Needs of the significant others of critically ill patients in eleven intensive care units in four private hospitals in Gauteng

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Abstract

Background: Admission of a loved one into a critical care unit can be stressful and devastating to the significant others. Recognising the patients' significant others' needs and ensuring that all the needs are met have been proven to have beneficial effects on the healing process of the patient.[1]

Method: A non-experimental, typical descriptive study was conducted to determine if the needs of critically ill patients' significant others are met in eleven intensive care units of four private hospitals in Gauteng. The study was conducted in four cardio-thoracic units, two coronary care units, two trauma units and three medical units. Convenience sampling was used to select the participants.

Results: One hundred and twelve participants completed a questionnaire and according to the study's findings most needs of significant others were met in the eleven intensive care units of the four private hospitals in Gauteng. However, needs such as introduction of family to the specialists taking care of their loved ones were not met. No counseling is offered to the patients' families and their spiritual needs are mostly not met.

Conclusion: Some psychosocial and spiritual needs of the significant others of patients are commonly overlooked by the critical care team. The multidisciplinary critical care team should pay sufficient attention to these needs.

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Background

On admission to the critical care unit, significant others feel overwhelmed, with the different and unfamiliar sounds and array of equipment and intravenous lines adding to their fragile emotional state.[2] Significant others report that the empathy and support they receive from health care professionals assist them in facing the critical situation of having their loved one admitted in an intensive care unit. Previous studies have also reported that the empathetic behavior of the health care professional creates a positive attitude among significant others.[3]

Significant others may be vulnerable as the circumstances may have a negative impact on their financial, psychological and emotional status. Significant others' response to the situation varies and may include denial of the seriousness of the event, short attention span when interacting with nurses and some may withdraw and become isolated from the family support and comfort.[1] Significant others have different needs that require individualised attention. Critical care nurses do not only have to advocate for their patients but they also have a vital role in addressing patients' needs and those of significant others as they are equally important.

The patients' families remain the most important social factor to consider when determining medical interventions to promote satisfactory patients' outcomes. Involvement of significant others in the healing process can be enhanced by becoming aware of the perceived needs of the family members and observing for signs of depression, feeling of fear, crying and feeling of guilt and anxiety which leads to distrust of nurses, anger, dissatisfaction with care and disregard of a treatment regimen.[2]

The intensive care environment can be intimidating to the family and add to their stress levels. Nurses play a vital role by orientating and reassuring the family. Critically ill patients

often are unable to make decisions and communicate their needs to the health care professionals. Significant others have a profound influence in the decision making process regarding the healthcare needs of their loved one, for instance consenting to surgical procedures.[2]

Significant others often express feelings of fear, anxiety and guilt. Many appear nervous and tense and it is not unusual for family members to faint.[1] Their needs may be viewed as the lowest priority for the health care professionals, more especially during the first few hours of admission as the focus is on stabilizing the critically ill patient. This may result in neglecting significant others' needs.[1] Meeting the needs would assist in promoting speedy recovery of the patient and reducing the stress and anxiety of the patient and family.

Poor communication has been proven to be a major source of stress to the family.[1] The unknown state of the prognosis is frightening and frustrating.[1] Significant others desire to know about new treatment and results of diagnostic tests that were performed on their loved one.[1] Open and truthful communication promotes trust and confidence in healthcare professionals on the care that they deliver.[4]

In a 2014 study by Nolen and Warren , nurses were the ones who provided valuable information to significant others about their loved one's condition.[3] Information from the doctors was scarce since doctors were not always available. Diagnostic studies such as x-rays and blood tests were performed on the patients but the results were not discussed with them or the family.[2] Significant others want to be informed as to how the patient is responding to treatments, regardless of whether the prognosis is good or bad. The unknown about the prognosis can be frightening and frustrating.[2]

Restriction of visiting hours in the intensive care unit has significant implications on the health and the wellbeing of patient and the significant others.[5] Although nursing staff have cited reasons to restrict visiting hours in critical care units, studies have proven that this practice may have detrimental outcomes on the overall health of the patient.[5]

