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FAMILY NURSING IN THE ICU

Systematic Literature Review

(Bachelor Thesis)

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Thesis Abstract

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Title of thesis: Family Nursing in the ICU: The systematic literature review

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Aim: The aim of this literature review is to systematically review the presence or identify the needs and the role of family members having a relative in the ICU, the role nurses play and also the impacts the nurses have to the patients. This study provides insight into the family's experience of being in the ICU

Purpose: The purpose is to conduct a comprehensive description and define roles and responsibilities been played by family nursing in the Intensive Care Unit (ICU).

Method: A systematic literature review of scientific articles obtained from Cinahl EBSCOhost, PubMed, Science Direct and Educational textbooks. The data is being analyzed using inductive content analysis.

Conclusion: These studies support the suggestion that family nursing in the intensive care unit (ICU) increases parents' satisfaction and coping. Patients´ needs and outcome are presided over needs of family members. Families nursing eventually resolved by seeking information and resources. Health care professionals can minimize the stress associated with hospitalization of relatives in the ICU by anticipating and addressing the family's needs for information and resources. Effective and improved communication between health care team and the family members, family friendly environment and proper satisfactory waiting rooms for relatives.

Keywords: Intensive care unit, Family nursing, Family, Family health care, Critical care, Promotion of family nursing, Family centered care, End of life care, Nursing intervention

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TAVÖITE: Tämän kirjallisuuskatsauksen tavoite on käydä järjestelmällisesti läsnäolon tai tunnistaa tarpeet ja rooli perheenjäsenistä, jolla on sukulainen teho-osastolle, sairaanhoitajien rooli ja myös vaikutuksia sillä on potilaille.

TARKOITUS: Tarkoituksena on tehdä kattava kuvaus ja määrittää roolit ja vastuut perheenjäsenten hoitamana tehohoidossa.

MENETELMÄ: Systemaattinen kirjallisuuskatsaus tieteelliset artikkelit ovat hankittu näiden kautta Cinahl EBSCOhost, PubMed, Science Direct ja Kasvatullisista oppikirjoista. Aineisto analysoitiin käyttämällä induktiivista sisällön analyysia.

YHTEENVETO: Nämä tutkimukset tukevat ehdotusta, että perheen hoitotyö tehohoidossa kasvattaa vanhempien tyytyväisyyttä ja selviytymistä. Potilaiden tarpeet ja tulokset ylitsee perheenjäseiden tarpeet. Perheen hoitotyön lopulla ratkaistaan etsimällä tietoa ja resursseja. Terveydenhuollon ammattilaiset voivat minimoida stressin sukulaisten vieraanvaraisuudella tehoosastolla ennakoimalla ja käsittelemällä perheen tarpeiden tiedolla ja resurssilla. Tehokas ja parannettu viestintä terveydenhuollon tiimin ja perheenjäsenten, lapsiystävällinen ympäristö ja asianmukainen tyydyttävä odotushuoneet omaisille.

AVAINSANAT: Intensiivinen hoito yksikkö, perheen hoitotyö, perhe, perheen terveydenhuolto, tehohoito, perhehoitotyön edistäminen, perheelle keskitetty hoito, saattohoito, hoitotyön väliintulo

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Abbreviations

CC	Critical Care
CCFNI	Critical Care Family Need Inventory
CCN	Critical Care Nursing
EOLC	End of Life Care
EU	European Union
ICU	Intensive Care Unit
US	United States

1 INTRODUCTION

Family members of patients in the intensive care unit (**ICU**) are a major obligation of ICU physicians and nurses and an important standard in assessment of quality of care in the ICU. Although experiencing expressive disorder, patients' family members are called on to actively represent the patients and share with healthcare staff in making crucial decisions about the patients' care. As patients recover and regain awareness, their family members become their most important source of personal support and relate to the healthcare team (Jacobowski et al. 2010.)

The most tenacious single documented need of patients' family members during **ICU** hospitalization is access to clear, understandable, and honest information about the patients' medical circumstance. In addition, the manner in which this information is transmitted and the development of trusting and reciprocally respectful relationships between the family members and the healthcare team are crucial factors in helping families, which bend to this traumatic situation. (Auerbach, Kiesler & Rausch 2005).

The day-to-day routine in a hospital without the **ICU**, as a highly specialized and engineered unity, is not credible. The fact that more and more people endure life-threatening health tragedy is due to the progress of intensive-care medicine. To account for this progress, the **ICU** familiarizes itself more to high-tech development than to the needs of patients or their relatives. To be seriously ill in intensive care affects the whole family and not only change life of affected people concerned.

The importance of family members for patients in intensive care is existentially and a critical factor for the assessment of quality in care in an **ICU**. (Department of Nursing Science, University of Vienna 2009.)

Families that have a seriously ill family member in an intensive care unit (**ICU**) face a challenging situation, threatening the normal functioning of the family. Specific characteristics for the **ICU** situation are the sudden commencement of illness and the

distressing experience it causes for the family. This may lead to a temporary family crisis, i.e. the pressure becomes so severe that the family system is powerless and debilitated. (Söderström et al. 2009.)

