain information given by the participants and field notes were also used to add detailed information to what was said by the participant. In this study, the researcher planned and described the research process, research design, sampling process, data collection method and data analysis with findings that are supported. A table was used for coding and identification, and labelling of data was implemented to ensure confirmability. Thus, themes and sub-themes that emerged were presented. In addition, the researcher used quotations from the participants' responses.

2.9.1.4. Transferability

Refers to how far the data can be transferred to other settings or groups. The researcher should provide an adequate description of data. This will allow the consumer to identify the relationship of the data to other contexts (Polit and Beck 2010: 492; Polit and Beck 2012: 585). Thick description of the research setting, the participants, and the experiences of the participants with respect to the understanding and interpretation of the phenomenon and processes involved in the research study were presented. Polit and Beck (2012: 595) and Creswell (2014: 252) indicate that a full description of the research settings with participants' experiences ensures that understanding of the phenomenon is maintained. In this study, transferability was ensured by collecting data that described the participants' knowledge, perceptions and experiences until data saturation was reached. This was done to ensure that information collected was sufficient enough to describe the phenomenon. Thus purposive sampling was used to obtain the richness of the information. Purposive sampling allows the researcher to gain more information because of the participants expertise (Polit and Beck 2012: 529). The researcher also discussed the findings with the registered nurses that did not participate in the study and also shared with her colleagues to obtain constructive criticism. Lastly, the

supervisor was accountable for checking the findings with supporting data and recommendations.

2.9.1.5. *Authenticity*

This refers to the ability of the researcher to display the experiences of the participants. The researcher ensures authenticity by allowing the reader to understand the language, emotions and experiences shared by the participants. Authenticity encourages the reader to develop sensitivity by getting the whole picture and experiences about the phenomenon described by participants (Polit and Beck 2012: 585). In this study, themes that were extracted or emerged described the knowledge, perceptions and experiences of the participants which involved their well being in the ICU environment without the researcher being biased. The researcher ensured this by describing the exact information shared by participants and providing the participants' quotations. According to Polit and Beck (2012: 595) participants' responses can maintain authenticity. Quotes from the participants also ensured authenticity of the study.

2.9.2. *Bracketing*

This emphasises the strategies that can be used by the researcher to put aside preconceived ideas. Bracketing allows the researcher to obtain as pure information as possible that will not interfere with the outcomes (Burns and Grove 2011: 96; Polit and Beck 2012: 495-496). Firstly, the researcher had to exclude any knowledge that she might have concerning the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs since the researcher worked in the same setting previously. Secondly, the researcher had to address any preconceived ideas about registered nurses involved in the study. The researcher had to ensure that by addressing preconceived ideas about nurses working in adult ICUs, these ideas would not interfere with the findings of the study. Therefore, by setting aside any preconceived ideas the researcher may have, this action will ensure a pure description of the nurses' experiences. Subsequently, ensuring that it does not affect the pure and accurate description of the phenomenon under study. This would conclude trustworthiness of the findings since the researcher presented the meaning and understanding of the participants' experiences. According to Bengtsson (2016:

8-14) a researcher is supposed to remain neutral. However, the researcher's experience in the context and any preconceived ideas can be an advantage to the researcher, hence the above should not interfere with the research outcomes, be it the participants or the findings. The advantage is that the researcher described the participants' experiences as accurate as possible without being biased as preconceived ideas were set aside to ensure that pure description is maintained.

2.10. Ethical considerations

Polit and Beck (2012: 150) indicate that ethical considerations are essential in order to protect the rights of the participants. The researcher had an opportunity to explain the nature of the study to the participants. Participation was voluntary therefore participants were given a letter of information (Appendix 4) and an informed consent to sign (Appendix 5). Participants were also informed that they were free to withdraw at any time and no questions would be asked. Ethical approval and permission was granted by the Durban University of Technology Faculty of Research Committee (Appendix 1). The Department of Health (Appendix 3) and Greys Hospital Management Office (Appendix 2) granted the researcher permission to use their facility. The following rights for the participants were maintained during data collection as per the Belmont Report principles (Polit and Beck 2012: 152).

2.10.1. Beneficence

This principle refers to the right to be free from harm or discomfort (Polit and Beck 2010: 121). This principle includes: the right to freedom from harm and discomfort and the right to protection from exploitation. The discussion on the implementation of these principles according to this study is provided below.

2.10.1.1. *The right to freedom from harm and discomfort*

Polit and Beck (2010: 121) indicate that participants should not be exposed to unnecessary harm and discomfort. Interviews were conducted in a separate room during scheduled times or at their convenience, where confidentiality and privacy policy could be maintained. Thus, participants were allowed to express and describe their knowledge, perceptions and experiences freely without experiencing any discomfort in the presence of their colleagues. For instance there were some

discrepancies on participants' responses where they made decisions that were not based on clinical policies to guide their practice. Participants were also informed that whatever information they were sharing would remain confidential.

2.10.1.2. The right to protection from exploitation

Participation in the study should not put the participants at risk of being exposed to trauma (Polit and Beck 2012: 153). During data collection, participants were informed that information given during participation was not going to be used against them or shared with anyone that is not authorised. The researcher also informed the participants that if there was a need to clarify any issues, the researcher would return to do so.

2.10.2. Respect for human dignity

Registered nurses that met the inclusion criteria participated in the study. Participation in the study was voluntary. Participants were informed that they could withdraw at any time they wish. The nature of the study was fully explained to the participants. The letter of information (Appendix 4) was given and the informed consent (Appendix 5) was signed by the participants before the data collection process began. This included the right to self-determination and the right to full disclosure.

2.10.2.1. The right to self-determination

According to Polit and Beck (2012: 154) participants have the right to participate voluntarily without anyone controlling their actions. Participants were informed that they had a right to withdraw from the study or refrain from giving information with no questions being asked. Therefore, the letter of information (Appendix 4) was given to participants to read and they signed a consent form (Appendix 5) before participating.

2.10.2.2. The right to full disclosure

Participants were given information (Appendix 4) about the research to be conducted. The full nature of the study to be conducted, duties of the researcher,

risks and benefits involved were described to the participants. Participants were informed that they had a right to refuse or withdraw at any time.

2.10.3. Justice

According to Polit and Beck (2010: 124-125) the principle of justice ensures that the participants' privacy is respected and the right to fair treatment is maintained during the research. In this study, all participants met the inclusion criteria, thus their participation was fair. Aspects that were maintained under the principle of justice included the following: the right to fair treatment and privacy, confidentiality and anonymity. These principles have been explained in details below.

2.10.3.1. *The right to fair treatment*

In this study participants received equal treatment since registered nurses that participated are from diverse backgrounds and care for diverse patients and families. According to Polit and Beck (2010: 124) all participants should be treated fairly and equally. In this study all the participants that were involved in the research study met the inclusion criteria. The selection for participants was not based on convenience or based on any position but participation was based on the research requirements, which was the inclusion criteria. Thus participants were informed about the research study including the risks and benefits involved before signing the consent form. Participants were informed that they were allowed to withdraw at any time if they wished so and they were not going to be discriminated against after withdrawal from the study. Participants were also informed that they had access to the researcher at any point in time to clarify information.

2.10.3.2. *Privacy, confidentiality and anonymity*

According to Polit and Beck (2010: 125) privacy should be maintained throughout the study and participants should be informed that confidentiality will be strictly adhered to. In this study, participants' privacy and confidentiality was ensured by informing the participants that information was going to be kept safe under lock and key for five years then after would be destroyed and shredded. No unauthorised person would access that information and their identities were not going to be linked to their responses or in the report on the findings. Participants' identity was not linked

to the codes used during data collection. Interviews were held with individual participants in a room where privacy was guaranteed and with a “do not disturb” sign on the door during interviews.

2.11. Conclusion

This chapter discussed the outline of the research study and how it was carried out. This included the research design, data collection, data analysis, trustworthiness and ethical considerations. The following chapter, chapter 3, will represent the data analysis.

CHAPTER 3: DATA ANALYSIS

3.1. Introduction

This chapter represents the analysis and findings of the study, which aimed to explore and describe the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs. Participants provided their responses in relation to their experiences in ICUs with regards to FCC. Three themes emerged with related sub-themes, which are presented in table 3.1 below. The results of the study also attempted to answer the main research question, which was “What are the knowledge, perceptions and experiences of nurses towards family centred care in adult intensive care units?”

3.2. Presentation of themes and sub-themes

Table 3.1: Presentation of themes and sub-themes

Themes	Sub-themes identified
3.2.1. Nurses’ awareness and knowledge on the components of FCC in adult ICU	<ul style="list-style-type: none">• Nurses’ background knowledge on the concept of FCC• Nurses recognising family needs in relation to their roles and responsibilities in ICU
3.2.2. Family involvement in patient care as perceived by nurses in adult ICUs	<ul style="list-style-type: none">• Nurses’ attitudes towards family involvement in nursing activities as part of FCC
3.2.3. Nurses’ experiences towards family presence in adult ICUs	<ul style="list-style-type: none">• Family’s presence in the ICU environment, including: being near the patient, family supporting the patient including giving patient’s information and family’s coping strategies.• Family visitation in adult ICU

3.3. Identified themes

3.3.1 Nurses' awareness and knowledge on the components of FCC in adult ICU

Findings in the current study showed that participants have knowledge of FCC, including the components that articulate FCC as an approach. In addition, findings demonstrated that nurses have acknowledged that the concept of FCC is about involving family members in patient care. However, participants indicated that FCC is 'something that is not practised and encouraged' in the selected ICUs. Furthermore, nurses' background knowledge revealed that FCC is about communicating with family members, encouraging family involvement in patient care and in the decision making process. Holistic nursing involves the principles and components of FCC to make up sound and realistic family nursing to improve quality patient care. Despite this, participants reported that FCC as an approach could be implemented as they feel that FCC can be practised in any health care setting. However, nurses feel that they require encouragement and motivation in order to be able to implement FCC. This statement is supported by the following responses:

Family centred care, I think for myself is when you involve the family in as many informed decisions as you possible can. (Unit A, participant 2)

Family centred care is allowing the family to take part in caring of their relatives who is admitted in ICU, I mean anywhere FCC can be practiced. (Unit A, participant 7)

I think it (FCC) does have a place in ICU. It could be explored more and we could try it out more and let the family have more of a working relationship in the unit. (Unit A, participant 5)

Findings in this study showed that nurses acknowledge the importance of their role in ICUs and having the family present as part of FCC. Thus, nurses' roles and responsibilities with regards to recognising family needs emerged as a finding. Participants indicated the following nurses' roles as important when dealing with family members in an ICU: giving information about the patient's progress and about the services that are available to the patient and family's rehabilitation, maintaining effective communication, being present during family discussions, giving health

education and encouraging family decision making. Nurses reported that the family deserves to receive information about the patient's condition in order to be able to make informed decisions. Consequently, giving honest and unbiased information to family members is another component that enhances effective communication, thus facilitates FCC. Participants also stated that information given to the family should be honest, truthful and clear because it is easier for family members to make a decision. This statement is supported by the quotes below:

It is very important, it goes back to the same explanation because they would want to know as their member of the family is in a very critical sort of a situation, so they will want to know the progress or about the condition of the patient so you have to work with them. (Unit B, participant 9)

My role is to explain maybe the patient's condition to the family informing them of any change in the patient's condition. (Unit A , participant 7)

My role ... and with regards to family as a registered nurse it's to be open with family and answer all their questions openly and truthfully and to be there to give them more information on their relative's condition. (Unit A, participant 3)

Effective communication also plays a role in the ICU as nurses are always interacting with family members and are at the patient's bedside for most of the time during their on-duty time. As part of FCC, communication should be effective and efficient. Consequently, nurses reported that their role is to communicate with family members. Furthermore, findings revealed that the manner in which a nurse transfers information can have a negative or positive impact on a person's well-being. This statement is supported by the quote below:

Sometimes the way you come forward and the way you speak to a person is very important because you could make or break the person just in the way you transfer that piece of information. (Unit A, participant 1)

Findings revealed that nurses have to liaise between the family and doctors on the patient's daily well-being. Findings indicated that nurses can also be inter-mediators to promote the patient's and a family's well-being. This is because ICU nurses are constantly aware of the patient's progress and in contact with the family and

members of a multidisciplinary team. This statement is strongly supported by the following response:

You have to be liaison between the family and the patient and doctors to be able to up-date the family of what's happening to the patient. (Unit A, participant 2).

Family meetings were highlighted as significant for family members and nurses in the ICU when giving information to family members about the patient's progress. Furthermore, doctors inform the family of the patient's progress in the presence of a nurse to ensure that there is clarity and reinforcement on issues that may arise. Nurses reported that it is part of their role and orientation that they receive when they start working in an ICUs. Family members get more information and moral support during these meetings from the nurses and doctors according to the participants. This statement is supported by the following responses:

It would be nice like maybe even if you get the immediate family or the spokesperson for the family comes to you, then the doctor, you can be present or maybe you can listen to what the doctor is saying, things like that. (Unit A, participant 1)

It is also involving them (family) in the interview with the doctors so that they know the continuity of the patient care on the daily basis. (Unit A, participant 6)

We have been taught from when I started working in ICU that the doctor speak to the family with the nursing personnel who's attending to that patient in the presence of the family. (Unit A, participant 2)

Findings of this study, revealed that at times, maintaining privacy and confidentiality may be a challenge when giving information to family members. This lack of privacy was reported to be due to inadequate facilities. However, findings indicated that at times, they hold family discussions behind the curtains just to maintain patient and family dignity. This statement is supported by the following responses:

Most of the time you have to bring them aside and talk to them behind the curtains or you know it's like that but it would be nice if you have a little area or a room where you could talk to the family. (Unit A, participant 1)

We don't have like proper facilities for family, let's say suppose you want to talk to the family, there is more than one family as such in that room. (Unit A, participant 1)

Findings revealed that as much as nurses noted that privacy is essential for patients in the ICU, they also try to maintain privacy even when family members perform their rituals and during death. Nurses provided privacy by using curtains around the patient's bed. This statement is supported by the following responses:

...but if it's a critical case and the patient is about to die we would like to close the curtains. (Unit A, participant 2)

It's a special case like they want to pray with the family but then you make sure you close the curtains around the patient so that it does not become an imposition on the patients next door. (Unit A, participant 2)

Patient safety includes maintaining confidentiality of the patient's information and not just the physical environment. Some of the participants indicated that they ask the family to appoint someone that will be the spokesperson to ensure that patient safety and confidentiality of patient information is maintained. This statement is supported by the following responses:

So you find yourself speaking to the family member and then they are not communicating with each other so you find giving interviews with five different family members who say they are not mates to the next person. (Unit A, participant 5)

We make the family to choose someone that we call a spokesperson, who will speak on behalf of the family, so that the person will serve as the intermediary. (Unit B, participant 9)

Nurses reported that sometimes a family's social issues may interfere with patient's care and the transfer of information as they all want to be in-charge of the patient and take control. Participants indicated that at times, there are family politics which

also become a challenge when delivering information. Furthermore, participants reported that a patient remains the nurses' primary priority. Nurses indicated that they ensure that they do not get caught in family conflicts when giving information. This statement is supported by participants' responses:

You get people that are genuinely concerned family members and don't get the nosy part of family and you have got to deal with that as well. (Unit A, participant 1).

Well you know as a nurse, I think you take a lot of things on trust, you pray that people tell you the truth, but if you find out situations where there is going to be some form of conflict, you try to diffuse the situation before hand. (Unit A, participant 2)

If they have a spokesperson but sometimes family have politics and they are fighting and there are two spokespersons. (Unit A, participant 5)

Findings indicated that nurses do not only give information about the patient's progress but they also give information about other aspects of health services that can facilitate the rehabilitation of the patient and family. Giving information is part of nurses providing family support, thus, rehabilitation in ICU and after discharge. Supporting patients and family members even after discharge from ICU is part of rehabilitation and palliative care. Involving other services available allows family members to be able to function independantly whilst using the information, skills and resources available to assist in the recovery of the patient.

Giving necessary information in relation to family members and patient's well being facilitates FCC, thereby reducing the rate of patient readmissions to the ICU. Findings of this study revealed that family and patients in an ICU can become very stressed with other social issues. Social services assist in the rehabilitation of the patient and family and assists with relieving stress levels. According to the participants, these stressors contribute negatively to the patient's progress because as they are lying in an ICU bed they have roles and responsibilities at home and it stresses the patient not knowing how everyone at home is coping. Nurses reported that they are able to identify family problems as they get to know the family and patient. Knowing the family more allows the nurses to give information and refer the

family for additional assistance. Furthermore, nurses believe that caring for the patient means looking after the whole family as well. This statement is supported by the following quotes:

If the patient is not working, is not employed and he has kids that he needs to take care of, so you get to refer the patient to a social worker, may be for a social grant. In that way you will be able to help the whole family. (Unit A, participant 4).

...and also referring them (family) to the auxillary services like for an example if they need help for or they have a social problem, a family problem like if the patient is an overdose you can refer the entire family to the social workers for counselling. (Unit B, participant 6)

Findings indicated that rehabilitation begins from admission, continues while the patient is still in ICU and even after discharge. The rehabilitation process is about involving family members and the patient in a journey to independence as part of the recovery process. Furthermore, making family part of the rehabilitation prevents and reduces readmissions. Participants acknowledged that by giving information to the family, it will assist the patient's recovery and enhances the patient's rehabilitation. This statement was evidenced in the following quotes:

If the patient is sick they [family] can also help the patient when the patient is discharged because they have seen what we have been doing to them [patients]. They [family] can go and practice at home as well to help the patient get better. (Unit A, participant 4)

If you give them the tools to be able to help with the healing process and the process of returning to normal as possible. (Unit A, participant 2)

I think it plays a very important part in the whole rehabilitation and recovery of the patient. (Unit A, participant 9)

Findings indicated that nurses' roles and responsibilities in ICUs include supporting families in shared decision making. Decision making happens as part of the family's involvement in patient care, thus participants also acknowledged the important contribution family can make to decisions. Involving family members in shared

decision making is the central component for FCC since patients in an ICU are mostly unresponsive. Nurses reported that the family needs to be involved in decision making and therefore, family should receive adequate information in order to make an informed decision. Allowing the family to make a decision is vital because they have pre-existing knowledge about the patient, according to the participants. Responses below support this statement:

Our role more importantly is to get the family involved in decision making, in some of the decision making process if the patient is unable to do so, and involving them in patient care. (Unit B, participant 6)

But I think things like surgery and stuff, family has the right to decide among themselves with the patient you know, if the patient can speak to their family and stuff and get back to you. (Unit A, participant 1)

The decision that may be raised by the families may somehow be something that may be overlooked, but then it's important when it comes out from the family, the person who knows him or her very well, they might be some things you may pick up along the interview we have with families while we are there. (Unit A, participant 7)

Recognising the family's right to decision making also includes giving necessary and adequate information with respect to decision making. Findings indicated that nurses also assess the family to see if they are able to make the right decision. Hence, looking at the situation that the family might be dealing with. This statement is supported by the following responses:

You have to make sure that you give the family all the information so that they make informed choices and decisions. (Unit A, participant 2)

So you have got to look at the situation first, will the person be able to manage the situation first, so you weigh the odds first before you just offer them (family) that opportunity to say that family is allowed to take care of the patient or make a decision. (Unit A, participant 1)

However, findings indicated that family involvement in decision making can also be limited. Hence, one participant indicated that family members can have many

opinions when it comes to a patient's treatment plan. Thus, family access to patient care can be limited. This could be due to the fact that family members are always looking out for the patient, thus, best care. This statement is supported by the following response below:

Yes I prefer them to be involved you know, not in everything, because sometimes you can't have them in decision making because they say I want my loved one or family member to have this treatment. (Unit A, participant 1)

Right now, I have not seen family being involved in decision making, I have been taking orders straight from the doctors and convey the same results to the patient or family members and say the doctor said this or doctor said that or I quote the doctor as such. (Unit 1, participant 1)

Nurses reported that they educate family members on the patient's condition. This is because the ICU environment is complex and technical, thus requires experts to care for the patient. According to the participants, giving health education on the patient's condition is part of the nurses' role and responsibility since family members have 'no basic knowledge' about ICU. Informing family members on the patient's condition will also reduce their anxiety levels. This statement is supported by the following quotes:

It's our responsibility to involve them (family) because it's an ICU, it's specialised care that the family has no basic knowledge of. (Unit B, participant 6).

We have to educate the relatives as educators on the patient's condition. It's a big, big role, you always involve your family. (Unit B, participant 8)

You tell them (family) the do's and don'ts. We have to educate the relatives as educators in the patient's condition. (Unit B, participant 7).