In a 2013 study by Hart et al, the authors suggest that the presence of significant others had a calming effect on the patients and also provided support and comfort and that this aided in a speedy recovery.[5] Nurses should orientate the family and significant others on the first day of admission in the critical care unit, as the environment can be overwhelming. Families tend to view a restrictive visiting policy as denied access to visit their loved ones.[3] They add that longer visiting hours is one of the strategies to enhance coping skills and the relationship between the nurse and significant others.[3]

In a 2014 study conducted in Rwanda by Munyiginya and Brysiewicz , visits from the pastor was identified as one of the needs of the significant others, as spiritual support was perceived as one of the most important needs during high anxiety and uncertainty periods. In other cultures, illness is viewed as a family affair and a social interaction that obliges the family members to visit ill loved ones to express sympathy and to wish them speedy recovery.[6] According to Munyiginya and Brysiewicz, among the healthcare professionals mostly social workers are willing to approach patients about their religion and spirituality.[6] Most healthcare professionals do not conduct spiritual history taking, they do not feel comfortable praying with their patients and they would only pray if asked to do so. Even then, they would still pray with some sort of discomfort.

In order to meet significant others' needs, interventions should be aimed at decreasing psychological stressors like ensuring that the nurse is able to perceive and manage their patient's need for safety by allowing family members to stay with the critically ill patient.[7] By allowing significant others to participate in routine nursing care at the bedside, they may feel empowered to further support their loved one. Involvement of significant others may provide the health care professionals with the opportunity to build a relationship with them and enhance the care given to the critically ill patient and family as a whole. Close family members (for example spouses and children) also get strength and support from other significant others. Satisfaction of significant others will result in better experience for the whole family and would encourage them to be supportive towards their loved one in a critically ill state.[8]

Objective

The objective of the study was to determine if needs of critically ill patients' significant others were met in eleven intensive care units of four private hospitals in Gauteng.

Method

The study was conducted in four cardio-thoracic units, two coronary care units, two trauma units and three medical units of the four private hospitals in Gauteng. Ethical clearance was obtained from the hospitals' Research Operations Committee. A quantitative, non-experimental, typical descriptive design was implemented. A questionnaire was compiled based on a literature review which looked into the needs of critically ill patients' significant others.

Data was collected by distributing the questionnaire to significant others who were visiting the patients on the data collection days. Data was collected in a period of two weeks. Participants were given time to complete the questionnaire during and after visiting hours, as needed.

