Uncertainly-Based Critical Nursing Model on Family of Family Needs in Bangil General Hospital, Pasuruan, Indonesia

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Abstract

Holistic care in the intensive unit should be provided for patients and their families. The patient's family waiting in the intensive care room may experience uncertainty. Not only because of the unfamiliar treatment rooms, but also because of the health workers who are strangers to them and speak with medical terms. The objective of this research is to develop the CCFN (Critical Care Family Need) Nursing Model towards the adaptation of the patient's family in the Intensive Care Unit (ICU). The research was conducted with an explanatory design. The population in this study was patients' most influential family member in making decisions (related to patients' care and medication) at Bangil General Hospital in 2020. The sample size was 105 with consecutive sampling technique. Research variables included: factors related to the patient, family psychology, health services, family needs and family adaptation. PLS testing was performed, then FGD was done to strengthen the statistical model. Results showed a different finding compared to the initial concept, where there the families' thinking capacity p showed no significant effect on the families' coping factor. The families' coping factor showed no significant effect on the critical care family need (CCFN). However, family coping factor showed a significant effect on family adaptation factor. In conclusion, there are two indicators that can explain the fulfilling of family needs factors, namely indicators of mental support from health workers and their closeness to patients. Calmness of family during discussion with health workers, as well as enthusiasm felt by the patient's family, are things that must be noted, so that the family adaptation process occurs optimally.

Keywords: *Patient's family, CCFN, Uncertainty, Adaptation.*

Introduction

Separation between patients and their family may cause stressful situations, especially for nuclear (main) families in Indonesia. People in Indonesia generally adhere to very close kinship, where if a family member is sick, all members would also feel the pain. When a patient undergoes treatment in the intensive care unit (ICU), the patient must be isolated and separated from their family. In Indonesia, a family can be seen as a system, where change in health or separation of a family member will impact other family members. Conditions like this are likely to create a situation where the family experiences stress or feelings of uncertainty[1,2].

Other causes of the feeling of uncertainty in patients' family is the lack or absence of supporting facilities to fulfill biological needs of the family in the waiting room, such as the waiting room itself, lighting, and bathroom/toilet facilities[1,2].

A research revealed that the feeling of anxiety was experienced by 27 parents for 11 months whose child was treated in the ICU. Through this study, 5 (five) nursing diagnoses arose, including, uncertainty, conflict in the role of parents, high risk of ineffective nutrition for children, high risk of damage of relationship with children, high risk of lack of home care and high risk of tension in the role of service providers. Based on these

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problems, nurses need to intervene with parents and other family members regarding to child care in the ICU to overcome problems that arise[3,4].

According to a preliminary study conducted by several researchers in February 2019 at Bangil Hospital, an interview was done to 10 families who were waiting outside of the ICU. Families stated that they almost never receive an explanation of the patient's illness, prognosis, development, treatment and action. The family would only be called if needed to buy medicine or when the patient's condition is in a nearly dying state. Other than that, every family that is called into the ICU always come out crying, which causes feelings of anxiety and uncertainty for the other families[5,6].

Families of patients in the ICU hope that nurses provide extra attention and care to patients. Around 90% of the families want nurses to explain the patients' situation, development and treatments using a language that is easily understood. Families also want to be able to be beside the patient. Efforts or research to solve the problems mentioned above has never been carried out before[5,6]. The services provided so far are routines and researches previously carried out at Bangil Hospital.

Based on the results of several research journals, the effort of medical staffs increasing the intensity of communication with the patients' family and showing affection towards them shows positive results. Often, patients' family members feel uncertain, in need of help, guilty, fatigued, sad, scared and anxious. Effective use of communication by health workers, improving communication strategies, helping families relieve emotions and increasing family independence are goals that have been set[7].