3.3.2. Family involvement with patient care in the adult ICU environment as perceived by nurses

Nurses' attitudes towards family involvement in patient care in an ICU as part of FCC emerged as the finding in this study. Findings revealed that participants acknowledge that FCC is an excellent approach to be used when implementing

quality patient care. However, findings indicated that there are discrepancies in nurses' perceptions towards family involvement in nursing care activities in the selected adult ICUs. Participants revealed that a patient in the ICU is their priority, thus family involvement may depend on their discretion, therefore, it is best that the family can remain at the patient's bedside. Ultimately, some participants perceived a family presence at the bedside as direct family involvement. Hence, family participation in patient care has been regarded as vital in promoting patient and family support, thus satisfaction.

Active and physical family participation in patient care enhances FCC in ICUs and it is part of the principles that facilitates FCC. Nurses reported that having someone close to you during an illness promotes love and hope, thus, it contributes greatly to the recovery process. Findings revealed that family involvement was permitted by some nurses on a high care patient with supervision, indicating that family involvement is necessary. However, family involvement in patient care was perceived by some participants as something that can be difficult to implement since findings demonstrated different perceptions that could hinder family involvement. These include the patient's condition, family interfering with the patient and equipment, ICUs being busy settings and therefore a lack of time, maintaining a patient's privacy and integrity, and nurses' confidence. Findings further revealed that respecting the patient's wishes is important in relation to family involvement. This is evidenced by the lack of family encouragement and involvement in patient care. This statement is supported by the participants' response below.

We would like them to be involved in the physical part of nursing care. (Unit B, participant 6)

You know I think it can be a problem in ICU but here in CCU I don't think we really can have a problem if it's quiet like this. (Unit B, participant 8)

..but if I find that the patient is more comfortable with the person I won't allow the person to do some things completely on their own but with me there. (Unit A, participant 1).

Findings revealed that participants' perceptions on family involvement was at times based on the following privileges: if the patient is a child, then a parent or grandparent

can be involved in the nursing care activities. The activities that parents or grandparents can perform include bathing and feeding. Nurses reported that involving the family in patient care can be exceptional. Furthermore, nurses can decide to use their discretion on whom and when to involve family members in patient care. This statement is supported by the following responses:

If I have got a younger child like the 15 year old or something, and maybe a granny or a mother is present, and they want to help with the bath or something ok, maybe that is something I can tolerate. (Unit A, participant 1).

If it's a little child like we had recently, you try and involve the father or the mother, involve in as much care as possible like if they want to be bathed you have got to bath them, and mom can be there to help you or mom can help feed them and mom can sit and read to them. (Unit A, participant 2)

Findings on this study also revealed that nurses have the perception that family members can better handle the patient when their condition has improved or is getting better. Thus, the nurses can allow the family to participate in patient care when the patient's condition is stable and where they are no longer ventilated and intubated. This means that when the patient is not critically ill and they are high care patients, then the family can be involved under nurses' supervision, according to the participants. This statement is supported by the following responses:

Sometimes it is impossible to but if there are (patients) in the unit for a long time and they become more like acute chronic patients then we involve the family in helping with, sometimes feeding of the patient. (Unit B, participant 6)

....with a high care patient I have seen family come through and they were massaging the patient. (Unit A, participant 3)

With the high care patient that we normally have post extubation they can care, feed them (patients), talk to them, bath them, do cares, mouth care and all, and turning. If it's possible and they are around at that time. (Unit A, participant 7).

One participant's perception was that family members can only be involved in other patient care activities besides the decision making process. Hence, FCC is basically

about involving patients and families in patient care, including the decision making process. Patients in the ICU are mostly unresponsive, hence, their families know almost everything about the patient, thus they become the spokesperson for the patient. This statement is supported by the following quote:

Family centred care, my perception would be that it is involving the family besides in the decision making ahmm....regarding patient care. (Unit B, participant 6)

Participants indicated nursing activities that family members can perform in a high care patient include: massaging, feeding, mouth care and turning. Findings revealed that nurses allow the family to be involved in patient care in limited and specific nursing care activities. Consequently, nurses indicated these nursing care activities as simple and basic for the family to be engaged in. This statement is supported by the following quotes:

Like if we want to turn the patient, we involve the family in helping us to turn the patient. That is basically what we do in ICU. (Unit B, participant 6)

But I have seen a family come through, they did feed the patient and rubbed the feet. Those are the two activities that I have seen on the patient, feeding, it's possible if it's a high care patient. We do allow it but if the patient is unstable it's mostly unlikely not. (Unit A, participant 3)

....let them come in and encourage them, hand them the cream and encourage them to put the cream on. (Unit A, participant 5)

Findings of this study demonstrated discrepancies in participants' responses with respect to family involvement in patient care, thus participants have different perceptions in relation to family involvement in patient care. Some professional nurses reported that family participation is not permitted in the adult ICU. Participants indicated that performing nursing care activities is their duty, thus family is not allowed. However, they have never seen family members involved with the nursing care activities. Thus the patient receives support from the family presence at the patient's bedside according to the participants, nothing more. This statement is evident by the following quotes:

I have not seen any of them getting involved with the nursing activities. (Unit B, participant 9)

Yes I would say it (FCC) is a good thing but we limit the activities as we stay with the patient but I would encourage the family to be at the patient's bedside whenever they feel like. (Unit A, participant 3)

We would like our morning routine to get over and done with before they come in. (Unit A, participant 2)

They were at the bedside for most of the day but as I told you before I have never seen any activities done on the patient because most of the time we don't allow them to do anything. (Unit A, participants 3)

Findings indicated that participants had a perception that there is not much that the family can do on a ventilated patient, therefore, this led to the inability of the family members to be involved in nursing care activities. Furthermore, participants indicated that there was lack of family encouragement and supervision from the nurses' side. Findings showed that family involvement is not encouraged in adult ICUs when compared to the paediatric units. This statement is supported by the following quotes:

Let's say there is a ventilated patient there's not much they can do besides bathing him and changing the linen but they might need supervision there and there so that they are not fiddling with tubing and stuff and they can disconnect and all. (Unit A, participant 7)

If the patient needs to be fed we feed them it's unlike at the children's ward I don't think its practiced that much. (Unit A, participant 4)

Family coming to help us with the patient I have not experienced it much. Sometimes we don't get it. We don't encourage it, I feel that we don't encourage it. (Unit B, participant 8)

Findings of this study revealed that nurses have the perceptions that family members can interfere with the equipment and the patient if they are physically involved with the patient. Furthermore, findings indicated that participants have the perception that family members can misinterpret and misunderstand other things concerning the

patient's condition and also the patient's charts as they get more involved with the patient, thus leading to misconceptions about the ICU. This statement is supported by the following quotes:

Not to interfere with care that happens because it's intensive care unit so they can't disturb. (Unit A, participant 5)

...sometimes too many family members come and they interfere with our work. (Unit B, participant 8)

They should not interfere with anything they should not have free access to anything because they can, they may not necessary understand what they are reading, start the roumers among the rest of the family members. (Unit A, participant 5)

One participant's perception revealed that it is not necessary to involve family members in patient care since family members do not display a motivation and interest to be involved. According to the finding, family members are 'reluctant to be involved'. This statement is supported by the following quote:

There are very reluctant to get involved in the patient care, no matter how much you encourage them to get involved and try to get them (family) involved. (Unit B, participant 6).

Findings revealed that the family is excused from the patient's bedside during nursing care activities, emergencies and invasive procedures to allow the patient privacy and dignity. Nurses' perceptions indicated that having family members during the procedures intereferes with the patient's dignity and integrity. Thus, nurses maintain the patient's privacy by limiting family involvement. Therefore, nurses are advocating for the patient. This statement is supported by the following responses:

Where you don't necessary want the men coming in touching the female patient when you are not sure of their relationship outside the unit because they can say they are somebody but they are not the relative they claim to be. (Unit A, participant 5)

Only when we are performing some nursing activities we have to screen and send them back to the room and do whatever for that patient and call them back when we are done. (Unit A, participant 7)

If we have got a resuscitation going on or if we have just receiving a patient back from theatre and they want to see a family member we explain to them that listen it's not a good time right now could you just wait for us if it's possible, but there's a policy there about visitation but I am explaining on how we work it. (Unit A, participant 2)

Participants acknowledged that involving the family in the ICU environment produces positive outcomes. However nurses' perceptions revealed that having the family around and getting them involved in patient care can delay their nursing routine. Time is the issue namely, that is not always on their side because of the busy pace in an ICU. Thus, nurses prefer to implement nursing activities on their own without involving the family because there is not enough time spend with the patient without interference. This statement is supported by the following responses:

....if the patient is sick and it also takes up time that you need to focus on the patient then you won't have time to deal with the family and helping them. (Unit A, participant 5)

Sometimes it decreases your time spent with the patient. (Unit A, participant 1)

We don't have time, a lot of time to involve the family and talk to them because we are always on the rush. (Unit A, participant 4)

Findings in the current study revealed that participants have the perception that the shortage of staff becomes a challenge when involving family members in patient care. Findings revealed that staff shortages was the other reason that prevented nurses from involving families in patient care, as they will need more hands. Participants felt that allowing family to be involved in patient care requires more nurses to be with each family as the family will require supervision. This statement is supported by the following quotes:

It is quite difficult to accommodate the family in situations like this because at the moment...because of not only the shortage of staff... (Unit A, participant 1)

...or maybe we need more staff, we need more registered nurses to come and work here maybe in that way can have time to practice the family centred care. (Unit A, participant 4)

Findings indicated that the participants had the perception that if family members are given an opportunity to be involved with patient care, they can decrease the nurses' workload. However, family involvement in patient care is about promoting partnership in patient care as this enhances family's and patient's satisfaction. This is evident because participants stated that they are too busy to involve family members in patient care. This statement is supported by the following quotes:

FCC it's a good thing I can say because we are somehow overloaded with work, it can decrease work load to nurses and make other things to be done in time and accordingly. (Unit A, participant 7)

I feel we can actually use the family more, where it's very important (Unit B, participant 8)

Findings revealed that nurses' confidence in encouraging and allowing family involvement in patient care seemed to produce different perceptions about families. This may be an indication that nurses lack the knowledge and skills in involving families in patient care. Findings indicated that participants perceive family members as a threat to their environment, thus nurses felt uncomfortable to have families involved. Findings may indicate that participants' perceptions in the ICU environment may play a big role in the nurses' confidence in carrying out their daily duties. Thus, lack of experiences and knowledge may lead to different perceptions in a situation. This might be because nurses perceive that family members judge their performance. The following excerpts from the participants' responses confirm this:

....you must just make sure that your care is going to be the best and not cause problems. (Unit A, participant 2)

You tell them, refer them to the doctors or whatever and then they take the offence because you are the nurse. (Unit A, participant 1)

...at times is when we get trained staff coming to visit that they might want more information or to do more stuff than the staff may feel comfortable with when doing. (Unit A, participant 5)

And if they (family) did not see you in that routine they would think you have omitted something and they think that you are jeopardizing that patient's care so you have to be very careful, also on with how you and the manner you allow family to make decisions in the care that is given. (Unit A, participant 1).

3.3.3. Nurses' experiences towards family presence in adult ICU

Findings revealed the nurses' experiences towards a family's presence in the ICU environment as visiting and being near the patient, the family providing support and information, and lastly, a family's coping strategies in the adult ICUs as the findings that emerged in the current study. Findings revealed that nurses are increasingly encouraging family members to be at the patient's bedside rather than active involvement in patient care. Family uncertainty and being in the unfamiliar surroundings may create anxiety. Infrastructure and physical design in the ICU promotes flexibility of the environment, and thus enhances FCC.

Family members of patients in the ICU become very emotional and display a sense of uncertainty when in ICU as reported by professional nurses in the current study. Professional nurses reported that when the family comes to the ICU, they display a feeling of being uneasy and scared, however, participants indicated this could be due to the ICU environment is different from other hospital wards, the patient's critical condition and the equipment that is attached to the patient. Unpredictable patient outcomes in the ICU also contribute to the family's perceptions and interpretations that most patients do not survive the ICU because they are unstable and critically ill according to the participants. This statement is supported by the following quotes:

I think that the family in general are so scared when they come to the ICU, that they don't vocalise much that they tend to just obey the instructions and commands about moving out of ICU or leaving the patient. (Unit A, participant 5)

My experience with visitors or relatives, especially visitation I have discovered that majority of the times that relatives are very scared when they are coming to ICU. (Unit B, participant 6)

...most of the time there is nothing that you can discuss with them (family) with respect to... because some of them become emotional and stuff, crying seeing the condition the patient is in. (Unit A, participant 7).

Moreover the ICU environment is complex with specialised equipment of which it can be challenging, thus participants' experiences indicated that the environment is intimidating for the family as they mostly do not have experience of an ICU. This statement is supported by the following quotes:

They think that ICU patient normally die because all the machines get connected to the patient. That's how they feel in the outside world. (Unit A, participant 4).

I think because they see the surroundings, equipment and instructions on the patient they get scared. (Unit B, participant 6)

Findings on the current study indicated that nurses' experiences with regards to the family's presence in the ICU is that families expectations have to be assessed and fulfilled. Family members come to the ICU to support their loved ones, thus, they need to know what to expect in such an environment. Consequently, the environment is strange and unfamiliar, however family members would want to support the patient by all means and as much as they can. Nurses reported that even if family members were interested in being involved in patient care, it is a challenge because family members are not aware of what is expected of them. This is because the ICU environment also adds to their stress levels. However nurses reported that providing orientation to family members is necessary, therefore, the family will be aware of what is expected in ICU. This statement is supported by the following quotes:

.....might need to set guidelines for the family so they know what they are allowed to do or what they are not allowed to do. (Unit A, participant 5).

You educate your patient's family beforehand and tell them what to expect and what they will see. (Unit B, participant 8)

We just don't tell the relative to go turn the patient or do an exercise because their idea of the exercise and what we want is two different things so we explain that getting you involved but we want you to do this, you must do it slowly. (Unit B, participant 6)

Reassuring family members in the ICU during their visits is an essential component in facilitating FCC. Findings of this study revealed that reassuring the family reduces family anxiety and at the same time, the family is able to reassure the patient. According to participants allowing family to be close to the patient gives reassurance to family members. Findings showed that if the family has reduced stress levels they are able to even give hope to the patient that everything is going to be fine. Thus, a patient's anxiety is reduced as they do not worry too much about things that are going on back at home. Nurses felt that the family becomes cooperative when oriented and reassured that the best care and treatment is given to the patient of each individual case. Ultimately, the family gets reassured. This statement is supported by the following quotes:

We have to like explain everything when they come in, that... this is for what like an ngt (nasogastric tube). That this is the tube, helping the patient to eat, all those things. So that they can be relieved that the patient is like not dying, if the patient is not dying. Things like those. (Unit A, participant 4)

A distant relative will come and say but Sr (sister) how is the patient doing, the most you can tell them is the patient is progressing well or is not doing well, what have you. (Unit A, participant 1)

It helps a lot because as I said when they (family) come in they don't understand a thing like if they have an idea of what's happening they become calm and each time they come in they ask questions as well because we let them ask questions. (Unit A, participant 4).

Nurses reported that patients in the ICU get reassurance from their family members and ultimately, the stress levels are reduced because family members will inform the patient of family matters that are not stressful and things that will make the patient

happy. Findings revealed that if patients in the ICU observe that their loved ones are not stressed by anything then patients feel at ease. Participants even reported that if the patient left children at home and when they get someone to tell them that everything is taken care of at home, the patient will be calmed. This statement is supported by the following quotes:

So she (patient) needs to see that the family members are ok so that they can check that everything is fine and reassure her that everything is carrying on at home and that her children are looked after and that sort of thing. (Unit A, participant 5).

If you are stressed thinking about your family at home while you are sitting here, you don't know what's happening to your kids at home. (Unit A, participant 4).

Nurses' experiences indicated that family members also require some kind of assistance emotionally in the ICU environment in order to be part of the patient's recovery process according to the participants. Findings in this study revealed that nurses provide family members with emotional support in order to maintain the patient's and family's well being, thus promoting reassurance. Nurses reported that families also experience emotional, spiritual and psychological stressors during the patient's admission into the ICU. These responses below made by participants during the interview supports this statement:

You have got to see if that family is strong enough to be with that patient or whatever before certain things you know I mean... (Unit A, participant 1)

Emotionally she might not handle it, you have got to also take into consideration that they are emotionally and spiritually are part of that person and have to look after them as well. (Unit A, participant 2)

So it helps to work with the family so that they can verbalise their concerns and fears as their member of the family has been admitted in the hospital. (Unit B, participant 9)

Participants' experiences indicated that, they felt that encouraging family to be in close proximity to the patient was very important. This made the patient recognise

that the families support them. As much as nurses limit physical family involvement in patient care, ultimately being present at the patient's bedside was acknowledged by nurses as more important than anything else. Encouraging family members to be near the patient has been recognised to be essential, hence it is part of the principles that enhance FCC. Family presence appeared to be more significant in a way that participants indicated that it contributes to the patient's recovery process and well being. This statement is supported by the following quotes:

... the patient can benefit a lot because by the mere presence of the family that contributes to the psychological recovery of the patient, it gives hope. (Unit B, participant 9).

I think that having your family member come in to visit you when you are actually ill promotes the healing progress of your condition because you feel loved and to me it's very, very important that the family is allowed to... in as much as possible to come and sit with their loved ones to talk to them. (Unit A, participant 2)

Findings indicated that as much as participants noted that being close to the patient can produce positive outcomes, they also acknowledged that the units are sometimes too busy to involve family members in patient care. Ultimately, findings indicated that nurses felt it was very important for the patient and family to be together even if family was not physically involved with the patient. This statement is supported by the following quote:

We are always busy with the patient but we try by all means to allow the family to be with the patient. (Unit A, participant 3)

Findings of the study revealed that allowing the family to be close to the patient, they can view some simple procedures. This can actually increase family confidence and trust in the care that the patient is getting. Nurses reported that having the family around the patient while performing nursing duties, even to allow the family to be involved in simple activities is vital for family as they are viewing the care the patient is receiving. Ultimately, nurses are able to establish rapport with the family, thus trust is enhanced. This statement is supported by the quotes below:

If you allow them (family) in, the family in to help you do simple things like brushing the hair or something and then they actually will walk away feeling that the patient is getting better care than if you have just chased them away, straight away. (Unit A, participant 5)

....if I have like an understanding couple, adults or understanding even like a mother and with the older child or something I prefer them to be present when I do something because also you build up rapport with that family member that they trust you to work with their child or their loved one. (Unit A, participant 1).

You have got to think of them as the extension of the patient and if you care for the family they will feel more confidence in the care that you are going to give their family member who is the patient. (Unit A, participant 2)

Participants reported that even if the patient is dying, their family members are very important to help the patient to anticipate their death, thus, results indicates that family supports the patient during this time. Findings revealed that family cohesion is even stronger during death of a patient. This statement is supported by the following responses:

We allow them to come and say their goodbyes. (Unit A, participant 6)

Sometimes family would be there when the person is passing away and stuff and spend those last few minutes with them it would probably be better. (Unit A, participant 1)

Nurses indicated that family members always sacrifice for one another especially during the times when one is down and out. Hence, to receive support during the ICU experience enhances positive family memories because the patient can recognise that he/she is not alone in their health crisis. Ultimately, nurses acknowledged that health was enhanced because the patient was aware that the family came to the unit to increase their strength and hope during their illness. This statement is supported by the participants' responses below:

For their parents or their brother or sister or wife or husband to sit there and talk to them and hear them speaking can help bring them out of the coma or

something like that, just knowing the touch, something, the smell of your mom's perfume can make the difference. (Unit A, participant 2)

The memory can come back and that person can fight harder for themselves because if they feel like they have been burdened by their family members they give up almost. (Unit A, participant 2)

If may be the children, it's been a long time since the patient has seen them. You can ask whoever is at home to bring those kids so that he can have a smile because they have seen their families. (Unit A, participant 4)

Findings indicated that nurses explain to the family that by touching the patient they are not hurting the patient. In addition, participants indicated that family members are encouraged to be close to the patient. This statement is supported by the following quote:

To get them (family) involved they have to get confident that they are not going to harm them (patients) but they are helping. But you explain to them (family) that they are not going to hurt the patient. (Unit B, participant 6).