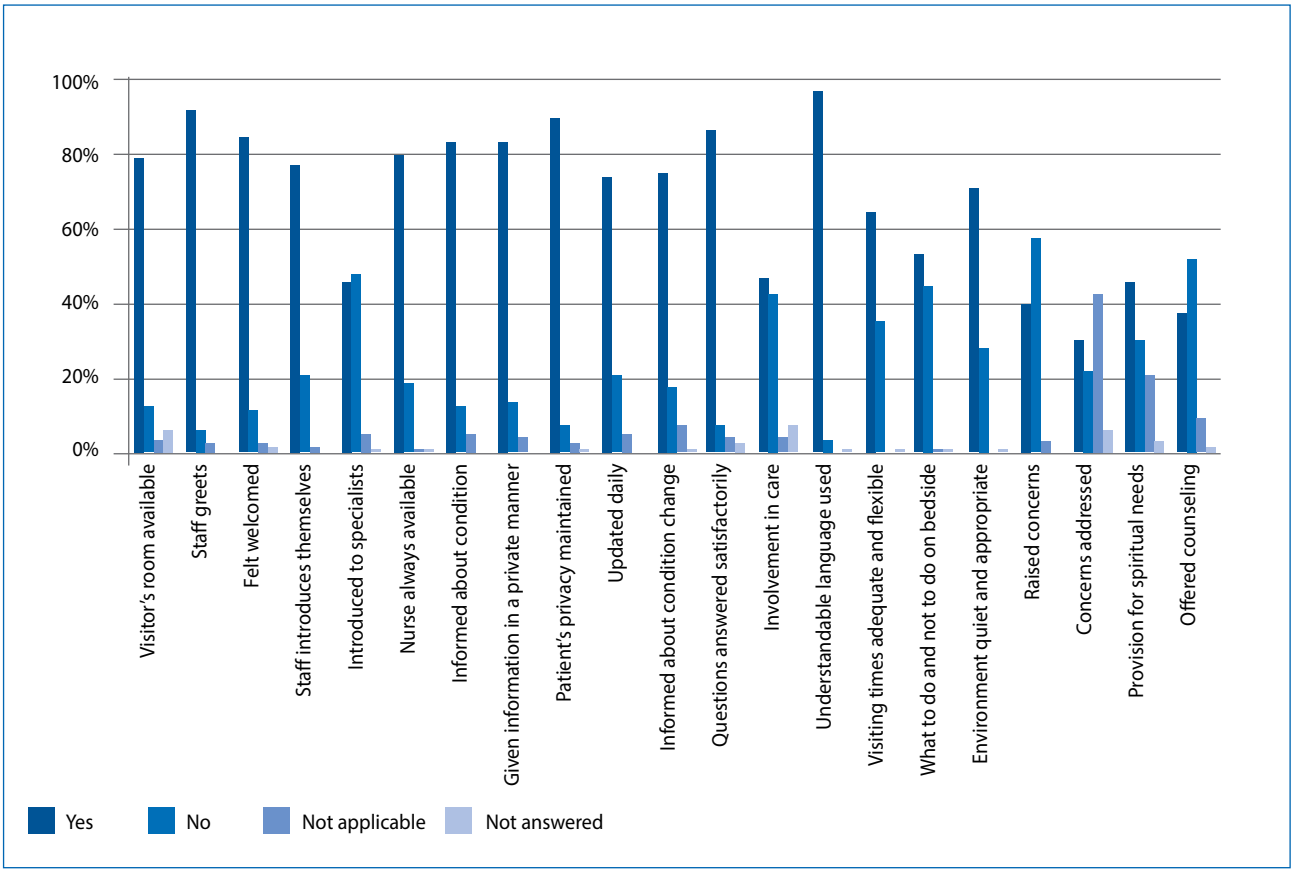

Figure 1: Needs of significant others that are met in the critical care units

Results

Out of the 112 participants, 79% (n = 89) indicated that there was a visitors' room available and close to the intensive care unit. Some significant others added in the comments column that the visiting room was too small and did not have enough chairs. One participant added that he/she did not know that there was a visitors' room available or where it was but he/she did not need to use it. One participant said there was not a visitors' room available near the intensive care unit where her significant other was admitted.

Out of 112 participants, 91% (n = 102) indicated that health care professionals greeted them, 84% (n = 95) indicated that they were made to feel welcomed by the health care professionals, 77% (n = 86) indicated that health care professionals introduced themselves to the visitors.

Only 46% (n = 52) indicated that they were introduced to the different specialists who were taking care of their loved ones. Reasons perhaps could be that doctors conduct their ward rounds before visiting hours and surgeons may be in the operating room during visiting hours. In a 2014 study by Nolen and Warren, one participant said communicating with doctors was not always possible as doctors were not present during visiting hours.[2]

Out of 112 participants, 80% (n = 90) found nurses always available next to the bedside, 83% (n = 93) indicated that information about their loved one's condition was given in a private manner and 89% (n = 100) indicated that they were informed about their loved one's condition.

Seventy-four percent (n = 83) were updated daily about their loved one's progress. One participant stated that he/she was updated daily because he/she phoned to enquire about the patient. Among those participants who reported that they were not updated daily about their loved ones, one significant other stated that they could not get hold of doctors when they wished to see the doctor, and another one added that he/she did not see the doctor for twenty-four hours.

Seventy-five percent (n = 84) of participants were informed when their loved one's condition changed and 86% (n = 97) stated that their questions were answered to their satisfaction. One participant stated that he/she did not have to ask questions as "the doctor explained the situation very well".

Ninety-six percent (n = 108) stated that healthcare professionals communicated with a language they could understand. Only 47% (n = 52) indicated that they would like

to be involved in the care of their loved one such as bathing, feeding, and giving medication. One participant said she prefers to leave the care to the professionals, as "nurses do it well".