Families who receive attentive care will be able to provide greater comfort for their illness, encourage improvements in care, and improve the skills assessment of health care providers. Leske categorizes five family principles that can be used to guide nursing interventions, which should be initiated at initial contact with family members[4]. This would provide assurance and a calm and relaxed atmosphere that would support trust and empathetic relationships. Increased closeness means allowing family members to become closer to the patient by visiting the patient. The five family categories according to Leske: Assurance, Proximity, Information, Comfort, Support[8].

The need for information about the patients in the ICU is proven to be the top need of the patients' family members. A study was initiated to determine the level of satisfaction of family members, and it was found that providing complete information of the patients in the ICU was associated with family members' overall satisfaction[5]. There are several ways to deliver information to the family: educational orientation programs, classes providing social support and information on disease management and recovery, and information packages. Learning the balance between too little and too much information and how to convey this information is an important skill for nurses in the ICU to learn[6].

The nurse must consider the nature of the information delivered to the family after deciding the best manner to deliver the information. In a study of 390 families of patients who passed away in the ICU, researchers found that the majority of respondents (82.6 percent) criticized the hospital, 17 percent felt the information received about the diagnosis was insufficient or unclear, and 30 percent expressed dissatisfaction regarding to the information received on the cause of death (particularly among family members who were notified of death by telephone and not in person)[7].Programs for family members to determine whether this program would increase family member's satisfaction with treatments, meeting their need for better information, and reducing disruption to ICU care. The intervention consists of three components, namely: 1) discussion with the nurse approximately 24 hours after admission of the patient 2) an informational pamphlet given during the discussion 3) daily phone calls from nurses who treat the patients that day[7,8].

The number of incoming calls from family members was significantly lower in the experimental group than in

the control group. In the experimental group, satisfaction with patient treatment increased significantly compared to before. Family members' perception is based on how well their information needs are met[6,9,10,11,12]. The family goes through three stages of adaptation in response to news on a family member suffering from a fatal disease. Various emotional responses may arise during this phase, including disorganization/division, anxiety, and emotional instability. The first phase is the preparation phase. This phase begins when the first symptoms appear and continues through the initial diagnosis[13,14,15].

Nurses can help families by informing them that it is natural to go through these phases and that they can expect direction from complex problems in each phase of a fatal illness[11,12,13]. Helping families accept their feelings and directing them to appropriate service resources, such as hospitals, family support groups, social workers, and family conferences, can be very useful.

Method

In this research, correlation analysis was performed and carried out in two stages. An explanatory design was used in the first stage and FGD was done in the second stage to reinforce the findings. Explanatory design was used to develop a Critical Care Family Need (CCFN) nursing model on family members of patients in the ICU. The approach used is cross sectional. This study examined the effect of patient, family psychology, service and family needs: CCFN factors on family adaptation. The research was carried out at Bangil General Hospital, Pasuruan, Indonesia in an integrated intensive care installation room which involved 265 respondents. Sampling was done in October-November 2020.

Results and Discussion

The majority of respondents' answers are summarized as following: Disease indicator, the majority stated that the family knew about the patient's illness, with 60% of respondent answers. Prognosis indicator, the majority said the family knew about the prognosis

of the patient, with 55.1% of respondent answers. Disease history indicator, the majority of the patient's families knew about the patient's history, with 89.4% of respondent answers. Action indicator, the majority of the patient's families knew enough about patient treatment that cause pain, with 70.2% of respondent answers.

The following is a summary of the majority of respondents' answers related to family psychological factors: Communication indicator, the majority of the patient's families do not have the communication skills to handle the uncertainties they experience, with 75.1% of respondent answers. Appreciation indicator, the majority said that there was no ability to appreciate things to overcome the uncertainty they experienced, with 86.4% of respondent answers. Togetherness indicator, the majority said that there was sufficient togetherness among family members to handle the uncertainty they experienced, with 72.1% of respondent answers. Health indicator, the majority of the patients' family stated that they had sufficient health to handle the uncertainty they experienced, with 60.4% of respondent answers.