Families of patients in the ICU form an important part of a patient, thus, they need support in order for them to cope and support the patient. Participants in the study reported that the patients in ICU are very ill and feel isolated. The study findings also revealed that family proximity in ICU enhances love, happiness and comfort from family members to patients. Participants reported that patients need the family to get through the health crisis. This statement is supported by the following responses:

....it tells you the type of family structure that they have got, because it tells you they have social support that they need physical support for instance if the patient is on PD (peritoneal dialysis) or unable to walk they help the patient and also with basically basic care. (Unit B, participant 6)

You can see a sense of happiness with them and they just need that love and support from family rather than feeling all neglected and alone in this big ICU. (Unit A, participant 3)

I think that having your family member come in to visit you when you are actually ill promotes the healing progress of your condition because you feel

loved and to me it's very, very important that the family is allowed in as much as possible to come and sit with their loved ones to talk to them. (Unit A, participant 2)

Family of a patient in the ICU can only hope for their loved ones to be close to them so that they can feel safe and protected. Findings of this study revealed that nurses' experiences indicated that a family's presence enhances the patient's sense of security in the ICU since they are in an unfamiliar environment. This statement is supported by the following responses:

...let's say suppose like you have the patient that says ok I want my spouse to remain here with me tonight and the next night says I want my spouse to do the same thing.... (Unit A, participant 1)

The family is here with him because it's hard when you are just around the strangers surrounded by machines. You are like it's the end of the world. (Unit A, participant 7)

....it's important to some of the patients or must I say all of them because the patients are also scared and emotional. (Unit A, participant 4)

Family also supports the patient by sharing the patient's information with the nurses working in the units. Participants reported that patients in the units are sedated and unresponsive, thus, it becomes difficult to obtain their history. The patient's history is important when identifying patient's needs and formulating a patient's care plan. Family members of these patients become their surrogate decision makers and thereby provide vital information needed for the treatment plan. Nurses reported that some of their patients arrive in the units unidentified due to trauma and injuries. This means that they need family members to identify them and give the patient's personal and medical history according to the participants. Therefore nurses are able to care for the patient holistically because they get the full picture of the patient by interacting with the patient's family members. Participants in this study have illustrated this finding as follows:

If the patient is unidentified, if it's an unknown patient we try our hardest to get the patient, family information, patient's name, family information as soon as possible. (Unit A, participant 2)

...family is a resource in terms of information, first when we admit the patient there are the ones who know what happened initially to the patient before he even came to our care or even go and seek medical care. (Unit B, participant 9)

In ICU we do need family because of contact details and names for diagnosis most of the time our patients are unconscious and we cannot get information. (Unit A, participant 3)

Families of patients in the ICU provide the medical history of the patient that existed before the patient was admitted to the ICU. Being close to the family and interacting with family allows the nurses to get to know more about the kind of a person they are caring for in an ICU bed according to the participants. The following responses made by the participants support this statement:

Regarding patient information we learn their habits, their moods, any diseases or illnesses that they have had. (Unit B, participant 6)

So they can be the source of information where the patient has not been able to disclose things. (Unit A, participant 2)

Some people don't wanna talk about their feelings, it helps a lot because you get history from family in that way. (Unit A, participant 4)

Family coping strategies should be encouraged since family members experience all different kinds of stressors in the ICU. Findings demonstrated that patients and their families have different belief systems compared to that of the nurses, which are mostly evident during a health crisis. Family coping strategies have emerged as the finding in this study. Encouraging family members to utilise their coping mechanisms during the health crisis forms part of the principles that enhances FCC. Participants reported that family members bring objects and request to practice some family rituals that they believe are going to promote the patient's recovery and health, hence, increasing hope. A family engages in cultural and religious rituals to increase their strength and energy. Different families have different beliefs regarding health, illness and death according to the participants. Rituals that the family and patient practice range from praying sessions, burning incense, big family gatherings around the patient, taking the corpse after death without sending it to the mortuary,

behaviours related to emotions, bringing holy water and bringing objects. FCC allows patients and family members to be recognised as unique beings by respecting their culture, values and belief systems. This statement is supported in the following quotations:

I have some family members that were feeding the patient Vaseline while the patient was intubated with the teaspoon in the mouth, but fortunately I was standing there. (Unit A, participant 5)

Like the Jewish people and Muslim people they like to bath the patient themselves, it's their religious rights. (Unit A, participant 2)

I mean if they are Muslim or Hindu family you are going to allow them to come in and do their prayers if they want to. (Unit A, participant 2)

Findings indicated that family members are also given an opportunity to conduct some rituals that are related to death and dying as their way of finding peace and fulfilling their religious and cultural rights. This statement is supported by the following responses:

I will be very honest, different races because of their culture, it's a cultural thing in different cultures people you know view illness and death and dying in different ways. (Unit A, participant 1)

If they are Zulu speaking culture, then if they want to come in and collect the spirit. You allow them to do that, is part of their healing and the closure process that everybody has in themselves and you can't just look at them as an irritating person that's coming to be noisy. (Unit A, participant 2)

The Muslim their patients when they die here, they don't go to the mortuary they wait somewhere and then they take the body straight to their mortuary which is respected by their culture. So we just don't take them to mortuary without notifying the family. They must do their thing whatever they do when a person passes away. (Unit A, participant 7)

Family behaviours can reflect their response to health systems and treatment. Findings revealed that the way families have been socialised when growing up has

an influence in their behaviour, especially related to health practices, hence coping with a health crisis. This statement is supported by the following response:

...sho, sho...sho...sometimes it's difficult ahmmm especially when you have to deal with the Indian families because in their culture they have to like the whole road in the township has to come and visit, sometimes it's very difficult to control. (Unit A, participant 4)

Participants indicated that nurses' training involves learning about different cultures and belief systems. Nursing as a profession prepares and empowers nurses to advocate for the well-being of patients and their families. Participants also indicated that experiences they have had in the units contributes tremendously in their practice, because they learn to respect all cultures and religions that they come across. This is done with confidence, competence, compassion and moral awareness according to the participants. This statement is supported by the following responses:

...one thing that does prepare helps us is our training, prepares us for total diversity by helping teach us different cultures and what is acceptable and what's not acceptable, but I think the majority of our learning experience comes from dealing with patients. (Unit B, participant 6)

For me I found it extremely interesting to learn different cultures and different religions and different ways people perceive things. (Unit A, participant 2)

The patient comes through here just that the religion part and cultural practices we tend to learn as we go along. (Unit B, participant 6).

Respecting the patient's and their family's values and beliefs while maintain nursing values was reported as another finding in this study. Participants reported that individual families should be respected for who they are, no matter their cultural and religious background. The following responses made by participants confirm this:

You have got to respect all people and walks of life and where they come from because this is cross cultural and you got to see that what the norms, the so called norms. (Unit A. Participant 1)

First it's culturally based on beliefs and practices, if I can make an example like for an Islam is admitted or someone to Shembe as their religion. So we consider those important aspects and we make sure that we provide those families, if we have to, especially with their relatives. (Unit B, participant 9)

There are problems at times when you don't respect the diversity and then problems arise but in that case we try to as much as possible. I mean the basic of maintaining patients' rights and integrity, that's followed everywhere through whatever diversity the patient is. (Unit B, participant 6)

Findings revealed that as much as nurses respect and honour patients and families belief systems, the ICU environment is also important to be maintained in order to promote quality patient care by protecting other patients and the environment, and, ultimately, to still be able to carry out routine procedures. However, findings revealed that nurses considered family beliefs even when they had to perform some nursing activities by explaining to the family their expectations in relation to the environment, and at the same time, to allow flexibility in respect of the family's belief system. Nurses reported that respecting diversity means to educate the family on things that are detrimental to the ICU environment, while at the same time finding other means to respect the family's beliefs. The responses below support this notion:

So you also need to tell them (family) that you know what yes I can allow you to pray but you know my patient needs to be kept in a certain environment, would you be able to do this around the patient? (Unit A, participant 1)

Your beliefs you don't put on to your patient or relatives, they must be allowed to do what they think as long it's not harmful to the patient or to any of the actual relatives around the patient. (Unit A, participant 5)

There is a line where we say now we cannot because we are looking at the environment that we are in, like if they would come in and burn the 'impepho' (incense). So we will not allow that to happen, but we will explain why we cannot allow it. Firstly, as we have oxygen in the unit connected so it can cause fire if we allow them to burn impepho inside the unit. (Unit B, participant 9)

Nurses reported that at times there could be problems that are related to diversity. However ICU nurses need to respect every patient and their family members because they have been socialised in that way and they also form part of the wider community. Participants indicated that patient behaviours can reflect their response to health and treatment. This statement is supported by the following excerpts:

With the Jehovah's Witness people, they don't want to receive blood or body transplants and if you go ahead and just give them blood and do things they are going to be ostracised in the community when they get back and it's not fair. (Unit A, participants 2)

Even our patients South African especially men, they don't tell you if they are in pain. So we have to like understand ok that this is a Zulu man even though he says he does not have pains but when you watch the monitor you can see that this person is uncomfortable. (Unit A, participant 4)

Nurses have acknowledged and demonstrated that family members play a crucial role in a patient's life when admitted in ICU. This has been evident by the positive impact a family makes on the patient when given an opportunity to be near the patient. This is supported by the participants' responses. However, nurses require guidelines and policies to guide and direct their practice and experiences in the ICU. Flexible and open family visits promotes and enhances family satisfaction. Consequently, liberal family visits form part of the principles that enhances FCC. Findings of this study revealed that participants acknowledged that open visiting hours are necessary for patient and family bonding and support. This is despite the hospital visiting policy which stipulates specific visiting hours, which includes other restrictions such as only close family members that are allowed, two visitors at a time and no children under 12 years are allowed. Thus, restrictive family visitation policies still exist in selected ICUs. However, there were inconsistencies with the visiting times that nurses indicated; hence times given were very different from the existing visiting policy.

It was apparent from the interviews that nurses allowed the family members to visit the patient provided that the patient's condition and the environment permitted visiting flexibility at that moment. Thus, the participants indicated that patients are their primary priority. Consequently, findings showed that family visiting policies

generally depend on the discretion of the professional nurse in charge of the unit, and based on patient's condition. Nurses also reported that they also allowed flexible visits with special cases such as dying patients. However, there were also discrepancies that were noted between the two units with respect to family visitation in unit A of the surgical ICU and unit B of the medical ICU. Visitation in unit A was more flexible at times compared to unit B where there were more restrictions. In general though, most participants practiced restricted family visits because they also indicated that only close family members are allowed in according to the hospital policy. This statement is supported by the following responses:

We do have family restrictions, sometimes we do especially that it's cardiac here. (Unit B, participant 8)

There is no restricted time to come to ICU. (Unit A, participant 4)

This study finding showed that there are discrepancies with the implementation of the visitation policy in these ICUs, when it comes to specific visiting times. Participants indicated that they are aware that there is a policy in place for family visitation, however their experiences of visiting family members is incongruent with the principles that enhance FCC. Findings also revealed that nurses used their discretion when allowing family to visit. This statement is supported by the following quotes:

We got stipulated visiting hours like in our unit visiting hours are from 15h00-16h00 and then 20h00 at night, so we allow those times. But with us because we are the intensive care unit there are times where there are emergencies so we do allow families but on request prior to come and see their loved ones. (Unit B, participant 9)

You will find at stages where patients are really ill and you know we have called the family and notify the family that the patient is not going to make it, they come in droves, yes we do allow that accommodation for some families to come in and speak to their relatives. (Unit A, participant 1)

In ICU as far as I understand the visitation is at the discretion of the unit so that the patient comes first.(Unit A, participant 5)

You better weight the odds and I think right now I am too junior to be able to make that decision on my own but I get that authority from the senior person in the unit that will tell me that you know what this person can or can't stay overnight. (Unit A, participant 1)

Participants indicated that only immediate family members are allowed to visit patients in an ICU according to the visitation policy. However, for this study, a family member is anyone who plays an important part in the patient's life. It does not necessarily mean that they have to be blood related. It could be anyone the patient prefers to be involved in their care, including friends. This statement is supported by the following responses:

We don't know if that person is the real mother or brother, sister or whoever they are. As they stay in the unit or stay longer we get to know who is a family on the personal basis. (Unit B, participant 6)

It depends and we try to follow the hospital policy which is normally in an ICU, we allow only immediate family sometimes that is impossible because on face value and good faith we allow that. (Unit B, participant 6)

Findings reveal that nurses acknowledged the importance of promoting and maintaining patient safety in the unit. Nurses reported that they have experienced cases where patients have been assaulted by other family members. Furthermore, participants felt that as nurses, they had to protect the patient from being harmed by anything or anyone while in the ICU. Hence, a patient's health is the nurses' primary concern and ensuring patient safety with respect to family visits. The reason is partly because of the nature of the patients' injuries or illness that are usually admitted in these units, some are trauma patients. Ultimately, participants are using the existing visiting policy to protect patients in the units. This statement is supported by the following responses:

Sometimes we have had some situations where family members actually been shot and stabbed by other family members and you have got to found out whose like in charge for this patient's family and well-being and get the list from them and limit the amount of visitors that they get as I said in the

beginning you have got to know that patient is nursed individually. (Unit A, participant 2)

Findings indicated that nurses have experiences where family members do not comply with the visiting policy. Yet the results also indicated that participants themselves at times do not follow the policy for family visitation. Findings showed that family members are restricted to visit because at times, they can change the patient's condition. This statement is supported by the following quotes:

As I have explained before the importance of it, but at times as I was saying we have experienced difficulties in terms of as I have explained the family behaviour, their compliance in terms of visiting hours and everything. (Unit B, participant 9)

You find like people that come from far sometimes like the whole weekend and holidays and staff. There's more visitors that are coming to visit they cannot come here on the daily basis but people that are local and staff you find there's tons of visitors sometimes and you can't handle you know. (Unit A, participant 1)

When they come in, they come all of them at the same time and even though you try and explain to them that this is ICU, they have to be like two visitors at the same time but they don't listen. (Unit A, participant 4)

Family members were perceived as demonstrating irrational behaviour when visiting a patient in the ICU. With this, findings indicated that nurses restricted family visitation. However, nurses indicated that at times family members can be helpful during visiting times when the patient is not being compliant with the treatment and their care plan. This statement is supported by the following quotes:

She just remained there, if she was not he would refuse any treatment. So he was not cooperative at that stage. So those are the instances that we have difficulty with, but other than that family do cooperate with us. They do stay with the patient for a while and then they leave. (Unit A, participant 3)

They can be very, very difficult to get around say suppose you want to turn the patient and the patient doesn't wanna that, but if they have got the family

member present like this (clicks the fingers) if you know the mum says but let the nurse help you turn, child will listen or sometimes it works the opposite way around. (Unit A, participant 1)

Findings revealed that at times the patient's condition changes due to family visits. Furthermore, findings showed that family members that cause the patient's condition to change would be requested to allow the patient to settle down. This statement is supported by the response below:

I have also seen where it goes the other way where it has made the patient very restless, sent the blood pressure to the ceiling and mmh...(silence) in that case I normally ask the relatives not to disturb the patient. (Unit A, participant 5)

Findings indicate that participants demonstrated that children are not allowed to visit adult ICUs according to the visitation policy. One participant reported that children are perceived as vulnerable beings in ICU because of their age, hence, children under 12 years are not permitted to enter in ICU. This statement is supported by the following response:

Children under 12 years are not allowed in ICU because they are vulnerable to infection and two people have to come in and not more than two at a time, they have to take turns. (Unit A, participant 4)

Findings indicated that infection control was essential to be maintained in the ICU as nurses want to promote patient recovery. Participants' experiences indicated that flexible family visitation can increase infection rates in units. Hence, findings revealed that nurses provided strategies and health education to family members in order to prevent the spread of microorganisms and maintained hygiene in the unit. The strategies included health education on hand washing, environmental hygiene and limiting the number of visitors at a given time in relation to the hospital policy. Nurses in this study, it was reported that when the family is visiting they can bring infection in the unit and it could delay the patient's healing process. Therefore, the family is encouraged to perform hand-washing when they come in and out of the unit. This statement is supported by the following responses:

We are very strict, hand washing so that no infection get brought into the unit but we are open. (Unit A, participant 2)

...and that they have to wash their hands before they come in, so that they don't bring in whatever they are coming with from outside into the ICU because it will affect the healing of the patient as well. (Unit A, participant 4)

Nurses reported that family members bring objects and 'holy water' that they believe has a healing effect on the patient. However, results on this study revealed that nurses ensure that they also keep an eye on things that are brought in by family members to prevent the spread of infection in the unit. This is because participants' experiences are that things that are brought from outside into the unit are not considered clean as they are not sure where they have come from. Hence participants indicated that the transmission of infection can delay the patient's healing process. This statement is supported by the responses below:

...they want to come and put objects on the bed and we don't necessary know how clean they are or where they have been before. (Unit A, participant 5)

Like the one lady wanted to give the patient holy water and our doctors said no because we don't know where that water is coming from. (Unit B, participant 8)

I don't know what is allowed as long as they don't give them anything to drink or put anything or something funny to drink. (Unit B, participant 8)

3.4. Conclusion

Data was analysed using qualitative content analysis. Themes and sub-themes that emerged from the data were presented with essential participants' responses. The summary of themes and sub-themes was illustrated in table 3.1. Chapter 4 will discuss the research findings with relevant literature control.

CHAPTER 4: DISCUSSION OF FINDINGS

4.1. Introduction

The previous chapter provided the data analysis for this study. This chapter will provide the discussion of the findings in details based on the research question in Chapter 1. Themes and sub-themes that emerged from data analysis will be presented with supporting literature. The aim of the study was to explore and describe the knowledge, perceptions and experiences of nurses towards FCC in adult ICUs.

4.2. Discussion of themes

4.2.1. Nurses' awareness and knowledge on the components of FCC in adult ICU

This study highlighted the nurses' background knowledge on the concept of FCC as a significant finding whilst caring for a patient in a critical condition in an adult ICU. Findings revealed that registered nurses demonstrated that they have knowledge of the concept of FCC, however, findings showed that some of their knowledge is not put into practice. Furthermore, findings revealed that FCC is not implemented adequately since participants indicated that FCC is not encouraged. One participant reported that FCC is 'something that has never been practiced'.

However, as much as FCC is not being implemented adequately, participants acknowledged their roles and responsibilities with respect to the implementation of the components and principles that are involved in facilitating FCC. These responsibilities include nurses giving information about the patient's condition and services available for the patient and family's rehabilitation, involving family members in decision making and giving health education. Ultimately, nurses' roles and responsibilities forms part of identifying family needs in the ICU. The results of this study are consistent with the findings of the study by Rippin *et al.*(2015: 80-98) who also revealed that nurses that participated in their study indicated that as much as FCC is 'good in theory,' it is however a challenge to implement it in their unit, especially, that patients are unconscious. Nurses indicated that FCC can be practical for patients that are responsive. Findings further indicated that participants reported that even if families wanted to be involved with in the patient's care directly, nurses

are required to be extra vigilant, thus limiting families from even touching the patient because of adverse reactions. Soh *et al.* (2012: 856-865) maintain that theoretical and background knowledge is essential for nurses especially when implementing change. Nurses have a major role in ensuring that FCC is achieved by being the patient's advocate and involving the patient's family in patient care. Nurses have the professional obligation to care for the patient and maintain patient autonomy (Casarez and Engebretson 2012: 2099-2107). Promoting FCC requires a culture that is grounded by valuing and recognising the great contribution a family makes in an ICU (Kodali *et al.* 2015: 961-967; American Academy of Paediatric Committee on hospital care 2012: 394-404). An organisational culture that values FCC as a holistic approach can be established by having managers that encourage their staff to improve their skills and knowledge (McLaughlin 2013: 20-25). Staff training and training of others are one of the strategies that were identified by Moretz and Abraham (2012: 106-110); where nurses should base their practise on the knowledge they have, thus they will maintain standards and confidence in what they are doing. In this regard, nurses need to get information required to broaden the meaning of the concept of FCC.

Meert, Clark and Eggly (2013: 761-772) add that education and training for nurses is essential so as to prevent increased stress levels and inconsistencies during the implementation of patient care. Nurses require continuous in-service training in order to keep their knowledge up dated with current trends. Such training will allow them to address family needs in the critical care environment, thus, self-esteem for nurses may be improved. Nurses need knowledge of the challenges associated with dealing with families of critically ill patients (Shirazi *et al.* 2015: 207-216). This will allow the nurses to be able to improve the conditions that the family have to deal with (Paim, Ilha and Backes 2015: 2001-2010). De Beer and Moleki (2012: 105-115) recommended that critical care nurses require hospital policies and guidelines to deal with family members in the ICU. Maintaining quality patient care means that nurses need communication skills and knowledge (Fox 2014: 93-98; Di Bernardo *et al.* 2015: 866-870).