Sixty-four percent of participants (n = 72) indicated that visiting hours were adequate and flexible. Among those who reported that visiting time was not adequate for them, some added that they would appreciate it if visiting time could be increased. Another participant said visiting time is at peak traffic time and as a result they miss the visiting time. One participant further commented that "sometimes they are bathing [the] patient during visiting hours".

Seventy-one percent (n = 80) of participants responded that the environment was quiet and appropriate for their loved one's healing process, 53% (n = 60) indicated that they were told what to do and what not to do at their loved one's bedside. One participant commented that only when he/she sat on the bed was he/she informed not to do so.

Forty percent (n =45) of participants raised concerns about their loved one's care. Of those who raised concerns, 73% (n = 33) had their concerns addressed. However, the researchers are of the opinion that some participants did not understand this particular question. A few answers were not consistent with the questions asked. Some participants answered NO to not having any concerns raised. However, the same participants answered YES for having their raised concerns addressed. Some answered NO to raising any concerns and also answered NO to those concerns being addressed.

Only 37% (n = 41) of participants were offered counseling. One participant said she did not need counseling. From the researchers' experience counseling is not being offered to the significant others in the intensive care units. Only 46% (n = 52) indicated that their spiritual needs were met in the intensive care unit. Only one participant commented on this item and said he/she was allowed to bring their pastor to pray for their critically ill loved one. It is interesting to note that 21% of participants (n = 24) said the spiritual need was not applicable to them.

Conclusion

The results of the study demonstrate that most needs were met.

In this study, significant others were mostly satisfied with the information they received from the healthcare professionals. However, there is still room for improvement in this regard by physicians making themselves available in the units during visiting hours to meet and update significant others with the progress of their loved one.

Significant others are not always aware when referrals to other specialists have taken place. They are often not formally notified of referrals by the primary doctor. A possible reason for this might be that significant others are not made aware that they can request to see the doctors even if it is not visiting hours.

Despite the fact that most participants agreed that visiting hours are flexible and adequate, a few participants commented that they find the visiting times impractical due to traffic and they are not always able to arrive on time for visiting hours. The visiting times also limit the opportunity to interact and communicate with the doctors.

Many intensive care units lack private space dedicated for the healthcare professionals to use when discussing private matters with the significant others. Many significant others do not feel comfortable receiving bad news in the presence of strangers.

The study results have indicated that there is a lack in meeting spiritual needs. Participants did not comment further on this regard.

Recommendations

The researchers recommend that intensive care staff should be given education on how to identify and address the needs of the family. Patients' and significant others' concerns should be addressed promptly by nurses to allay anxiety. If family members understand and know what to expect, they tend to be cooperative and less anxious.

Significant others should be allowed space and time to address their concerns and to ask the multidisciplinary team members any questions regarding their loved one's health status. Intensive care unit family meetings are of utmost importance for communication and decision-making regarding the appropriate goals of care for critically ill loved ones, as they may lack the capacity to participate and must rely on significant others to serve as their surrogates. Family meetings are important to provide objective information, to share opinions and to reach consensus on what will benefit the critically ill patient and significant others.[9]

Critical care nurses should communicate what can be expected by the family and information letters can be given with contact details for future reference, as in the first few hours significant others tend to be overwhelmed by the critical care unit environment and have poor concentration.

An effort should be made to locate a room or office and conference rooms to provide privacy for the healthcare professional and the significant others. Significant others should be given a room to deal with the sad news they receive and discuss the implications with no fear that

strangers would be listening and judging them on their decisions and family history.[10]

Intensive care unit staff could evaluate if the family needs were addressed by doing a survey during the patients' stay. For needs that are commonly and frequently not met in each specific unit, staff members should develop an action plan for improvement. Each intensive care unit can train and allocate a nurse specifically to offer counseling to patients and families. As devastating and stressing as it can be, significant others need to be told the truth regarding prognosis of their loved one and assistance should be provided in dealing with the facts.

South Africa is a diverse country with different cultures and religions. This study revealed that the spiritual need of most family members was overlooked. Healthcare professionals should make means of honoring this need as it is equally important, particularly in certain cultural and religious groups.

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