The following is a summary of the majority of respondents' answers related to health service provider structure: Responsiveness indicator, the majority stated that there was no responsiveness of the service provided by intensive care workers to the patient's family, with 59.6% of responses. Empathy indicator, the majority stated that there was no empathy service provided by intensive care officers to the patient's family, with 85.3% of responses. Assurance indicator, the majority stated that there was no service assurance provided by the intensive care staff to the patient's family, with 90.2% of responses. Tangible indicator, the majority stated that there was sufficient tangibility (real evidence) of the services provided by intensive care workers to the patient's family, with 70.6% of responses.

The following is a summary of respondents' answers related to indicators on family coping factors: Regulatory indicator, the majority of the patient's family had no opinion on regulatory regarding to a family member being treated in intensive care, with 54% of responses.

Congenator indicator, the majority of the patient's family had no opinions on congenator regarding to a family member being treated in the intensive care unit, with 70.9% of responses.

The following is a summary of respondents' answers related indicators on family coping factors: Therapeutic communication indicator, the majority of the patient's families were not given therapeutic communication between them and health workers, with 75.8% of responses. Involvement on family in treatment indicator, the majority of patients' families were not involved in patient treatment, with 88.3% of responses. Mental support by health workers indicator, the majority of the patient's family felt that they were not given mental support by health workers, with 88.7% of responses. Comfortableness with health facilities indicator, the majority of the patient's family did not feel comfortable with existing health facilities, with 84.9% of responses. Closeness to patient indicator, the majority of the patient's family was given the opportunity to be close to the patient, with 75.1% of responses.

The following is a summary of respondents' answers related to indicators on family adaptation factors: Enthusiasm indicator, the majority of the patient's family felt that they did not feel enthusiastic, with 91.3% of responses. Discussion indicator, the majority of the patient's family felt uneasy discussing their experience, with 54.3% of responses. Decision making indicator, the majority of the patient's family felt uneasy in making decisions related to their experience, with 95.8% of responses. Participation indicator, the majority of the patient's family felt no sense of calmness in terms of participation in their experience, with 87.9% of responses.

The Family Needs on Family Adaptation factor has the highest value, namely 0.227. This indicates that when the needs of a family are increased by 1 unit, family adaptation would increase by 0.227 times. The family coping factor on the family adaptation factor is -0.126. The value of the relationship is negative, which indicates that these factors are inversely related. If the family coping value is increased by 1 unit, family adaptation value would reduce by 0.126 times. Patient factor on family adaptation factor has a value of 0.042. This indicates that if the patient factor is increased by 1 unit, family adaptation value would increase by 0.042 times. The Service Provider Structure Factor on the Family Adaptation factor is -0.032 which indicates that these factors are inversely related. If the value of the service provider structure is increased by 1 unit, the value of family adaptation would decrease by 0.032 times.

Conclusion

Family coping factors affect family adaptation factors. The value of the effect is -0.126, meaning that if the family coping factor is given a value of 1 unit, the patient's family adaptation value would decrease by 0.126 times. There is no effect of the Family Coping Factor on the Fulfillment of Family Needs Factor/CCFN. The family coping factor has no effect on the Fulfillment of family needs factor. Fulfillment of family needs factor affects the family adaptation factor. The effect has value of 0.227, meaning that if the family needs fulfillment factor is given a value of 1 unit, the patient's family adaptation factor would increase by 0.227 times. Findings in this study reveal that the factors required to fulfill the needs of families' whose family member is treated in the ICU include: therapeutic communication, family involvement in treatment, mental support, comfort and closeness to patients. These factors directly affect the adaptation of the patient's family. Meanwhile, indirect factors include the patient, psychology of family, services and family coping. In conclusion, the most effective factors that help patient's family adapt to the situation are closeness to patient and mental support. Not all factors affected family adaptation. This may be related to the location of study, which was at Bangil General Hospital.

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