This study highlighted the importance of giving information to family members of a patient in ICU. Nurses indicated that giving information to family members is part of their role and responsibility. Many participants in the current study acknowledged

that information about the patient's progress and condition was vital because family members deserve to know, hence, patient and family form a unit. The results of this study corroborates those of several international quantitative and qualitative studies (Wilson *et al.* 2015: 1317-1323; Rensen, van Mol, Menheere, Nijkamp, Verhoogt, Maris, Manders, Vloet and Verharen 2017: 77; Hashim and Hussin 2012a: 12-23; Gaeeni, Farahani, Seyedfatemi and Mohammadi 2015: 8-19; Farahani, Gaeeni, Mohammadi and Seyedfatemi 2014: 1-7; Rensen, van Mol, Menheere, Nijkamp, Verhoogt, Maris, Manders, Vloet and Verharen 2017: 77) with findings suggesting that giving information to the family of patients in an ICU is essential because it reduces anxiety levels. Since family members have been recognised as active partners in patient care, the FCC approach trusts that recognising family needs is an essential component in promoting FCC. Therefore, family members of patients in the ICU need nurses to be available and present in order to provide information. Information given to family members should be clear, complete, honest and easy to understand.

Findings indicated that nurses acknowledge their important role in the health care team and they are also aware that giving information to the family can reduce a family's stress levels. Nurses in ICU have the responsibility to provide information at a level one can understand and also to clarify reasons for giving information if the physician is holding back information. Information given to the family needs to be repeated because the ICU environment is stressful and complex, therefore, it can be difficult for the family to process information quickly (Wilson *et al.* 2015: 1317-1323). Ultimately, nurses are required to identify and assess the family's experiences and concerns so that nurses can provide adequate support (Iranmanesh, Sheikhrabari, Sabzevari, Frozy and Razban 2014: 290-297; Wilson *et al.* 2015: 1317-1323).

The needs of families in the ICU include continuous and open information, knowing the patient's progress, treatment plan and prognosis which contributes greatly to a family's inner strength and feelings of safety, and empowers their experiences of the ICU (Wilson *et al.* 2015: 1317-1323). A study by Frivold, Dale and Slettebø (2015: 232-240) revealed that some family members reported that information given by doctors had medical jargon and they were always busy to explain which made it difficult for family to understand, therefore, nurses had to provide clarity on the content. Family felt that there was no confusion when information was given by the

same nurse that was caring for the patient. In addition, family members reported that it is important for them to receive all the information about the patient as they did not want to be protected from the truth.

The current study findings are contrary to the results of the study reported by Farahani *et al.* (2014: 1-7) who found that there was a gap in the perception of family needs by the family and nurses. Results in that study showed that family scored higher in educational and informational needs than nurses did. Nurses perceived the above as being influenced by the nurses' educational level and years of work experience. Information that is given to family members should be accurate, simple, complete and should also offer emotional support to the recipient. The approach that is used when giving information is vital as it could be ethically challenging for ICU nurses. Giving information to the family will also depend on their emotional status because information given will be on the patient's condition and diagnosis (Farahani *et al.* 2014: 1-7). Findings from the current study indicated that nurses assess the emotional status of family members when giving them information. Moreover, one participant also indicated that it is essential to acknowledge that information given to family members can have a positive or negative impact, and it is essential to find effective ways to communicate with family members.

In their study in Saudi Arabia, Al-Mutair *et al.* (2013a: 135-144) conducted interviews 24 hours after admission of the patient into the ICU. Results were that information appeared as the significant finding in this study; family members felt that knowing information about the patient's well-being in ICU was essential as they experienced feelings of uncertainty and anxiety. Results indicated that family members perceived honest, simple, understandable and consistent information as being vital for their well-being, despite the type of information given, be it bad or good news. Family members felt that information given to them about the patient should include equipment, tubes attached to the patient, medication, vital signs, tests and procedures, meaning of numbers and waves that appear on the monitors. Furthermore, family members felt that they should ask more questions to get information about the patient. The abovementioned study found that families' need for information was not met due to restricted family visitations leading to the lack of time to meet the caring doctor. However, in the same study, some participants revealed that they were satisfied with information given to them as it was

understandable and consistent. They therefore perceived that they could cope with the situation as they could more or less predict the outcomes.

Similarly, the study conducted by Wong, Liamputtong, Koch and Rawson (2015: 51-63) supports the notion that the family requires information about the patient's progress. In addition, even if a family missed the doctors to get patient information, families trusted the nurses to give honest information. Hence nurses passed the exact information that was given by the doctor. Family members felt that it was necessary for nurses to consider carefully how they deliver that information to the family, meaning the tone and voice should match the message and information conveyed, be it good or bad news. This was particularly important for family members to understand the patient's condition as they felt this approach was supportive for them.

In general, nurses only give clarity on the information that was given by doctors. Information that might have a negative impact needs to be communicated in a sensible and understandable manner. Giving information that is not ambiguous and allowing the family to be close to the patient enhances family adaptation in the ICU environment (Wilson *et al.* 2015: 1317-1323; Shirazi *et al.* 2015: 207-216). With this, nurses are able to plan individualised care for the patient. Wong *et al.* (2015: 51-63) found that family members of patients in ICU require the truth regardless of the patient's condition. This kind of approach helps families to face reality and their anxiety levels are reduced as a result. As much as communication has to be tactful, the balance of requirements has to be maintained. This involves being mindful of the different levels amongst family members of being able to grasp information, of maintaining hope and of being culturally sensitive. Information given to the family should include the patient's condition and treatment; this will allow the family to be aware of what is expected and gain more knowledge on the patient's progress.

Participants in the current study reported that doctors give information to the family about the patient's progress, hence, nurses have to be present for clarity of information during family meetings. This notion is well supported by Hashim and Hussin (2012a: 12-23) who stated that family felt that medical information can be given by a doctor and basic information can be given by nurses. Nurses were not keen to give information on patients conditions so they were following the hospital

policy, stating that doctors were the only ones allowed to give medical information to the family. Hence, a family's well being can be improved by family meetings (Kodali *et al.* 2015: 961-967).

Noome, Dijkstra, van Leeuwen and Vloet (2016: 56-64) found that nurses preferred to be present during family discussions as they felt that consistency should be maintained when transferring information to family members. Results of their study indicated that family members have confidence in how nurses conveyed information, as they gave simple explanations and answered their questions. However, the same study revealed that nurses' roles in family meetings was limited. The reason could be that the doctors made the final decisions. On the contrary, a study conducted by Ahluwalia, Schreibeis-Baum, Prendergast, Reinke and Lorenz (2016: 33-38) revealed that nurses were not in favour of their role during family meetings. The abovementioned study indicated that nurses' limitation in the meetings was due doctors who did not actively involve nurses in family discussions and nurses indicated that there were inconsistencies in these meetings. Consequently, nurses felt 'undervalued and underpowered' during family meetings.

Wiegand *et al.* (2013: 60-8) maintain that nurses should advice and advocate for families and patients during family meetings. The nurses' responsibility during these meetings is to reinforce the discussion and clarify misconceptions after the meeting. A study conducted by Gill *et al.* (2016: 1-16); Noome *et al.* (2016: 56-64) and Al-Mutair *et al.* (2013a: 135-144) revealed that family members indicated that it was important for them to have a nurse that is always present, friendly, proactive and knowledgeable. This also included information that was given by a nurse, that it should be clear, honest and complete because at times, families were not sure of the things to be asked. This reduces family anxiety and psychological symptoms (McAdam *et al.* 2012: 386-393). Hence, information given by doctors at times it not simple and understandable (Schwarzkoft *et al.* 2013: 1071-1079).

Aslakson, Wyskiel, Thornton, Copley, Shaffer, Zyra, Nelson and Pronovost (2012: 910-915) assert that nurses require communication skills because doctors were reported to always being in a hurry during family discussions. Thus information that is given is inadequate, not effective and too quick. Consequently, this forms a barrier in communication. Honest, accurate and readily available information needs to be

shared with the family in a timely fashion. Giving information during family meetings is useful, especially if the patient's condition changes. It also leaves the family at peace knowing what is going on with the patient. Information sharing can prevent misconceptions and ensures good collaboration and continuous communication. This can promote family peace and trust but sometimes it is difficult to handle such information.

Findings in the current study revealed that facilities such as visitors rooms are not conducive and adequate for family meetings, given that there could be more than one family present in the room. Thus, there is lack of privacy and confidentiality. A study conducted by Al-Mutair *et al.* (2013a: 135-144) showed that participants indicated that a waiting room for visitors should be comfortable with furniture and sleeping facilities should be available. However, a study conducted by Magesh, Darolia and Singh (2014: 50-52) revealed that the waiting room in their study appeared to be comfortable, however family members felt isolated and anxious due to the patient's condition and perceptions based on the patient's outcomes. Findings of the study conducted by Hashim and Hussin (2012b: 103-111) are contrary to the above findings. In their study, family members did not have waiting rooms. Consequently, family members in their study did not consider waiting rooms as an important need. A study conducted by Kumari and Das (2015: 337-340) revealed that the lack of waiting rooms leads to reduced privacy, thus family members were not satisfied. Rippin *et al.* (2015: 80-98) indicated that the ability of the nurses to promote, enhance and hinder the delivery of FCC can be influenced by the built environment.

Patient's information is kept confidential which is a critical nursing responsibility, although there are challenges associated with this concept. The close environment of the ICU during interaction with family members as well as the emergency situations that can occur, may not be ideal for maintaining patient confidentiality and privacy (Urden, Stacy and Lough 2012: 5). Findings from the current study, indicated that participants had acknowledged that there were family members that are not close to the patient who would want to know everything pertaining to the patient's condition. Thus, participants had to request family members to appoint one member that will get and distribute information to the whole family. This is in line with the study conducted by Akyüz and Erdemir (2013: 660-671) which indicated that nurses

need to ensure that a patient's privacy is maintained by preventing access of information to others and also maintaining physical privacy during patient care. Results of this study revealed that 17.2% of nurse participants stated that they do not discuss relevant information in front of other patients, considering that nurses can only share important information with family members. Findings in the same study indicated that hospital policies, hospital rules and regulations maintain, respect and protect a patient's rights to privacy. Maintaining patient's privacy means to promote patient autonomy and maintain self-determination. However, nurses and patients felt that the physical environment needs to be improved in this regard through the installation of doors in single rooms or curtains to provide adequate privacy.

Similar to the study by Al-Mutair *et al.* (2013a: 135-144), participants in the current study stated that giving information to family members was perceived as difficult at times. Findings indicate that nurses asked family members to delegate someone that would receive information on behalf of the family and then convey information to the rest of the family of any changes, and keep them updated on the patient's condition and progress. According to Al-Mutair *et al.* (2013a: 135-144) family members feel that information given to them should be of a good quality because it reduces their stress levels and increases their ability to cope. Furthermore, families feel that one close, adult person in the family should be nominated as a spokesperson that will receive information and convey it to the whole family. Wilson *et al.* (2015: 1317-1323) and Gill *et al.* (2016: 1-16) maintain that family members of patients admitted in an ICU become the patient's surrogate decision maker and surrogate spokesperson.

This is in line with the study conducted by Rippin *et al.* (2015: 80- 98) which revealed that nurses checked with ICU patients regarding which close family members the patient wishes to have as visitors and that can access the patient's information. However, it was challenging if the patient was not responsive because nurses encountered uncertainty as to who are the real family or close family members, particularly when family members requested to be given information on the progress or condition of the patient. However, nurses tried to delegate one family member to convey a message to the whole family if there were too many visitors for one patient. The findings in the current study indicated that the other reason that nurses requested a spokesperson for family was because of patient's safety due to the type

of patients that they admit, including some who have been assaulted by other family members.

Findings of the current study indicated that nurses play a liaison role in order to promote communication in the unit. Iverson, Celious, Kennedy, Shehane and Eastman (2014: 77-85) and Alberto, Zotárez, Cañete, Niklas and Enriquez (2014: 31-7) and Moretz and Abraham 2012: 106-109) attest to this notion by indicating that having a liaison nurse in the ICU has positive outcomes on the patient's recovery. It improves communication and education and decreases readmissions into the ICU. Thus there is satisfaction for all parties concerned. The development of the role of a liaison nurse was established in pediatric units due to staff shortages to prevent and minimise delays in treatment and deterioration in patients. Having a liaison nurse has the benefits of improved communication between the ICU and wards, nurses are able to integrate their knowledge, improves support for staff through educational opportunities in caring for complex ICU patients, maintains autonomy of practice and is satisfying professionally. However, it a responsibility that is challenging. Having liaison nurses can be of assistance in meeting family needs.

A study conducted by Slatore *et al.* (2012: 410-418) supports the notion of liaison by indicating that nurses' roles in the ICU is to be a translator nurses are there to clarify information given to family members and patients. Thus, it is important that nurses are present when doctors give information to family members so as to reinforce and answer questions the family might have after the doctors has spoken to them. Results of their study indicated that nurses felt that it was not their role to make decisions on medical issues that are related to doctors and they perceived their role as a translator where they can explain information to patients and family so that they can understand.

Promoting family support and comfort during the time of a crisis creates positive memories of an ICU, even if a family has experienced any loss. The FCC approach acknowledges support and comfort as essential when caring for an adult patient and their family (Wiegand *et al.* 2013: 60-8). Assisting the family and patient's well being lasts throughout their lives, as an experience in the ICU has a great impact and effect on the lives of such people. The experience does not only last during their stay in the ICU, but continues even years after. It is the nurse's role to ensure that their

experience is as pain free as possible due to the nature of the environment (Iverson *et al.* 2014: 77-85; Rippin *et al.* 2015: 80-98; Kourti, Christofilou and Kallergis 2015: 47-54; Wilson *et al.* 2015: 1317-1323; Gill *et al.* 2016: 1-16; Al-Mutair *et al.* 2013a: 135-144). Findings from the current study indicated that nurses acknowledged that family members should be given skills by giving information on relevant services that the family and the patient may need for rehabilitation. Nurses referred to these services as 'tools' to equip them so that they will also be able to help the patient at home.

Many nurses in the current study agreed that rehabilitation is essential for family and patient progress and satisfaction. Nurses reported that at times, they give information about other services that are available in the hospital. Thus, nurses referred the family to those services such as social services, counselling and rehabilitation services to ensure that they maintained the family's well-being. Maintaining family comfort promotes energy, reduces family anxiety and thus patients receive support from the family. This approach is supported by Cypress (2012: 53-64) who revealed that referring family to other services, being sensitive to their social being and encouraging the family members to receive support is essential. These factors form part of support family members can receive from nurses in the ICU. This is achieved through adequate and consistent communication (Cypress 2012: 53-64). Findings from the study conducted by Al-Mutair *et al.* (2013a: 135-144) revealed that family members were not informed of social services available in the hospital. Thus, family indicated that social services could be useful during a time of crisis. Levy and De Backer (2013: 2223-2225) maintain that a consistent family policy including social work, palliative and other counselling services should be implemented with flexible visiting policies in order to improve and enhance interaction, especially, during life saving procedures.

Negative effects of stress can be reduced by providing social support as a valuable resource for confronting stressful events (Noohi, Peyrovi, Goghary and Kazemi 2016: 150-158). Høghaug, Fagermoen and Lerdal (2012: 263-8) conducted a study on visitors' needs with regard to support, comfort, information, proximity and reassurance in the ICU. Findings were that participants from families with lower educational levels rated the need for support, comfort and proximity as more important than the participants with higher educational levels. The authors suggest

that nurses should be more knowledgeable about socio-demographic background as these can affect the family's perception of patient care and their needs. Findings concluded that nurses should be mindful when identifying the needs of younger people, females, and those family members with a low level of education. Hence, nurses should treat family members differently according to their socio-demographic background.

Critical care nurses can encourage families to utilise these services by giving adequate information on the importance of attending such professionals (Morton and Fontaine 2013b: 11). A study conducted by Wong *et al.* (2015: 51-63) indicated that family members felt supported when nurses identified the way they felt during their everyday visits. Family members perceived that nursing staff were concerned about their well-being because they were able to observe their emotions and dealt with them right there and then. Findings on the current study revealed that nurses referred family members to the social worker if the patient was a breadwinner or not working as this assists the whole family financially. Patients are happy if their family members receive support from the nursing staff (Baumgarten and Poulsen 2015: 205-214).

Family and patients in the ICU require more support from the nursing staff so as to prevent the symptoms and occurrence of depression and post-traumatic stress syndrome, particularly for families of patients that have died. Findings of this study showed that family members experience more anxiety and depression than patients (Fumis, Ranzani, Martins and Schettino 2015a: 1-12). A study done by McAdam *et al.* 2012: (386-393) revealed that providing support to family members such as coping strategies and emotional support should be part of ICU nurses' responsibility. This can be done through referrals, discussions and reassurance. Authors further indicated that home care and rehabilitation services should be provided to patients and families in order to individualise care. Therefore, nurses should collaborate with case management and social services. Consequently, families with mild depression were assisted with this kind of support and care. Findings in the current study indicated that nurses felt that family members should be educated on the patient's condition and be given guidelines so as to address family expectations. This is possibly done to reduce family anxiety and clarify misconceptions that the family might have. Identifying and prioritizing patients' needs can assist nurses to better

handle stress and reduce the negative reaction of stressors that are caused by the ICU environment, thus proper nursing interventions can be implemented (Wilson *et al.* 2015: 1317-1323; Akroute and Bondas 2016: 67-80; McAdam *et al.* 2012: 386-393; Hashim and Hussin 2012b: 103-111; Frivold, Dale and Slettebø 2015: 232-240; Carlson *et al.* 2015: 557-561; Karlsson, Bergbom and Forsberg 2012: 6-15)

Findings of the current study revealed that nurses acknowledge the important role family members can play in decision making. Participants indicated that family participation in decision making is their right as surrogate decision makers. Thus, findings indicated that participants give adequate and honest information to family members so that they will be able to make a sound decision. One participant indicated that her experience is that the doctors make the final decision and the family does not experience any involvement in making a decision. Findings further indicated that nurses also noted that they have a role in encouraging families to participate in decision making. The lack of patient involvement in decision making could be related to the nurses' experience in such an environment. Family support and considering the patient's treatment plan is more effective when routine family meetings are implemented. Family can also participate in patient care by being involved in decision making. Decision making is a complex procedure that promotes effective patient care.

Family meetings are held in the ICU, especially for critically ill patients. Constant input from patients and family is necessary to ensure that the needs of patients and family are met. Needs should be reflecting policies and their implementation in the clinical area. Ultimately, patients also want to be involved in their care including decision making. Being a passive recipient of care is not enough for patients in the ICU, they also want to become active partners by participating when their cognitive status is stable. The nature of the environment can contribute to patients' confidence in participating in patient care (Thyssen and Beck 2014: 585-592; Lindberg, Sivberg, Williams and Fagerström 2015: 294-302; Frivold, Dale and Slettebø 2015: 232-240; Giannini, Miccinesi, Prandi, Buzzoni, Borreani and The ODIN Study Group 2013: 2180-2187; Lind, Nortvedt, Lorem and Hevrøy 2012: 61-71).

Frivold, Dale and Slettebø (2015: 232-240) attest to this notion by revealing that the extent of family members involvement in decision making varied among family

members. Family members that were involved, indicated that they felt good when they were involved although they had no knowledge of medical activities, thus doctors had the power to make the final decision for the patient. Furthermore, the authors found that family members that were never involved in decision making had difficulties in understanding why certain procedures were not conducted on their loved ones. Thus, feelings of anger and sadness were experienced by family members. Nurses indicated that they encountered difficulties when family members did not want to face reality and recognise the serious condition of the patient.

The current study findings are contrary to the results of the study reported by Kuniavsky, van Heerden, Kadmon, DeKeyser and Linton (2014: 86-92) in Israel, who found that surrogate decision makers experience a burden when they have to make a decision for a patient in an ICU. These patients are not competent to make their own decisions, therefore, the court appoints someone to be the legal guardian for non-threatening procedures. Participants in this abovementioned study felt that was a burden since they required support. Findings concluded that participants perceived that they needed more support in the following areas: improved communication so that it is easier to understand the situation, identifying the patients preferences prior to admission in the ICU so that the family is aware of the patient's needs, and the health care team to be involved in the legal process so that challenges can be addressed.

A study conducted by Abou-Mrad, Mourad and Najem (2012: 95-99) in Lebanon revealed that the capacity of the family to make a decision may be influenced by a high prevalence of depressive symptoms when deciding on behalf of the ICU patient. Thus, the family cannot play the role of a protector because they also become vulnerable. Authors concluded that the family should have a psychiatric work-up and screening for depression. The screening should be individually based, meaning that those that qualify for treatment should have a score above 10 in the psychiatric work-up. In order to protect vulnerable patients, family members should be adequately assessed and treated. The PHQ-9 depression assessment tool can be used as the authors perceived its validity. Decision making and information sharing is vital as everyone concerned about the patient is involved, thus family views and ideas are considered.

According to the FCC approach in the ICU, family members have expectations of being active role players in decision making. Yet making a 'right' decision may become a burden on the member taking responsibility, especially, if the patient's wishes and preferences are unknown to family members. The family makes a decision for a patient when the patient's cognitive status is impaired. Family members have a major responsibility to make in ICU since most patients admitted in ICU are not fully responsive and they have limited time to adjust. Nurses in the ICU have a key role in assessing the needs that are related to shared decision making which can promote family comfort and confidence when making decisions. The decision making process has changed from paternalism to FCC where the care does not only involve the patient but the family also forms part of that unit in the care. Family participation in decision making in an ICU environment is very important since patients cannot advocate for themselves (Meert, Clark and Eggly 2013: 761-772; Azoulay, Chaize and Kentish-Barnes 2014: 37; Iverson *et al.* 2014: 77-85; Hashim and Hussin 2012b: 103-111; Huffines *et al.* 2013: 56-59). Akbari, Mofrad and Dabirian (2014: 312-315) indicated that nurses can use mapping of concepts in order to assist in decision making. Making a decision in the clinical setting, nurses keep the following in mind: patient's information, pre-existing knowledge, nursing care and experiential learning.

Langley, Schmollgruber, Fulbrook, Albarran and Latour (2013: 9-17) found that about 76% of respondents in their study indicated that they participated in patient care, while 35% revealed that they were involved in decision making. Findings further indicate that there were discrepancies in nurses' involvement in decision making. Nurses (39%) with ICU experience participated in decision making whilst those nurses (14%) that had no ICU experience were not involved in decision making. Nurses' involvement in the discussions showed that about 24% of respondents reported that they were actively involved in these discussions. 13% of nurses indicated that they were requested by the doctors to be involved in discussions during the end of life decision making process. Overall, 68% of respondents indicated that they experienced increased positive job satisfaction when involved in end of life decision making. The authors further state that 86% of respondents stated that it is essential that family members should be involved in decisions related to end of life. About 62% indicated that family members were already and has always been

participating in decision making. Findings also revealed that 90% of respondents without ICU experience compared to 82% with ICU experience favoured family members to be better informed before making a decision related to the end of life.

4.2.2. Family involvement in patient care as perceived by nurses in adult ICU

Nurses' attitudes towards family involvement in nursing care activities as part of FCC was significant in the current study. However, family involvement in patient care is one of the principles that enhances FCC. Hence, participants demonstrated different perceptions towards family involvement in nursing care activities. However, discrepancies were noted as most participants, particularly in unit A (surgical ICU) reported that families of patients in the ICU are not allowed to participate in patient care as opposed to a few participants who favoured family participation for high care patients. The majority of participants in unit B (medical ICU) reported that a family may be allowed to perform some nursing activities, depending on the patient's condition compared to a few participants that did not favour family participation.

Family involvement was reported to be based on the nurse's discretion and the patient's condition, if ever the family was given an opportunity to be involved at all. Participants that favoured family participation from both units indicated the following nursing activities that can be implemented by family members in the ICU: feeding, bathing with assistance, brushing the hair, massaging and applying cream, exercises and helping with turning the patient. However, participants in general recognised and acknowledged the important contribution family involvement can make in patient's well being. Consequently, this indicates that nurses' perceptions can hinder the implementation of FCC in the units. However, barriers in the nursing profession can be dealt with by engaging in evidence based practices such as the FCC approach. Ultimately, nurses in these units will require knowledge and skills on the strategies to involve family members so as to clarify any negative perceptions and attitudes when implementing family nursing.

Similarly, a study conducted by Kean and Mitchell (2014: 663-672) in the United Kingdom and Australia on nurses' perception of families in the ICU, found that ICUs in the United Kingdom treated family members as visitors, thus not involving them in patient care, whereas ICUs in Australia actively involved the family in patient care.

The authors further stated that family involvement allows the family to become resources and nurses can provide constant support to the family, and in turn the family can support the patient during times of acute phases of the illness. Furthermore, nurses also require support through specific strategies in order to ensure that FCC in adult ICUs are meaningful. Family presence shows positive benefits in relation to the patient and family's well-being (Longhmani, Borhani and Abbaszadeh 2014: 67-82). Al-Mutair *et al.* (2013a: 135-144; Longhmani, Borhani and Abbaszadeh 2014: 67-82) found that family involvement is one of the family needs that should be met in the ICU, as this shows support for the family during the patient's illness.

Rippin *et al.* (2015: 80-98) found that ICU nurses felt that the patient care in the ICU was very complex. This led to the view that family and patient needs may be in conflict and competing. Participants in the current study stated that family members are not involved in patient care, particularly the nursing routine, because family members might disconnect and fiddle with the patient's tubes and look at the patient's observation charts. Furthermore, participants' perceptions were that family could start spreading rumours about the patient's progress, thus nurses felt that there is nothing the family can do for the patient other than just be at their bedside.

On contrary, findings of the study conducted by Frivold, Dale and Slettebø (2015: 232-240) indicated that family members were satisfied with patient care because at times they were physically involved in patient care and they were also able to observe the nursing care as it was implemented by the nursing staff in the same room. A study conducted by Karnatovskaia, Johnson, Dockter and Gajic (2017: 106-111) revealed that family can cause more harm to the patient than good. The authors further showed that family can increase patient stress, thus causing more stimulation. However nurses suggested that a situation has to be assessed in order to protect the patient from psychological stress. This was indicated as the other strategy that can reduce a patient's emotional stress.

The aim of this study was to explore and describe nurses' knowledge, perceptions and experiences, however findings further revealed that family members were regarded as having no background knowledge and experience of the ICU. Al-Mutair *et al.* (2013a: 135-144; da Silva Barreto, Silva Marcon and Garcia-Vivar 2017: 633-

642) attest to this notion by revealing that nurses were “ignorant” towards the family’s presence in a way that the family was perceived as lacking ICU knowledge. Hence, families were considered not interested, neglectful and unpleasant, and were not welcomed in the unit. Frivold, Dale and Slettebø (2015: 232-240) indicated that nurses and doctors have medical knowledge and they are able to treat the patient with knowledge and experience, whereas family members have the personal knowledge and experiences of the patient. The authors further indicated that family’s expectations in relation to patient care is determined by their previous experiences.

Findings from the current study revealed that some nurses performed nursing care activities without encouraging or allowing family members to be involved. Moreover, participants reported that they ensured that the nursing routine is completed before a family visits the patient. Findings further indicated that nurses preferred family members to remain at the patient’s bedside without being physically involved, although participants’ regarded family members as being involved in the care by being at the bedside. Possibly, the reason for this could be due to the fact that nurses are keen to maintain the patient’s privacy and integrity. This is in line with findings from the study conducted by Blom, Gustavsson and Sundler (2013: 1-8) which revealed that family presence at the patient’s bedside meant that the family was involved in patient care. Family members reported that their presence made them feel that they were contributing to the patient’s progress in one way or the other. The abovementioned authors further stated that a family’s willingness to participate in patient care differed among family members.

Some family members preferred to remain at the bedside while others felt better being physically involved in patient care. The same study also reported that family participation depended on the nurses’ discretion. Family participation was encouraged but not consistent among nurses. A study conducted by Rippin *et al.* (2015: 80-98) also found that nurses in the ICU are reluctant to involve family in physical patient care, with participants saying that they had acquired training in family nursing but implementation was a challenge. These authors further recommend that more investigation is required so as to indicate the problem behind the inability of the nurses to practice family nursing. The study findings are contrary to the results of the study reported by Trajkovski, Schmied, Vickers and Jackson (2012: 2477-2487) who found that nurses involved family members by setting a

scheduled time for family to be involved in patient care, preferably during routine times. Family members were allowed to participate during the nursing routine times in order to promote patient and family relationships, thus 'bonding'. This study revealed that nurses also involved the patient's siblings and extended family in the patient care. This notion is well supported by da Silva Barreto *et al.* (2017: 633-642; Loghmani, Borhani and Abbaszadeh 2014: 67-82; Knutsson and Bergbom 2016: 33-41; Rippin *et al.* 2015: 80-98; Shirazi *et al.* 2015: 207-216) who revealed that family members of patients in the ICU were happy to participate in patient care because they were able to connect with the patient emotionally and physically, and thus communication was effective, and ultimately family members felt useful. Family members felt that being involved in patient care allowed them to do more than just assist in basic patient care, as they were given an opportunity to display their positive attitudes that they cared for their loved one. Therefore, support from the bedside nurse is important and essential.

Findings from the current study indicated that family involvement is mostly practiced in paediatric units so they have never experienced it in adult units. Consequently, a study conducted by Davidson (2013: 152-156) on family presence on rounds in neonatal, pediatric, and adult intensive care units, indicated that there is a greater assumption that adult ICUs prevalence of family participation in units or ward rounds is less than in the paediatric and neonatal ICUs due to the fact that families and parents are not visitors in these units. However, this study concluded that there is no survey available to indicate the prevalence of family presence and participation on ward rounds in adult ICUs or wards. Encouraging family presence during procedures is part of family involvement.

Findings in the current study revealed that participants excused family members to wait in the visitors' room during nursing procedures such as bedbaths, emergencies such as admissions, receiving theatre cases and resuscitation. Nurses ensured that a patient's privacy is maintained as findings demonstrated that at times, nurses are not sure of the relationship of the patient and that particular family member. This notion is well supported by Akyüz and Erdemir (2013: 660-671) who indicated that patients as participants agreed that privacy during nursing procedures was maintained and it was important to them, for instance during dressings. Furthermore, nurses perceived that patient integrity was important to maintain for the patient, thus,

nurses requested family members to leave the room whilst they were busy with the patient, especially during activities such as bathing or changing bed linen.

The same authors indicated that visitors' rooms were not adequate to provide family confidentiality and privacy, thus, nurses felt that meeting family needs was not adequately attended to due to the lack of infrastructure. A study conducted by Loghmani, Borhani and Abbaszadeh (2014: 67-82) indicated that nurses revealed that their nursing routine was disturbed when families came outside the stipulated visiting hours and this also threatened their privacy. A study conducted by Levy and De Backer (2013: 2223-2225) revealed that nurses requested family members to leave the patient's bed during their procedures. However, this study further revealed that nurses felt that they also needed support in this regard. This is because they felt that family members' behaviour was disruptive at times. A study conducted by Rensen *et al.* (2017: 77) indicated that family participation in patient care was ranked as very important. However, maintaining privacy and providing the waiting room for family members was ranked as second important.

A study conducted by Zeilani and Seymour (2012: 99-107) on Muslim women's narratives about bodily change and care during critical illness found that maintaining privacy was very crucial for them because culturally women are supposed to be cared for by a nurse of the same gender as the patient in order for the patient to feel safe and respected. The abovementioned study also indicated that participants felt that they lost control of their independence and their bodies because they could not help themselves with basic activities of daily living. Authors indicated that patients reported that they wished to have their families for support, especially because their communication was impaired during their critical illness (Zeilani and Seymour 2012: 99-107). Allowing family to witness procedures such as resuscitation in adult ICUs is still a controversial issue (McLaughlin 2013: 20-25).

Frivold, Dale and Slettebø (2015: 232-240); Sak-Dankosky, Andruszkiewicz, Sherwood and Kvist (2015: 2595-2608) asserts that a set of standardized guidelines should be put in place so as to provide guidance and a sense of security for nurses when implementing supportive care. Al-Mutair *et al.* (2013c: 1805-1817) further assert that nurses in an ICU require written policies that can be used as guidelines during procedures such as family presence during resuscitation and invasive

procedures. Hospitals can do their part in promoting best practices to enhance FCC by putting in place the appropriate policies (Cockcroft 2012: 105-110). A study conducted by Fridh (2014: 306-311); Olausson, Ekebergh and Lindahl (2012: 176-184) indicated that allowing family to be with the patient during death and an emergency situation is important. This is well supported by open visiting hours enabling the family to have enough time to spend with the patient during the last hours of life. However, privacy still poses a challenge in an ICU where family, patients and fellow patients require privacy. The design of the ICU should include private rooms for visitors in order to provide privacy. Rippin *et al.* (2015: 80-98); Akroute and Bondas 2016: 67-80) states that allowing and encouraging family participation in patient care promotes nurses' understanding of how to implement FCC. In addition, the family is able to provide adequate support even after discharge as their needs have been met. Ultimately, to involve family in patient care enhances holistic care.

The current study found that participants reported that staff shortage and time management are some of the things that they experienced as challenges in the ICU, thus, limiting their involvement of family in patient care. This is in line with the studies conducted by Akyüz and Erdemir (2013: 660-671); Loghmani, Borhani and Abbaszdeh (2014: 67-82); Matlakala and Botha (2016: 49-57) who found that ICU nurses face the challenge of staff shortages, which hinder the implementation of patient care, hence, quality care. The authors further stated that staff shortages lead to institutions employing agency nurses to care for ICU patients. Matlakala and Botha (2016: 49-57) found that family satisfaction in ICUs was lower due to the high patient to nurse ratio. Such a ratio means that there is less time and increased workload and patient care is neglected. This leads to fewer chances to include the family in their care or interact with them. Quality patient care can be influenced by the nursing shortage, especially in ICUs. An underlying cause could be the inability of institutions to retain nurses, and secondly, it could be due to working in a stressful environment that leads to the development of post-traumatic stress disorder (Mealer, Jones and Moss 2012: 1445-1451).

The quality of patient care can be affected by nursing shortages, especially in the ICU environment (Mealer, Jones and Moss 2012: 1445-1451). Staff shortages hinder the promotion of FCC. Nurses find it difficult to support families and at the same

time, implement other nursing duties; ultimately it creates increased stress levels. Thus, the quality of care can be compromised by staff shortages (Matlakala and Botha 2016: 49-57; Loghmani, Borhani and Abbaszadeh 2014: 67-82). Staff shortages is a worldwide issue according to Smith, Ayele and McDonald (2013: 363-368) who conducted their study in Ethiopia. According to Loghmani, Borhani and Abbaszadeh 2014: 67-82) nurses experience difficulties in the clinical area such as staff shortages, lack of time, lack of skills and increased workload which leads to their inability to support families. This affects the delivery of FCC. Results indicated that nurses were not happy with the health delivery system because of the shortage of staff as the quality patient care is compromised. This is in line with the study conducted by Trajkovski *et al.* (2012: 2477-2487) who indicated that time constraints are a challenge when involving the family. Time may be limited in the ICU for nurses to provide both treatment and give support to the family which may lead to role constraints and conflict (Schubart, Wojnar, Dillard, Meczowski and Kanaskie 2015: 315-321).

Findings of the current study revealed that nurses had knowledge on FCC but they lacked confidence on the care they delivered for the patient because one participant reported that family members may feel that nurses are jeopardizing patient care if they observe different ways of implementing nursing care activities. Some participants felt intimidated by a family presence during nursing routines because nurses felt family members might have misconceptions about patient care. A study done by Blom, Gustavsson and Sundler (2013: 1-8) supports the notion that family members felt at ease when they trusted the care that the patient was receiving in the ICU when they were present during the nursing routine. Findings of the current study revealed that junior nurses are unable to make their own decisions due to lack of experience and confidence in such an environment, hence they always rely on the senior nurses for direction and supervision.

This abovementioned finding is supported by Trajkovski *et al.* (2012: 2477-2487) who indicated that nurses become more confident with more experiences received because they are able to accomplish daily duties and attend to the social needs of family members. Authors further indicated that nurses also gain experience, skills and confidence in the care they deliver by involving the family because they also give reasons to the families for doing things. However, junior nurses reported that

they only involve family members when they felt ready to do so. Nurses indicated that family has become an important part of the patient over the past years in the ICU. This is because junior nurses focus more on the patient as they are still learning and grasping what is important for the patient. A study conducted by Al-Mutair, Plummer, Clerehan and O'Brien (2013b: 185-195) revealed nurses' experience in ICU play a big role as nurses that are new and have less than one year's experience are considered junior in ICU and may not consider family support as important. This was reported to be due to an awareness of the necessary support that family may require, whereas the experienced nurses ranked family support as less important. Similarly, Voldbjerg, Grønkjaer, Sørensen and Hall (2016: 1751-1765) conducted a study on newly graduated nurses' use of knowledge sources. Their study revealed that newly qualified nurses find it difficult in clinical areas where expectations are high because of their lack of knowledge. Moreover, time constraints may lead to a lack of confidence. This can then contribute to an unfavourable environment to exercise critical thinking skills in the decision making process.

However, findings in the current study revealed that some nurses favoured family involvement in patient care, especially with high care patients. Nurses preferred the following care activities to be performed by family members with nurses' assistance: feeding, combing hair, massaging feet and bathing. Family members were given an opportunity to choose activities that they were comfortable with, thus individualising patient care, with the availability of nurses help and support. Family participation enhances collaboration between nurses, patients and families with the aim of promoting optimum outcomes for patient and family. Patients in the ICU are not in the position to fully participate in their care. Family members can be included in patient care as they are a natural extension of the patient. Building a relationship between families, nurses and patients can be enhanced during family involvement in patient care and in this way patient quality care can be promoted (Al-Mutair *et al.* 2013c: 1805-1817).

Nurses can support and help the family to adjust in the ICU environment by encouraging involvement in patient care and reducing stress levels. The same authors concluded that nurses acknowledged that patients cannot be cared for in isolation. Thus, family members are not just visitors but should be allowed to participate in patient care. Furthermore, nurses can assist in redressing an

unbalanced relationship that can develop between the family and the nurses by understanding the family as a whole and promoting family participation in patient care. Implementing the concept of FCC requires leaders with a vision and who understand the value and significance of involving the family (Moretz and Abraham 2012: 106-110). A study conducted by Loghmani, Borhani and Abbaszadeh (2014: 67-82) revealed that nurses showed that patients that are long term, family members are encouraged to be involved in physical care, such as rubbing the patient's hands or feet.

A study done by Cypress (2012: 53-64) indicated that guidelines that are evidence based are required to be established by looking at the assessments of nurses' beliefs and attitudes towards the benefits of the families' contribution to patient care. Families' contributions to critical care has been understudied and thus, nurses should participate in such studies in collaboration with other health care team members to find ways that can enhance family involvement in all aspects of patient care.

4.2.3. Nurses' experiences towards family presence in adult ICU

Families experiences in the ICU environment as experienced by nurses in an adult ICU was identified as the other finding that emerged in the current study. Morton and Fontaine (2013a: 11) indicated that the nurses' first encounter with family members in an ICU is crucial because it assists in the development of a nurse-family relationship. Ultimately, this relationship is based on trust and respect. The authors (Morton and Fontaine 2013a: 11) further state that the minutes that follow, the nurse can then start to learn and understand the relationship between the patient and family members. Thus, the nurse's primary goal is to assist the family in dealing with the situation at hand. In addition, the nurses will establish a trusting relationship through continuous information given to family members. Consequently, the ICU is an environment where two worlds meet, the professional world for nurses and the uncertain world for the family.

Findings of the current study revealed that nurses' experiences with regards to a family's presence in the ICU environment is that they are very scared and remain emotional and anxious. Thus, according to the findings, a family experiences feelings

of uncertainty in relation to the ICU outcomes. Increased family stress levels produces emotions that nurses have experienced as the family's inability to cope with the situation. This is evidenced by nurses in the current study who reported that family members would become very emotional and scared at the patient's bedside. Therefore, nurses felt that the family is too fragile and vulnerable to be involved in patient care.

The results are congruent with the study done by Abuatiq (2014: 3-10) who revealed that nurses find it difficult to interact with family of the patients in ICU. In such cases, the family is perceived as very emotional and having preconceived ideas without their needs being identified and communicated. In the current study, several nurses reported that there is not much information that could be discussed with a family because the family gets so emotional and anxious. In addition, nurses reported that family members are even scared to verbalise or ask relevant questions so they just follow the instructions that are given by the nurses. The reason for this could be that their needs are not properly identified or that family members are very overwhelmed in such an environment. This could contribute negatively to the perceived patient outcomes by family members. This notion is well supported by Blom, Gustavsson and Sundler (2013: 1-8) who also found that family members of patients in the ICU are uncertain about the patient's chances of survival, hence, they rely heavily on nurses for support as they are vulnerable.

Magesh, Darolia and Singh (2014: 50-52) found that increased anxiety and confusion about the condition and prognosis of a patient may lead to a negative attitude and perception about ICU treatment. Lack of knowledge about the ICU, inadequate information on the patient's condition given by staff and fear of death of a loved one may cause uncertainty. Consequently, the ICU environment has a stigma that is associated with it; family members of patients in ICU perceive that once their loved one is admitted, the chances of survival are slim. There is an increasing need for education regarding the ICU environment in general to the family. Several studies (Baumgarten and Poulsen 2015: 205-214; Kourti, Christfilou and Kallergis 2015: 47-54; Au *et al.* 2017: 132-136; McAdam *et al.* 2012: 386-393; Kumari and Das 2015: 337-340) have shown that admission of a patient to the ICU produces symptoms of anxiety, depression and post- traumatic stress disorder.

When a family member is admitted, especially in ICU, it becomes stressful for all the family members. This may be referred to as a health crisis. Being unprepared for the admission of a critically ill patient may be emotionally and physically draining for the family. Admission to ICU is always sudden, so this leaves less time to assess the family of the patient and has an immediate impact on the family. Thus, the family may experience feelings of uncertainty and anxiety (Frivold, Dale and Slettebø 2015: 232-240; Rippin *et al.* 2015: 80-98; Kourti, Christofilou and Kallergis 2015: 47-54). The authors further indicated that at times, this anxiety and depression persist despite the patient's condition. This is partly due to the fact that the mortality rate of patients in the ICU is high, about 12%-17% (Obringer, Hilgenberg and Booker 2012: 1651-1658). Nurses in the current study, revealed that family are scared of the monitors and the name of ICU more than anything else because of the perception that the ICU has a high mortality rate. This notion is well supported by results from the study conducted by Kisorio and Langley (2016b: 57-65) which revealed that family members that were willing to participate in physical patient care were afraid of the machines, lines and tubes that are connected to the patient.

In the ICU environment nurses need to take responsibility of identifying stressors. The ICU environment is complex because of the patient's health problems, therapy and the environment. Thus, it is different from other hospital settings. A family's coping abilities may be over stretched as there are multiple and persistent stressors. A single stressor cannot cause a strain that is excessive, however, it may become unbearable for the family to make an accurate decision for the patient. This may be the cause of severe psychological distress. Nurses should manage stressors when delivering patient care as the ICU environment is considered stressful and it can produce negative reactions which may be associated with the patient recovery process. Recognising the importance of how care is given and delivered to the critically ill patient creates an environment conducive to healing (da Silva Barreto *et al.* 2017: 633-642; Frivold, Dale and Slettebø 2015: 232-240; Kisorio and Langley 2016a: 30-38). Infrastructure, the design of the patient's room accompanied by caring attitudes of nurses goes a long way toward promoting the patient's well-being and satisfaction with care. Caring also demonstrates respect for the patient's needs, which creates an experience that is vital in the ICU (Olausson, Lindahl and Ekeberg 2013: 234-43).

Committed and educated critical care nurses are essential for an improved ICU environment, including advanced equipment. This is because a patient's prognosis and their family's well-being can be affected by a variety of environmental factors in the ICU (Iranmanesh *et al.* 2014: 290-297). Furthermore, family members of the ICU patient experience a great amount of stress due to uncertainty. This stress may lead to confusion and anxiety. Family members may experience feelings of imbalance where they are frightened by the highly technological environment and the nursing staff that are too occupied with the patient to inform them of anything. This may cause even more uncertainty (da Silva Barreto *et al.* 2017: 633-642).

A study conducted by Olausson, Ekebergh and Lindahl (2012: 176-184) revealed that the design of the room in ICU can be a challenge for family members when they want to be close to the patient. This leads to a situation where family members find it difficult to connect with the patient. In addition, a study conducted by Johansson, Bergbom, Wayne, Ryherd and Lindahl (2012: 269-279) revealed that the design of the patient's rooms did not offer adequate sound proof. The abovementioned study further showed that some participants (patients) in their study indicated that they experienced sounds that were frightening. Moreover patients could even hear nurses discussing other patient's conditions. These patients revealed that they were forced to hear sounds that were disturbing at times, however they had no choice because there was a thin fabric curtain that separated the rooms that were shared between two patients.

Olausson, Lindahl and Ekebergh (2013: 234-43) support the above finding by stating that a patient's room should enhance patient and family's trust and feeling of safety by having life saving equipment and interacting with the nursing staff. Contrary, a study by Stayt, Seers and Tutlon (2015: 2051-2061) revealed that patients feel lonely and invisible in the presence of ICU equipment. However on the same abovementioned study their results also showed that some patients indicated that they are reassured with ICU equipment because they also learn as nurses care for them. A study conducted by Wiegand *et al.* (2013: 60-8) and McAdam *et al.* (2012: 386-393) revealed that nurses are the ones that are in most contact with family members and patients in the ICU, therefore orientating and assisting them is crucial. Hence, the patient and the family members are vulnerable in their time of crisis.

A study conducted by Kohi, Obogo and Mselle (2016: 18) in Tanzania is in line with the above findings. Their study indicated that the anxiety and stress that is associated with the ICU environment and the machines around the patient showed a significant association. The authors indicated that this could be due to the fact that many adult participants in their study had only a primary education or less, meaning that they could not follow the instructions that were given in ICU, which were also written in English. In this study, the majority of patients admitted into these units are Zulu speaking. Increased anxiety levels for families may be due to the realities of the environment including the complexity of the information, the inability of families to understand and the uncertainty may lead to frustration and distress (Carlson *et al.* 2015: 557-561). According to Frivold, Dale and Slettebø (2015: 232-240) and Au *et al.* (2017: 132-136) family members may appear to be suspicious and confused but this is because they are in a challenging position as their loved one is in a critical situation. Family members are also stressed because patient outcomes are unpredictable. Changing the ICU environment, thus creating a family friendly environment can lead to changing and improving the outcomes that are related to aspects of staff performances (Hartog and Jensen 2013: 1650-1652).

Reassurance is the experience of being encouraged in order to have the strength for the expected outcomes. Reassurance and support is one of the principles that enhance FCC in the ICU. Family members of a patient in the ICU want to know that their loved one is cared for as a person. Comfort and support that is given to the patient by nurses gives reassurance to the family. The family prefers to be informed on everything such as treatment and care of the patient, even the technical issues. The family wants to be assured that nurses and doctors are doing their best and that they will not cause unnecessary suffering. Reassuring the family does not mean that the family is happy to receive false hope about the patient's recovery if their recovery is not going to happen. Demonstrating a caring attitude is more effective than spoken words, especially, when issues of death and dying arise (Lindberg *et al.* 2015: 294-302; Akroute and Bondas 2016: 67-80; Noame *et al.* 2016: 56-64; Kohi, Obogo and Mselle 2016: 18; Meert, Clarke and Eggly 2013: 761-772). On the contrary, a study conducted by Høghaug, Fagermoen and Lerdal (2012: 263-8) indicated that assurance was rated lower among the older family members. Findings in the current study indicated that establishing rapport, orientating the family, explaining the

equipment and allowing them to perform simple tasks in the environment, will encourage them and enhance hope as they perceive the best care is being provided for the patient. Thus, family members will be reassured that their loved one is receiving the best care possible.

Findings further indicated that nurses reported that they provide reassurance to family members as it reduces anxiety. Notably, participants further reported that family members have increased hope and strength once they are reassured. This study is in line with study conducted by Wong *et al.* (2015: 51-63) which revealed that a family was reassured when nurses gave them information on things they wanted to know about the patient because this gave them an indication of what to expect. Open and honest information allowed the family to adapt and cope with the situation. Moreover, doctors and nurses met this need for reassurance in the ICU. In a study conducted by Hashim and Hussin (2012b: 103-111) conducted in Brazil, the authors attest to the above findings by reporting that information and reassurance were identified as important family needs in the ICU.

A study conducted by Obringer, Hilgenberg and Brooker (2012: 1651-1658) revealed that family members felt that during hospitalisation, other hospital services were not as important as reassurance. This study recommended that nurses should take the initiative in identifying family needs and be engaged in evidence based practices in order to meet those needs. Al-Mutair *et al.* (2013a: 135-144) found that family members need reassurance as it gives them hope. The authors further stated that honest information gives reassurance to family members, including non-verbal cues. Hence, nurses are in the best position to meet family needs at all times in ICU (Hashim and Hussin 2012a: 12-23). Family members perceive nurses as having a positive attitude when they maintain assurance. This includes body gestures such as maintaining eye contact and different positive facial expressions. Motivational words and effective communication are considered essential by family members as this strengthens their coping skills, and family members trust the care that is given by the nursing staff. Despite the patient's condition, family members felt that hope and reassurance kept them going.

It is the responsibility of nurses to display understanding and acceptance of family members and the patient. This involves reassuring the family that the interventions

used to control and minimise the illness are adequate and informing the family of what to expect in this regard (Urden, Stacy and Lough 2012: 3). Nurses reported that giving honest and repeated information to family allows the family to deal with the situation as it is and not being led to have false hope, especially regarding dying patients. Findings of the current study indicated that participants revealed that family members are reassured when they see what is being done to the patient and this gives them hope as they establish trust, rapport and a 'working relationship with nurses'. A study conducted by March and Bosch (2013: 53-75); Noome *et al.* (2016: 56-64) and Huffines *et al.* (2013: 56-59) is in line with the above findings by concluding that family members are highly satisfied with the care that is provided in the ICU by the nurses of critically ill patients. Findings indicated that quality patient care led to patient, family and nurses satisfaction.

According to the participants, family members provide support to the critically ill patient by being close to them. To be physically close or near the patient was highlighted as a finding in the current study. Participants reported that family members were given an opportunity to remain at the patient's bedside. Nurses indicated that being close to the patient is one of the family needs that have to be met in the ICU, hence, family proximity is part of FCC components. This is in line with the study conducted by Al-Mutair *et al.* (2013a: 135-144) which revealed that family members wished to remain close to the patient as they gave love, comfort and hope to the patient. The current study revealed that visiting times would not permit family to spend as much time with the patient as they would like to from a proximity point of view. This is particularly difficult for family members that visited from far away places.

In the current study, nurses reported that they encouraged family members to touch and talk to the patient even though the patient may be ventilated and unresponsive. Furthermore, some participants revealed that other family members appear distressed and scared, thus they felt that they would 'hurt' the patient by touching them. This is in line with the studies done by Al-Mutair *et al.* (2013a: 135-144) and Kisorio and Langley's (2016b: 57-65) which indicated that family members are scared of the ICU environment and are worried that they are going to hurt the patient because of the equipment and tubes that are connected to the patient. This is one of the reasons nurses reported that it is a challenge to involve family members as

patients in the ICU are connected to so many things such as infusions and screens. Findings revealed that nurses should provide supervision, which would be appreciated by family members. Al-Mutair *et al.* (2013a: 135-144) revealed that as much as the patient's family desired to be close and be involved with the very sick patient, they were uncomfortable to do it as the family felt they would 'harm' the patient.

Participants from the current study indicated that a family's presence at the bedside encourages the patient to be strong and fight harder to get better. Their presence facilitates love and hope. McAdam *et al.* (2012: 386-393); Frivold, Dale and Slettebø (2015: 232-240) found that nurses encouraged family members to remain close to the patient and to touch the patient. A sense of safety was created as the nurses ensured that they orientated the family to the environment, thus the environment was calm and warm. A study conducted by Karlsson, Bergbom and Forsberg (2012: 6-15) revealed that the patient's condition indicated that nurses are required to be present at the bedside the whole time for close monitoring. At the same time, as much as the patient feels safe with the nurse's presence, it also brings challenges when the patient is unable to communicate sensitive issues with the family members and friends. Consequently, this means that the patient has to hold back important information from sharing with family members.

Nurses' experiences towards family presence in adult ICUs further demonstrated that family members and the patient are able to share memories which can promote 'patient recovery' because the patient can gain more strength to carry on. This notion is supported by Engström *et al.* (2013: 88-95), their study was on people's experiences of being mechanically ventilated in an ICU. The findings of the abovementioned study revealed that patients indicated that they had memories during the time when they were ventilated and sedated. However, some participants indicated that they couldn't remember what they were doing when they were ventilated and sedated. A study conducted by Ågård, Egerod, Tønnesen and Lomborg (2012: 105-13) indicated that patients that survived the ICU reported less psychological trauma, and instead, they reported a sense of happiness that they survived the ICU but could not recall the events of ICU. They indicated that being reconnected with their partners and family members was the most important thing that could have ever happened. Findings from the current study showed that patients

in the ICU can improve their conditions because of the hope and support that they receive from their family members when they are with them in the ICU.

A study conducted by Kisorio and Langley (2016a: 30-38); Karlsson, Bergbom and Forsberg (2012: 6-15) revealed that family members felt and experienced the pain and suffering that the patient was enduring. This family suffering promoted a bond between family members. Thus, family members were ensuring that their loved one received the best care, as they protected the patient by observing what the nurses were doing with the patient and if they were making the correct decisions. Kohi, Obogo and Mselle (2016: 18) conducted a study on the perceived needs and level of satisfaction with care by family members of critically ill patients at Muhimbili National Hospital intensive care units in Tanzania. The study revealed that more females than males favoured being at the patient's bedside. However, the explanation for this was that the household is taken care of by the wife or mother, especially when ensuring that the health of families and children are maintained.

In addition, families experienced the feeling of being connected and togetherness. Patients felt that their family members cared too much for them because they became too protective, and did not allow them to resume their roles at home as family members felt responsible for ensuring that the patient does not get sick again. Thus, nurses have the responsibility to facilitate this type of support because togetherness promotes strength and support (Abdalrahim and Zeilan 2014: 570-577; Frivold, Dale and Slettebø 2015: 232-240; Al-Mutair *et al.* 2013a: 135-144). Findings in the current study indicated that during critical illness, the patient can fight even harder by knowing that the family cares about them.

Findings further indicated that a patient can feel much better by knowing that their family members came to support them. Participants indicated that a patient can recognise this by the family's conversation at the bedside, smell of their perfumes and touch, therefore, it promotes a sense of love. Hence, most patients in the ICU are unconscious, sedated and unresponsive. The presence of families at the patient's bedside enhances communication and the family members are able to convey the patient's needs to nurses. However, patients in the ICU find it difficult to communicate their needs since they are intubated and ventilated (Abuatiq 2014: 3-10).

Findings in the current study were that nurses encouraged the family to be present when the patient is dying because they felt that it is important for both the patient and family. Findings revealed that nurses had to be flexible with family visits and this was evident by nurses allowing the family to be with the patient even at night, especially, when the patient is dying. These findings are congruent with the study conducted by Kohi, Obogo and Mselle (2016: 18) who reported that family members perceive their last moments with the patient as very important and they would do anything to be with the patient. Results indicated that family members ranked the need to be called at home when the patient's condition changes as important. The authors further explained this as due to the fact that families in the African culture prefer to spend the last moments with the patient (Kohi, Obogo and Mselle 2016: 18).

This is because many people do not make wills, so families would hope that during that moment the patient might give important information. Thus families consider the patient's last moments as important and serious. Bloomer, Endacott, Copnell and O'Connor (2016: 5-11) attest to the above finding, as their study revealed that families are allowed to spend more time irrespective of the visiting hours. This happens when a patient who is a child died and then a family is granted flexible visiting hours. Wiegand *et al.* (2013: 60-8) showed that family members should be supported by nurses during the death process. In their study, Kisorio and Langley (2016a: 30-38), revealed that nurses encouraged family members in direct patient care during the patient's death. This was done to promote family comfort and a feeling of fulfilment.

According to Frivold, Dale and Slettebø (2015: 232-240) family members feel relieved by being close to the patient during a critical illness. Results indicated that family members felt empowered by the flexibility of visitation, when allowed to be with the patient for as long as they needed. Being welcomed into the ICU created feelings of safety and security as family members are able to maintain control because their anxiety levels are minimised by observing the delivery of patient care. Participants from the current study indicated that family proximity contributes greatly to patient's psychological recovery. The findings of this study were in agreement with literature from Levy and De Backer (2013: 2223-2225); Knutsson and Bergbom (2016: 33-41) which revealed that a family presence at the patient's bedside was essential and nurses encouraged family members to visit patients. Moreover, results

demonstrated that being close to the patient was an important way to support the patient, therefore it is imperative that family members feel that they are recognised in the ICU. Al-Mutair *et al.* (2013a: 135-144) found that family members wished to remain with the patient for extended periods of time but this was difficult because of the restricted visiting time; even though they came from distant places, they were asked to leave when visiting time was over. Facilities were not adequate since there was no waiting room for visitors. Results revealed that family members felt that there could be adverse developments in the patient's condition if they were not present.

Physical presence gives the patient and family an opportunity to be together (Frivold, Dale and Slettebø 2015: 232-240). This also allows the family to satisfy their need of knowing that their loved one is being cared for. Flexible visiting hours enhance the facilitation of meeting the needs of being near the patient, therefore, it increases patient support. Nurses have to maintain a balance between providing nursing care, allowing the family to be involved, and maintaining the patient's integrity at the same time. Protecting the patient's integrity is the nurses priority and visitors are limited or restricted (Al-Mutair *et al.* 2013a: 135-144; Giannini, Garrouste-Orgeas and Latour 2014 730-733; Kumari and Das 2015 337-340; Moretz and Abraham 2012: 106-109). Being there physically and actively for the patient has shown to promote patient safety and patients tend to respond positively to the family's support (Kisorio and Langley 2016a: 30-38; Karlsson, Bergbom and Forsberg 2012: 6-15). According to Magesh, Darolia and Singh (2014: 50-52) family presence in the ICU is gaining recognition with potential positive outcomes such as positive attitudes of those that are involved. Thus, a protocol on family presence should be implemented.

Family providing support to the patient such as love and a sense of security emerged as another finding for this study. Family integrity and function can be affected by the illness of a family member; the whole family is affected because a family unit is an integrated system. A study conducted by Liamputtong and Suwankhong (2015: 263-271) on women living with breast cancer indicated that women that were diagnosed with breast cancer considered social support from family members as important, be it the children, a spouse or parents. This included family being engaged in different forms of support such as household chores and other responsibilities. Support that participants received from family members uplifted their emotional status and therefore they were able to maintain hope.

Findings from the current study further revealed that family members of patients in the ICU form an integral part of the patient, supporting the patient and forming a unit. Consequently, findings showed that patients in the ICU feel lonely and isolated as the environment is 'strange'. This notion is supported by the study that was conducted by Al-Mutair *et al.* (2013c: 1805-1817); March and Bosch (2013: 53-75) and Wilson *et al.* (2015: 1317-1323). The results revealed that patients in the ICU are part of the family unit and family members were viewed as important figures for the critically ill patient. Their involvement was encouraged and viewed as positive. Thus, the family deserves to be near or be with the patient. Lind *et al.* (2012: 61-71) indicated that families of patients in the ICU have the desire to protect the patient thus respecting their wishes and values. Hence, the patient's ability to communicate in the ICU is limited thus the patient is unable to make a decision. Then this responsibility falls onto the family members (Lindberg *et al.* 2015: 294-302)

A study conducted by Balasubramanian (2013: 89-92) attest to this finding by revealing that 48% of severe anxiety in patients admitted in the adult ICU is due to isolation. According to Magesh, Darolia and Singh (2014: 50-52) there is still a stigma attached to the word 'ICU'. This leads to the perception that the ICU has a high mortality rate of patients admitted to such an environment. On the contrary, a study conducted by Engström *et al.* (2013: 88-95) revealed that patients in their study indicated that tubes and lines were uncomfortable but they felt calmer than they had expected about the medical staff and the ICU environment, thus, patients felt safe. Family members ensured that they received emotional and physical support in order to maintain family stability during a health crisis (Smeltzer *et al.* 2010: 103).

Smeltzer *et al.* (2010: 103) further stated that the family has five functions which ensure essential growth of each member, namely; management which involves decision making, managing finances and the use of power and family roles; setting boundaries which is the ability of the family to assign roles within the family structure; communication within the family which is about direct, clear and meaningful understanding among its members and education and support through skills that family members learn within the family which allow them to care for and love one another, which in turn, promotes health stability. The last function of the family includes socialisation where family members are taught norms within the particular family and acceptable behaviour in society. Determining the family structure during

their assessment by nurses, promotes coping strategies especially, if the family requires additional assistance (Smeltzer *et al.* 2010: 103).

According to Morton and Fontaine (2013a: 29-32) patients in the ICU cope well with their critical illness through family support. Family members of the patient in ICU know the patient's past and present, and therefore, the patient relies heavily on them for support. In addition, family members know the patient better than the nurses and therefore the patient receives unconditional love from family members. Furthermore, family members can assist the patient by being personally and physically involved in patient care, which allows the nurses to understand the patient as a person from family members particularly, for unresponsive patients. With such an experience of the ICU environment, the patient is confident that their whole being is understood even if only a little is shared about them. Ellis, Gergen, Wohlgemuth, Nolan and Aslakson (2016: 39-45) indicated ways that the family use to provide patient support in the ICU such as being with the patient, providing emotional support, being present during rounds and being involved in simple tasks. Nurses ensure that families that are supportive are encouraged to participate in patient care because they perceive family members as motivators that help the patient reach a set goal.

Findings from the current study indicated that patients in the ICU are happy and feel at ease when the family is around because of the complexity of the ICU environment. Participants reported that family members are able to share special moments with the patient that nurses cannot offer such as comfort, love and belonging, hence they had shared a life before ICU admission. This contributes greatly to the patient's psychological well-being. The study's results are congruent with the study conducted by Engström *et al.* (2013: 88-95) who indicated that patients in adult ICUs were satisfied with the family visiting as they felt supported, especially, the emotional aspects of care that the nursing staff couldn't provide for the patient. Family members reported that they were able to communicate with the patient. In addition, patients felt at ease when nurses supported their loved ones that came to visit. This is because family members of patients in the ICU indicated that they get physically exhausted, trying to find a balance between their ICU experiences and caring and supporting the critically ill family member.

Family as a source of information forms part of the family providing support to the patient, hence, it emerged as a significant finding in the current study for patients that were admitted into the ICU. Several participants shared the view that family members provide crucial information about the patient's history. The findings further indicated that nursing staff in the ICU who care for the critically ill patient, may need vital information to improve a patient's health status and survival. Families of patients are in a position to provide such information (Wilson *et al.* 2015: 1317-1323). Participants further stated that some of the patients that they receive in the ICU are unidentified and unresponsive and it becomes difficult to identify and meet the needs of that particular patient and family. Due to the fact that the patient is unable to participate in decision making, family members become surrogate spokespeople and decision makers (Gill *et al.* 2016: 1-16; Al-Mutair *et al.* 2013a: 135-144).

Studies conducted by Gill *et al.* (2016: 1-16); Wilson *et al.* (2015: 317-1323) and Al-Mutair *et al.* (2013a:135-144) found that family members of a patient in the ICU provide nurses with information about the patient, thus nurses learn more about the patient through the patient's family. The current study's findings are congruent with the abovementioned studies . Nurses in the current study reported that they try by every means possible to get hold of the patient's family, particularly when the patient is unidentified. However, nurses indicated that by interacting with family members they are able to get the patient's history including the patient's feelings, previous illnesses, likes and dislikes. This assist the nurses to care for the patient holistically.

Nurses recognise that the family is valuable in the ICU, as they paint the whole picture of the patient; the family provides all the information that allows nurses to plan individualised care. Nurses get the opportunity to gain knowledge on the patient's interest and hobbies thus the patient can be cared for as a person (Wilson *et al.* 2015: 1317-1323). Frivold, Dale and Slettebø (2015: 232-240) attest to this notion by reporting that family members feel that they contribute significantly in patient care by giving nurses and doctors important information about the patient's history. Results in this study indicated that nurses and doctors have a background in medical knowledge so they are able to care for the patient, while families have personal knowledge about the patient to formulate a plan of care.

Findings in the current study reported that family members use different coping strategies, including: spirituality, religiosity and cultural rituals to cope in ICU, especially, during critical illness. Culturally, nurses reported that family members believe that the patient's illness may be caused or related to the ancestors as some families burn incense (impepho) to collect the 'spirits'. Religiously and spiritually, families request to have prayer sessions and bring objects that they believe will bring hope and promote patient recovery. Findings indicated that nurses can enhance and promote family coping mechanisms or strategies in order to facilitate family stability during times of crisis (Cypress 2012: 53-64; Hashim and Hussin 2012b: 103-111; McAdam *et al.* 2012: 386-393). According to Berman, Snyder and Frandsen (2016: 1015), loss is when something that a person values and honours is no longer available. Being hospitalised can produce feelings of loss, especially in the ICU. These losses can include a change in body image, the inability to communicate, loss of well-being, separation from loved ones and death.

Findings from the current study reported that family members may request to collect the spirits of the dead meaning they burn incense (impepho). Findings show that nurses give health education to family members where family rituals may be detrimental to the patient or fellow patients and family members. This is in line with the study conducted by Hunt (2009: 327-339) who reported that traditional healing in South Africa is understood by considering the way people perceive illness and death in order to be able to provide holistic care. Some of these illnesses are believed to be caused by witchcraft, vengeance of the ancestors, natural illness or the illness may be caused by God as a punishment. Believing in ancestral spirits is common among black people. Cultural dilemmas can happen when the family and patient want to engage in cultural rituals that are not included in institutional policies, and when some cultural practices may be detrimental to fellow patients (Hunt 2009: 327-339). A study conducted by Brysiewicz and Bhengu (2010: 42-50) supports the notion that family members come to collect spirits after the death of a patient. Ultimately, nurses allow family members to have that opportunity.

Findings from the current study indicated that participants respected the families and patients' belief systems without imposing their belief system, therefore, still maintaining professionalism and nursing norms and values. Berman, Snyder and Frandsen (2016: 1021) indicated that nurses need to assist the family during the

critical moments in the ICU, thus effective communication is important. Nurses can provide emotional support by implementing the following in order to help the patient and family during the grieving phase: respecting and exploring the patient's religion, culture and values; encouraging the patient to engage in daily activities so as to regain their health; encouraging the patient to share their grief; ensuring that the patient maintains their sense of control and informing the patient and family about the support services that are available to them. A study by Al-Mutair et al. (2013c: 1805-1817) indicated that nurses felt that it was essential that the family maintained hope. Informing the family about the patient's progress was also necessary and that information should be honest and real. Nurses provided more support when they realised that there was no hope and family members felt despair.

Casarez and Engebretson (2012: 2099-2107) and Zeilani and Seymour (2012: 99-107) state that cultural competency allows nurses an opportunity to realise their own belief systems, and thus, respect and understand the patient and family's belief system. The best patient care is provided through the identification of the patient and family's spiritual needs, thus effective communication skills are also essential. This is in line with the findings of the current study, where participants indicated that they respect the patient's and family's cultural and religious background as they care for diverse patients. Findings further showed that even if participants were not sure of a certain cultural or religious ritual, they would ask the family and provide apologies if there was any disrespect towards that particular culture.

Findings from the current study revealed that nurses preferred to care for patients of the same ethnic group to enhance better understanding and communication. There are challenges that may be experienced by family members whose ethnic background is different from the majority of the population within the ICU environment. This notion is supported by Al Mutair *et al.* (2014: 254-8) who stated that nurses should avoid certain gestures when trying to establish rapport such as in the Muslim community if you are female you are not supposed to shake hands or hug someone from the opposite gender. This notion is supported by Khosravan, Mazlom, Abdollahzade, Jamali and Mansoorian (2014: e12686) who conducted a study in Iraq and stated that family participation is encouraged on the basis that a patient can be cared for by a nurse of the same gender, which is practiced by Islamic

religious culture. Maintaining privacy during participation is encouraged if a nurse of the same gender is not available.

Smeltzer *et al.* (2010: 117) provided guidelines that can be used by nurses so that they will be able to cope with cultural diversity. These guidelines include the following: (1) Be aware of your own culture, belief system, values and attitude.(2) Respect each person including their cultural background and provide the best care for the patient and family.(3) Understanding your culture makes it easier to adapt when dealing with someone of another culture.(4) Always have a flexible attitude and open mind, always expect the unknown. (5) Avoid cultural grouping and treat families the same way because they are from the same culture but they are still different individuals. (6)Try by all means to understand certain behaviours that the patient might present with by consulting someone of the same ethnic group. However, findings of the current study revealed that nurses had training in diversity as well as experiences in diversity from their work.

Findings of the current study reported that family members requested to perform religious rituals as a coping mechanism to deal with the patient's condition. One participant reported that a patient was 'fed vaseline' by a family member that was brought in from home. These study results are congruent with the study conducted by Abdalrahim and Zeilani (2014: 570-577) who reported that patients appreciated being given another chance in life by Allah (God). They stated that using spirituality gave them (patients) a "new meaning in life" as they felt that they had to show appreciation to Allah by visiting holy places. The authors further reported that participants' gratefulness for being alive went as far as encouraging other people to commit themselves to Allah. Baumgarten and Poulsen (2015: 205-214) conducted a study on patients' experiences of being mechanically ventilated in an ICU which revealed that patients felt that using religion as a coping mechanism helped them in ICU because at times, they felt lonely, scared and anxious because of thoughts of death and technical problems that might be associated with the equipment.

This finding is supported by Noome *et al.* (2016: 56-64) and Al-Mutair *et al.* (2013a:135-144) who stated that allowing family members to engage in religious practices and rituals enhances and strengthens their belief that the critical illness will be resolved, feelings of hope are enhanced, and levels of stress are reduced. The

authors (Noome *et al.* 2016 and Al-Mutair *et al.* 2013a: 135-144) further found that family members became more concerned about their religious values during a health crisis. Consequently, family members became more interested in religious rituals, thereby strengthening them and those that were not interested before, started engaging in such rituals because of the critical illness. Family members demonstrated that they were able to provide emotional support to the patient and gained more strength to advocate for the patient due to their religious practices. Hence, family members who are not physically involved in patient care because of restrictions in visitation, could still find their strength, and share it, by communicating with God (Noome *et al.* 2016 and Al-Mutair *et al.* 2013a: 135-144).

Findings in the current study revealed that patients may behave in a certain way in relation to their cultural up-bringing, creating difficulties for the nurses caring for the patient and provide quality patient care. One participant demonstrated that in certain cultures, men are not allowed to share and display their feelings, especially, regarding pain. This is in line with the study conducted by Andrews and Boyle (2008: 333-335) which indicated that experiences and interpretation of pain may be culturally related as patients respond to pain differently. However, nurses have to respect the patient's right to pain and how they respond to that pain. In addition, nurses that are aware of patient's cultural background will respond effectively and responsibly to patients' needs that are associated with pain. Pain that is experienced by the patient can also be relieved by family involvement in patient care. Pain assessments must include cultural sensitivity so that the nurses can understand the location, severity, duration and type of sensation (Andrews and Boyle 2008: 333-335). According to Al-Mutair *et al.* (2014: 254-8) cultural competence in the hospital setting is important and necessary. This allows nurses to care for patients and families holistically. Cultural assessment should be addressed in order to identify and meet cultural needs.

This study highlighted nurses' experiences towards family visitation in adult ICUs as part of FCC. Findings of this study revealed that participants allowed family members to visit the patient at times without following the stipulated visiting hours in the visitation policy. Findings showed that participants have different experiences with regards to family visitation in the selected ICUs, hence, results indicated that there is a policy in place for family visitation which still restricts family visitation. Findings

indicated that family members were allowed to remain at the patient's bedside as long as they could during the day and night, depending on the patient's condition, the nurses' discretion and the ICU environment. Furthermore, nurses reported that as much as there is a visitation policy, nurses used their discretion based on the patient's condition to allow the family to be with the patient. When patients were dying, family members were allowed to come in even at night time. Ultimately, nurses did not strictly implement or follow the visitation policy. This was obvious, because findings demonstrated that the indicated visiting times by the participants were somehow different from the stipulated times in the visitation policy; nurses were inconsistent. However, this meant that the visitation policy restricted family visitation. In addition, nurses restricted the number of visitors, given that they only allowed two visitors at a time and children under 12 years old were not allowed in, based on the existing visitation policy. This indicated that as much as nurses demonstrated knowledge of the family's needs in ICU, family visitation was still restricted.

The study conducted by Langley *et al.* (2013: 9-17) indicated that the South African health care system faces challenges which hinder family visitation such as poverty, which means less money for family to visit patients and violence directed at nurses in public hospitals, therefore, family visitation is restricted. This is contrary to the findings from the current study, which revealed that family members that were travelling from far away places were allowed to spend more time in the units because they only visited during weekends and holidays, unlike the local family members that visited everyday and come in 'tons'.

Nurses are in a great position to change attitudes towards the factors that can promote the implementation of flexible visiting hours. Liu, Read, Scruth and Cheng (2013: 1-7) conducted a survey in 2008-2009, which indicated that the majority of ICUs in US still practice restricted visitations, however, small hospitals are implementing open visitation. Authors (Liu *et al.* 2013: 1-7) further found that family visitation in ICU had the following restrictions: visiting hours, age of the visitors and the number of visitors at one time. This study concluded that there were exceptions, thus indicating, that the policy on family visiting was not rigidly implemented. The study concluded by indicating that policies on flexible visitation still need to be developed and implemented. This abovementioned study is in line with the results

from the current study, which indicated that the visiting policy is restrictive. However, nurses allowed visitors to come even at night if the patient is dying and the number of visitors is not restricted. A study done by Plakas, Taket, Cant, Fouka and Vardaki (2013: 243-254) indicated that family members had to be on good terms with the nurses in order for them to get privileges such as being allowed to visit the patient at night.

Findings in the current study indicated that some participants experienced that family members have an impact on the patient's condition, thus patients in the ICU require rest to recover. Participants reported that family can negatively or positively influence a patient behaviours related to their condition. One participant reported that they had experiences where family members caused the patient to be hemodynamically unstable, with the patient's 'blood pressure shooting right up to the ceiling'. Similarly, a study conducted by Rippin *et al.* (2015: 80-98) revealed the same findings that the family's presence can be detrimental to the patient, particularly, if the patient manifests physiological responses to the family's presence. This occurs when there is a presence of an agitated or extremely anxious family member.

Thus, family members should be supported by reducing their anxiety levels (Frivold, Dale and Slettebø 2015: 232-240; Loghmani, Borhani and Abbaszadeh 2014: 67-82). Similarly, a study conducted by Athanasiou, Papathanassoglou, Patiraki, McCarthy and Giannakopoulou (2014: 326-333) indicated that family visits increase physical and psychological stress and increases the patient's blood pressure and heart rate without any significant change in the patient's stability. This was reported by the two thirds of nurses. The study also revealed that nurses workload was one factor that led to family restrictions in the ICU. However, nurses attitudes indicated that they would make exceptions to family members for patients that are dying, emotionally weak, and for family members with practical problems. Ultimately, family visitations remained restricted.

Findings in the current study revealed that it is challenging to identify the patient's family since they often receive unknown and unidentified patients. Therefore, it becomes a challenge to identify and define a family until they get to know family members during the patient's stay in the ICU. Participants were strict about the family members identity as anyone that is not a family member could hurt the patient.

This is one of the reasons nurses limit the number of visitors, hence, only two family members at a time. However, encouraging open visitation has shown to produce positive benefits such as decreased patient and family anxiety levels. Policies on family visitation should be reviewed periodically. Nurses should ensure that on the family's first visit, family expectations and an orientation to the environment is given before-hand, which prepares the family. However, the visitation policy should be individualised (Morton and Fontaine 2013b: 12).

Fumis, Ranzani, Faria and Schettino (2015b: 440) conducted a study in Brazil using a modified version of Critical Care Family Needs Inventory (CCFNI) and the Hospital Anxiety and Depression Scale (HAD) to assess and evaluate family satisfaction and symptoms of anxiety and depression in family members in an open visitation policy ICU. Findings revealed high scores on family satisfaction and lower scores on symptoms associated with anxiety and depression. Thus, open visitation appeared to be a protective factor for family members with higher HAD scores. As one family member becomes ill, the whole family wishes to protect the member from distress by remaining together. Positive satisfaction was associated with family members that visited up to 10 hours per day. Similarly, another study by da Silva Ramos, Fumis, Azevedo and Schettino (2013: 1-8) found that Brazil as a country, encourages and embraces family units during a health crisis so the family spends a lot of time in ICU, even though some nurses do not favour open visitation as they felt it disturbed the routine of the unit. Nurses acknowledged the benefits of open visitation to the patient. Da Silva Barreto *et al.* (2017: 633-642) attest to this finding, by stating that flexible family visitation reduced family anxiety and they therefore remained calm. The same study also indicated that if the patient was a child or a health care professional, then the family would be allowed flexible visiting hours.

Findings on the current study indicated that children under 12 years of age were not permitted to visit an adult family member in the ICU. Nurses' experiences indicated that children are not allowed to visit because they are vulnerable to infection and they cannot be controlled. The visitation policy also stipulates that children under 12 years should not be allowed to visit. The current study's findings are congruent with the study conducted by the American Association of Critical Care Nurses (2016: e15-e19) who reported that children's visits in an adult ICU still remain restricted based on hospital policies that children will be harmed, uncontrolled and vulnerable. Health

institutions should provide policies and procedures that promote unrestricted visiting hours and support systems for patients as well as ensuring that other patients and nurses' privacy and safety is protected.

The previous study findings are contrary to the those reported by Knutsson and Bergbom (2016: 33-41) who stated that allowing children to visit in an adult ICU assists them with their involvement in patient care because they are also concerned and have the perception that they are needed and they have something to do. Children also suffer when exposed to the family member's critical illness, however, flexible visitation can reduce feelings of anxiety as they see the condition of the patient. Ivany, LeBlanc, Grisdale, Maxwell and Langley (2016: 61-65) implemented a program in a children's unit, whereby, siblings were given an opportunity to use the playroom. Screening was done before a child could play to be able to detect any infections. Hence, there was prevention of the transmission of infections in ICU. This program was developed to promote and enhance FCC.

A study conducted by Knutsson, Enskär and Golsäter (2017: 9-17) revealed that knowledge and experience is required when implementing the process of involving children in an adult ICU. This study further showed that children need to be involved as this reduces emotional stress. The participants (nurses) indicated that this can also have some challenges, however orientation and answering children at their level of maturity was another tactic that can be used to facilitate the children's involvement. Thus, support and comfort can be promoted. Consequently, their findings also revealed that involving children in the adult ICU is an evidence based practice, hence, emotional and structural support was indicated as important to promote such an approach.

Findings in the current study revealed that infection control in an ICU was significant in limiting family visits. Findings showed that nurses indicated that family members bring infection to the ICU. Participants reported that they ensured that the patient and environmental hygiene are maintained to be free of infection, and to promote patient recovery. Nurses encouraged family members to wash their hands when entering or leaving the unit. This is in line with a study conducted by Magesh, Darolia and Singh (2014: 50-52) which revealed that almost all the nurses that were

participants in the study, reported that it was important for them to maintain hygiene by ensuring that hands were washed before entering the ICU environment.

According to Huisman, Morales, van Hoof and Kort (2012: 70-80) if hands are washed more often, chances of contamination are lowered. The authors further indicated that there are serious implications that are associated with family visitation which includes the spread of infection, even though family contributes greatly in patient care. A study conducted by Smith, Ayele and McDonald (2013: 363-368) in Ethiopia attest to this notion by revealing that infection rates were the cause for a high mortality rate (58%) due to lack of resources that led to poor hand washing.

Bishop, Walker and Spivak (2013: 14-24) conducted a study on family presence in an adult Burn Intensive Care Unit during dressing changes. The study revealed that nurses ensured that family members were informed about dressing changes. Consequently, support was offered to family members that felt that they were not ready to view the dressings. Authors (Bishop, Walker and Spivak 2013: 14-24) further revealed that infection rates decreased with family members being introduced into the ICU, especially, during dressing changes. Results further demonstrated that the multidrug resistant organisms that cause infection remained low, hence, rates were reduced. The infection rates decreased from the time when the presence of family members was implemented, given that the unit baseline decreased from 13.5 per 1000 patient days in 2008 to 6.25 per 1000 patient days in March 2009 to December 2011. Authors (Bishop, Walker and Spivak (2013: 14-24) further stated that infection rates decreased as there were other interventions that were implemented since 2009 to control and eradicate infection in the unit. Hand hygiene surveillance was one of the interventions that was emphasised. Findings revealed that nurses noted that the implementation of a family presence in the burn unit was a challenge, and was becoming a barrier. In-service training was provided on the information about family presence during a dressing change, even though according to the authors there was no available literature on family presence during dressing change in the adult burn ICU. This study concluded by stating that involving family members during dressing changes with nurses providing support, was beneficial as it manifested positive outcomes (Bishop, Walker and Spivak 2013: 14-24).

4.3. Conclusion

Data was analysed using qualitative content analysis. Themes and sub-themes emerged from the transcripts were broken down into meaning units. Presentation of themes and sub-themes are illustrated in Table 3.1.

Identifying family needs in ICU is the first step where family is welcomed and acknowledged in such an environment. Implementation of these needs is another step that allows the family of patients in the ICU to be part of the health care team. Since family members of patients in ICU are the 'voice' and 'ears' of the patient, ultimately, they should be involved in decision making, to be physically and actively involved in patient care and be involved in policy development. Hence, FCC is an approach that involves family members in the planning, implementation and evaluation of patient care. In addition, their beliefs systems, cultural and spiritual background and coping mechanisms are taken into considerations.

Findings from this study indicated that nurses' knowledge towards FCC existed, thus it is correct in relation to the concept. In addition to this, findings indicated that even though participants had knowledge on the components that facilitate FCC, they also acknowledged the significant contribution that can be made by family members. However, the actual implementation of some of these components was inadequate due to various reasons that were indicated by the participants. Their roles and responsibilities were significant in a way that findings revealed that participants as nurses could be the driving force of this approach. Participants acknowledged their roles and responsibilities in relation to the facilitation of meeting family's needs in ICU. These roles included giving information to family members about the patient's condition and other services, and allowing and involving family members in decision making.

Nurses' perceptions towards family involvement in patient care, especially nursing activities, revealed barriers that prevented the facilitation of family satisfaction in the ICU environment. However, findings indicated that participants have again acknowledged that family members play a significant role in patient care. Consequently, nurses' perceptions revealed that there were discrepancies with regards to family involvement in nursing care activities. Some participants indicated that they have and would involve family members in active patient care. Findings

showed that nursing activities that family members could perform included rubbing their feet, turning the patient and feeding the patient. In addition, family members were only involved in patient care if the patient was in high care, not intubated, ventilated or too young. The majority of participants felt they could not involve family members in patient care, especially nursing care activities. Findings indicated that the following factors caused a hindrance in involving family members in patient care: less time to involve family members, being short staffed, the family interfering with equipment, nurses being overloaded with work, nurses lacked confidence, maintaining patient privacy and integrity.

Nurses' experiences towards family presence in adult ICUs appeared to be positive as participants reported encouraging outcomes that are related to family presence in ICU. Consequently, findings revealed that family visitation remained restricted. In addition, participants indicated that there is a visitation policy in place. However, findings indicated that nurses did not strictly follow that policy since they used their discretion when allowing family to visit the patient. Family visitation also depended on the environment and on the patient's condition. This demonstrated that nurses had different experiences of family visitation in the ICU.

Ultimately, nurses should be using the family visitation policy to guide their practice in the ICU environment. Participants' experiences have also revealed that they encounter challenges when identifying close family members in the ICU. This also leads to family restrictions as they try to protect the patient. Findings further indicated that participants revealed that at times it was a challenge to identify close family members. Consequently, in the visitation policy, only close family members are allowed to visit the patient. Literature has revealed that open and flexible family visitation is another principle that facilitates the implementation of FCC because family members become part of the team. Hence, they form an integral part of the patient and their care. Nurses' experiences indicated that they are aware of the policy on visitation but the implementation at times is not strictly followed according to the hospital policy.

However, findings indicated that participants require the knowledge and skills that will assist them with the strategies that can be used to facilitate FCC. This means to actively involve family members in patient care, especially nursing care activities.

Basic training and in-service training are required to improve understating on the concept and implementation of FCC, as part of family nursing in the ICU. Consequently, family nursing has been proven to be important and essential in the ICU, since patients can not advocate for themselves as most patients are unconscious and unresponsive. Policy development is also essential as it acts as the guideline that will ensure that nurses are well equipped for their practice allowing them to maintain quality patient care.

Paim, liha and Backes (2015: 2001-2010) and Al-Mutair *et al.* (2013a: 135-144) indicated that nurses require continuous education in order to keep up with the demands of society, thereby being able to meet the patient's and family's needs in ICU. A study conducted by Karnatovskaia *et al.* (2017: 106-111) revealed that even patients gain confidence and trust with nurses because of the knowledge and experience they have in the ICU environment. Thus, their results further showed that patients felt their autonomy was not important until they are weaned off from the ventilator. Identifying the patient's and family's needs and negotiating patient care with the family is also part of the nurses' responsibility. Urden, Stacy and Lough (2012: 2) state that "the critical care nurse should not only be able to work with technology but also needs to 'know the patient' in order to humanize and individualize the care". Recommendations and limitations will be presented in Chapter 5 below.

CHAPTER 5: RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1. Introduction

This chapter discusses recommendations and limitations of this study. Recommendations include: policy development, nursing education and training, institutional layout and management and lastly, further research.

5.2. Recommendations

5.2.1. Policy development

Policy formulation and development committees in health institutions need to involve patients, family members and nurses when developing clinical related policies. Thus, family involvement in patient care and family visitation should be included in these policies in order to allow family members to become fulltime partners in the care of the patient. Literature indicates that incorporating family members and patients in policy formulation is one of the principles that enhances FCC, where families are to be treated equally, regardless of their circumstances. Policies on family visitation and patient care should stipulate the expectations and needs of the family and other members of the health care team in the ICU environment. New nurses in the units should be orientated to such policies.

Orientation to such policies can guide nurses' knowledge, perceptions and experiences in adult ICUs. According to de Beer and Moleki (2012: 105-115) nurses require guidelines and policy to be able to practice. Findings from this study showed that nurses have acknowledged the positive impact family presence has on the critically ill patient. The current visitation policy is still restrictive towards family visitation but the policy allows nurses to use their discretion when allowing family to visit, depending on their circumstances. Policy on FCC should be formulated as this will give guidance to the nurses, this policy can be an umbrella to other policies that enhance family satisfaction in adult ICUs.

Findings of this study indicated that nurses encourage and allow family members to be close to the patient even though the policy is restrictive. Allowing family members to be close to the patient also allows nurses to give support, reassurance and information to family members about the patient's progress. Ultimately, these findings are supported by other studies that indicated that family members require flexible and liberal visiting hours to be able to enhance FCC and support the patient in the ICU environment. Moreover, being close to the patient reduces the patient's and family's anxiety levels (Abuatiq 2014: 3-10). Liberal visitation promotes family satisfaction through the nurses' ability to identify and meet the family's needs in ICU. Therefore, policies and guidelines that support and give directions to nurses are recommended. Operational managers can also be involved in the policy development so that they will be able to address family expectations in the ICU. Developing policies that involve and include family members as partners is recommended in adult ICUs.

5.2.2. Nursing education and training

The researcher recommends that the curriculum for basic and post basic training should include FCC as a component in the curriculum that is taught to student nurses and surgical and medical nursing staff. This will include strategies that facilitates the implementation of such an approach. This will allow the nurses to be flexible and diverse in their care, thus, promoting holistic nursing. Findings from this study indicated that nurses are not adequately implementing all the components that facilitate FCC, even though findings demonstrate that ICU nurses have knowledge of FCC. In addition, findings revealed that nurses acknowledge the important contribution that the family makes in ICU, for the patient's well being. However, active family involvement is limited in nursing care activities and nurses demonstrated discrepancies in their perceptions towards family involvement. FCC includes many aspects of patient care and well-being including that of family members. Training and in-service training will correct any negative attitudes and misconceptions towards family involvement in patient care.

The researcher recommends that operational managers should encourage and organise in-service training on components that facilitate FCC so that it can be implemented in the units and in-service training can be done periodically. Ultimately,

nurses will be able to update their knowledge and skills. In-service training encourages nurses to practice and use the skills that they have learned, hence, following current trends such as evidence based practices.

Family forms an important part of the patient and therefore, deserve to be part of patient care, especially in an acute setting such as the ICU where communication with the patient is limited. Hence, Karnatovskaia *et al.* (2017: 106-111) revealed that family support and presence was indicated as a positive factor that patients experience in ICU. Training on FCC will equip the ICU nurses with the necessary skills to care for the patient and the family and enhance the quality of patient care. This will allow the nurses to be able to individualise family's needs and to meet such needs once they are identified. In addition, nurses can educate family members on such concepts, and family members will become aware of what is expected in ICU.

Implementing evidence based practices is part of improving patient care; FCC provides scientific knowledge because literature shows us that it has been researched, but more research is required on the strategies to implement FCC in various health care settings. Consequently, it has been established that FCC can be practiced in any health care setting. Technology is always changing with the times, so nurses need to keep up with the new trends in the market. However, humanity needs to be maintained as well. ICU nurses are supposed to be experts in their field of care, to have more knowledge and skills because they are always at the patient's bedside and constantly communicating with the other members of a multidisciplinary team (Obringer, Hilgenberg and Booker 2012: 1651-1658).

The ICU environment can be stressful because it is complex and the technical aspects causes stress for patients and family members in ICU. Nurses are involved more than anyone one else with patient care. Ultimately, nurses are in the best position to keep everything and everyone neutral. Nurses can only achieve this by acquiring the adequate and necessary knowledge and skills. Training at basic and post basic level is essential and recommended for all nurses, thus, nursing curriculum should include FCC as a component.

5.2.3. Institutional layout and management

Critical care settings should provide enough space at the bedside to allow visitors and equipment, and also should provide other rooms for family discussions and waiting areas. Findings demonstrated that nurses utilise curtains as screens during procedures, family rituals and when giving information to family members because patients are lying next to each other. Findings further showed that the other ICU had no waiting room for visitors. Providing adequate facilities especially in ICU is essential given that families and health care providers have meetings and discussions. Therefore, privacy and confidentiality is a priority. Giving the patient's prognosis to the family is vital but at the same time, it is personal and confidential. Consequently, the family may need some time alone and to ask questions without other families overhearing what is happening. Findings indicated that there is one visitors' room that is used during family meetings and it is also used by family members whilst waiting to see the patient.

At times, families hold religious and cultural rituals that require some space and privacy. Encouraging families to pray and practise their rituals as a coping mechanism, is important for families in ICU (Al-Mutair *et al.* 2013a: 135-144). Having curtains to screen around the patient is not adequate and ethical, hence, the dignity and respect for patients and families is essential. Olausson, Ekebergh and Lindahl (2012: 176-184) and Olausson, Lindahl and Ekebergh (2013: 234-43) maintain that the ICU should design and build rooms for patients that protect the patient from being exposed to others to maintain confidentiality, privacy and social support.

Facilities should be adequate to enhance FCC. FCC promotes and recognises the family as active partners in patient care. Family nursing care has to be stress free in order to be able to cope in ICU. The physical built environment of the ICU should not be a hindrance in the promotion of FCC in adult ICUs. Maintaining patient and family integrity and privacy is essential. This can be achieved by facilities that provide adequate space for the technical equipment that is used on the patient, as well as the space to allow the family to be close to the patient without compromising the work environment for nurses (March and Bosch 2013: 53-75).

Screens such as curtains don't offer sound and noise proofing, meaning that anyone moving close to the screens can access all the information discussed behind the

screens. A patient's illness and admission to ICU is traumatic for the family and a lack of proper facilities add more stress to the family and patient. Holding constant family meetings is necessary to discuss the patient's condition in ICU. During this time, the family needs to feel at ease with the support given to them. The ICU environment plays an important role in patient recovery and family well-being. Nurses' perceptions in this study also indicated that family involvement in patient care is limited because nurses want to maintain the patient's dignity and privacy. Limiting family involvement because of inadequate facilities hinders the delivery of family friendly patient care. Thus, adequate and conducive facilities are recommended for facilitating family friendly nursing.

5.2.4. Further research

Further research can be conducted in order to identify FCC experiences in South African adult ICUs using a bigger sample and in a different or similar setting, and family members can also be part of the sample. These results can be compared to similar studies that have been carried out internationally and nationally. This can give ICU nurses an insight into the experiences in adult ICUs to maximise patient and family satisfaction.

Quality patient care is measured through family satisfaction, thus more investigation is required on how family members perceive their experiences in adult ICUs, given that the results of the study of nurses' perceptions, revealed that physical and active family involvement in the selected ICUs so far, is limited in nursing care activities. Family participation forms the central component that enhances FCC. Family members are recognised as active partners in patient care and their values, belief systems and cultural backgrounds are considered vital because they need to have adequate energy in order to support the patient's recovery. ICUs are being introduced to and engaged in the current trends of embracing FCC as a strategy to promote quality patient care in ICUs.

Several international and national studies have been conducted on family involvement to identify ways that can be used to facilitate FCC in health care settings, especially ICUs. Family needs have been explored because the family is an integral part of the patient, thus identifying their needs ensures that they are

incorporated adequately into patient care. This also reduces their stress levels and prevents conflict in the ICU environment (Al-Mutair *et al.* 2013c: 1805-1817).

Further research is required to formulate practice guidelines to enhance family involvement and visitation in ICU (Santiago, Lazar, Jiang and Burns 2014: 13-21). However findings can assist ICU nurses to explore barriers and find strategies that can be used and implemented to enhance and encourage active family involvement in ICU. Thus, further research on the same topic including other stakeholders such as family members and patients or related topics, is recommended in order to increase the existing body of knowledge in the nursing profession. This will further facilitate knowledge, skills and experiences in the clinical area, thus maintaining quality patient care.

5.3. Limitations

The researcher acknowledged several limitations in the study. Firstly, the study was conducted in one health care setting, and therefore, the sample size of nurses was limited and small. Ultimately, results of the study cannot be generalised. If the researcher involved other hospitals in the study, results might have been different. Secondly, the researcher utilised only nurses in the study rather than using other stakeholders such as family members and patients in order to get their experiences on the same topic such as family members and patients.

5.4. Conclusion

Recommendations and limitations of the study were discussed. Recommendations can assist in the development of nursing strategies that can be used to facilitate FCC, thus, quality and holistic nursing care can be achieved.

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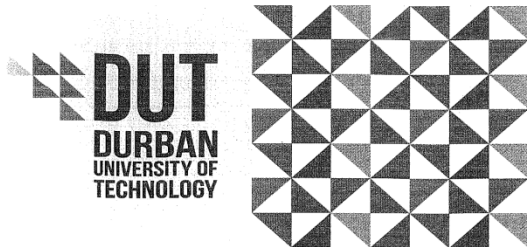
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APPENDICES

Appendix 1: University Ethics Clearance



Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

15 January 2015

IREC Reference Number: **REC 70/14**

Mrs A Ngcobo
P O Box 40739
Elandskop
Pietermaritzburg
3226

Dear Mrs Ngcobo

Knowledge, perspectives and experiences of nurses towards family centred care in adult intensive care units

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Please note that you may now proceed with research on the proposed project.

Kindly ensure that participants used for the pilot study are not part of the main study.

Yours Sincerely,



Professor J K Adam
Chairperson: IREC

Appendix 2: Permission from the Nursing Service Management



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

GREY'S HOSPITAL
OFFICE OF THE NURSING MANAGER
Private Bag X 9001
PIETERMARITZBURG 3200
201 Townbush Road, Northern Park,
PIETERMARITZBURG, 3201
Tel.: 033 – 8973322, Fax.: 033 – 8973328

To :	Mrs A Ngcobo
From:	Mrs K T McKenzie
Date :	20 November 2014
Re :	Request for permission to conduct research at Grey's Hospital: Knowledge, perspectives and experiences of nurses towards family centered care in adult intensive care units.

Dear Mrs Ngcobo

Your request to conduct research at Grey's Hospital refers.

Permission to conduct the above study is hereby granted under the following conditions:

- Your provisional ethical approval and research protocol is assumed to be valid and final ethics approval is a prerequisite for conducting your study at our hospital. Once obtained from BREC, please submit a copy of the full ethics approval;
- You are also required to obtain approval for your study from the Provincial Department of Health KZN Health Research Unit prior to commencing your study at Grey's Hospital. You will find more information on their website: <http://www.kznhealth.gov.za/hrkm.htm>
- Confidentiality of hospital information, including staff and patient medical and/or contact information, must be kept at all times;
- You are to ensure that your data collection process will not interfere with routine services at the hospital, i.e. research activities to be conducted after hours or during lunch/tea breaks;
- You are to ensure that hospital resources are not used, e.g. staff collecting data; photocopying; telephone; facsimile, etc.;
- Informed consent is to be obtained from all participants in your study;
- Policies, guidelines and protocols of the Department of Health and Grey's Hospital must be adhered to at all times;
- Professional attitude and behavior whilst dealing with research participants must be exhibited;
- The Department of Health, hospital and its staff will not be held responsible for any negative incidents and/or consequences, including injuries and illnesses that may be contracted on site, litigation matters, etc. that may arise as a result of your study or your presence on site;
- You are required to submit to this office a summary of study findings upon completion of your research.
- You are requested to make contact with the Nursing Manager. Once you are ready to commence data collection.

MRS K T MCKENZIE
NURSING MANAGER

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3: Permission from the Department of Health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 330/14
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mrs A. Ngcobo

Subject: Approval of a Research Proposal

1. The research proposal titled '**Knowledge, perspectives and experiences of nurses towards family centred care in adult intensive care units (ICUs)**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Greys Hosital.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

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

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 11/12/14

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4: Letter of Information



LETTER OF INFORMATION AND CONSENT

Dear participants

Title of the Research Study: ' Knowledge, perspectives and experiences of nurses towards family centred care in adult intensive care units'.

Principal Investigator: Mrs A Ngcobo (B. Cur. In Nursing Administration and Education)

Telephone number: 033 8973267/69

Supervisor: Dr Basson (PhD: Senior Lecturer)

Telephone number: 031 3732687

Brief introduction and purpose of the study: Thank you for willing to participate in my study. I am currently registered for the M Tech Nursing Degree at DUT.

The purpose of the study is to determine and explore the knowledge, perspectives and experiences of nurses towards family centred care in adult intensive care units. The emergent aim is to improve health care delivery, quick patient recovery and patient satisfaction.

Outline of the procedure: The in-depth interviews will be conducted for 20 minutes, but if there is further clarification required during the interview, methods like probing will be used by the registered nurse. Purposive sampling will be used in the study where the registered nurses will be the participants during their lunch hour. The

interviews will take place on an agreed time and place as it will be done on the researcher's off time. The operational managers will be approached about the research study that will be conducted in the intensive care units. Therefore, registered nurses that qualify to participate can do so voluntarily. I promise to keep your identity confidential by not using your name in the report or interview guide and the information given will be kept confidential. If you have any questions or you need clarification during interviews, please feel free to ask. Registered nurses that meet the inclusion criteria will participate in the study voluntarily.

Risks or Discomfort to the subjects: There are no risks to participate in the research.

Benefits: You will benefit since the study is looking at your experiences and then at the end of the study, I am hoping to come up with recommendations with your help.

Reason/s why the subject may be withdrawn from the study: You may withdraw at any stage of the interview with no questions asked.

Remuneration: No remuneration

Costs of the study: You are not expected to cover any costs towards the study.

Confidentiality: All data that will be collected will be private and confidential and will be used only for the purpose of the study.

Research related injury: There will be no risks of injuries.

Persons to Contact in the Event of any problems or queries:

Head of Department: Dr N Sibiya

Telephone number: 031 37732032

Supervisors : Dr Basson

Telephone number: 031 3732687

Ethics administrator: 031 373 2900

Appendix 5: Consent Form



Statement of Agreement to Participate in the Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of the study- Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Information Letter) regarding the study.
- I am aware that the results of the study, including personal details regarding my gender, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirement of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent to participate in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature / Right Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full name of Researcher Date Signature

Full name of Witness (if applicable) Date Signature

Full Name of Legal Guardian (if applicable) Date Signature

Appendix 6: Interview Guide

INTERVIEW SCHEDULE

The broad question for this study is: Tell me about the knowledge, perspectives and experiences of nurses towards family centred care in adult intensive care units?

Knowledge and roles

- What are your roles with respect to family centred care as registered nurses in an adult intensive care unit?
- Tell me what do you know about family centred care, the implementation and practice of family centred care?

Experiences and perspectives

- What are your experiences during relatives' visitation and involvement as part of family centred care (FCC)?
- What are your perspectives/ views as the nurse in ICU with regards to family centred care in adult ICU?

Benefits and challenges

- How do you deal with family and patient diversity when implementing FCC?
- Describe if and how family is /are resource to the patient and nurses.

Further clarification of questions

Please tell me more about this.

What do you mean?

Please elaborate more on what you have said

Appendix 7: Editor's letter



6th of August 2017

To whom it may concern

EDITING OF DISSERTATION FOR MRS ANDILE NGCOBO

I have a master's degree in Social Science, Research Psychology and TEFL qualification from UKZN. I also have 15 years of teaching experience. I have been editing academic theses for students from UKZN, UNISA and DUT for the past five years. I have further completed editing, transcribing and other research work for private individuals and businesses.

I hereby confirm that I have edited Andile Ngcobo's dissertation titled "**KNOWLEDGE, PERCEPTIONS AND EXPERIENCES OF NURSES TOWARDS FAMILY CENTRED CARE IN ADULT INTENSIVE CARE UNITS**". Corrections were made in respect of grammar, tenses, spelling and language usage using track changes in MS Word 2016. Once corrections have been attended to the dissertation should be correct.

Yours sincerely

Terry Shuttleworth (TEFL, UKZN, MSocSci, UKZN).