An ICU provides care for seriously ill or injured patients. Patients are admitted to the ICU as part of a planned stay, such as following major surgery. Others are admitted unexpectedly after an accident like a heart attack, or serious infection.
The **ICU** varies from other divisions in the hospital for the reason that it has special equipment to observe and support a patient's body systems like the lungs, kidneys, or heart. In addition, the team of doctors, nurses, dietitians, therapists, and technicians has exceptional training in caring for the critically ill.

The aim of this study is to systematically review the presence or identify the needs of family members having a relative in the **ICU** and the impacts it has to the patients. The purpose is to conduct a comprehensive description and define roles and responsibilities played by families and the nurses in the Intensive Care Unit **(ICU).**

1.1 Family nursing

According to Hanson (2005, 9) family nursing, also referred as family health care nursing, is defined as the process of providing care for the health care needs of the families that are contained by the scope of nursing practice. Family nursing is skill and science that has developed since the 1980s as way of thinking about and working with families when one of the members is receiving nursing care (Hanson 2005, 4).

According to Hitchcock,Schubert & Thomas 2010, family nursing presents as caring that a nurse relates to individuals within the context of the family with the aim of improving the complete health position of the family or an individual member. This is done by analyzing the strengths as well as the health needs of the family. Thus, the behavior or character, shown by the nurse when caring for an individual is the same shown by the family.

It is well thought-out that health affects all families when dealing with family nursing, and families have consequence on the process and result of health care (Kaakinen 2010; Hanson and Kaakinen 2005). When conducting family nursing, nurses need to be aware that families varies in structure, function and processes.

The variation happens even inside given cultures. The family variables are dependent on the health status of the patient, and the overall health status of the family. (Kaakinen 2010.)

There is consequence on the whole family when one person is ill and it can cause changes in the family roles and in the daily life of the family. If an individual of the family is in hospital, other members of the family usually want to visit him/her, which causes changes in the family's time management and daily routines.

In family nursing, the patient and his family are seen as a unit of care (Kaakinen 2010.) By way of this observation, the nurses have wider viewpoints in approaching the health care need of the patient and his family as a whole (Mae Harmon Hanson and Rowe Kaakinen 2005.)

The subject area of family health care nursing has been growing over the last years. For some, there is distorting of lines as to how family health care nursing is unique from other specialties that involve families, such as community health nursing, maternal-child health nursing, and mental health nursing.

Family health care nursing is a partnership approach to health care decision-making between the family and health care supplier. Family health care nursing is commonly used to describe ideal health care as experienced by families. (Kuo et al. 2011.)

Family health care nursing is the process of providing for the health care needs of families that are within the latitude of nursing practice. This nursing care can be intended toward

the family as context, the family as a whole, the family as a system, or the family as a component of society. (Kaakinen 2010.)

1.1.1 Family Health Care Definition

Denham 2012 describes family health as members caring for one another's well-being (i.e. mental, emotional, spiritual, and biophysical needs). Thus, family health as a collective experience prejudiced by values and goals where members help one another to make changes, fulfill roles, provide support, make effective use of household assets and resources, and address exclusive health needs. Families required to find balance between solidarity and individual needs in order to balance the capricious challenging demands.

1.1.2 Family Health Promotion

Members of the family play different roles in ensuring healthy living style of its members and one of the roles is by ensuring good eating behavior. (Ryttylainen, 2008) explains that Families passionately influence the eating attitudes of children as they learn about different kinds of food and also learn variety of skills and acquire knowledge of food preparation and consumption. This takes place in the family through observation, imitation and sometimes direct teaching.

Healthy eating behavior together with exercises are basics for healthy living. Making available the right nutrients is essential to the growth and development of members in the family as well as improving learning ability and preventing health problems such as dental decay, anaemia, obesity, and others that garner up as a result of proper nutrition.

There are many factors, which determined nutrition such as the demography, which reflects age, household size, sex, the economic status, place of living, talking of income

level etc. The eating behavior of people are critically influenced by social environment in which one finds himself/herself and for children, they are largely determined by family factors such as the social status of parents, education and profession.

1.1.3 Definitions of Family

There is no commonly agreed-upon definition of “family.” “Family” is a word that conjures up different images for every individual and group, and the word has evolved in its meaning over time. Definitions differ by discipline, as presented in the following examples:

- Legal: relationships through blood ties, guardianship, adoption or marriage
- Biological: genetic biological systems among people
- Sociological: collections of people living together
- Psychological: groups with strong passionate bonds

Early family social science theorists (Kaakinen 2010, 7-8) adopted the following traditional definition in their writing:

“The family is a group of persons joint by ties of marriage, blood, or adoption, creating a single household; interacting and interconnecting with each other in their respective social roles of husband and wife, father and mother, son and daughter, brother and sister; and creating and maintaining a common culture.”

Presently, the U.S. Census Bureau defines “family” as two or more people living together who are related by genetic, marriage, or adoption (Seccombe & Warner, 2005, 6). This traditional definition continues to be the basis for the application of many social programs and guidelines. This definition is not very satisfying because it excludes many diverse groups who consider themselves families, for example cohabiting couple’s families, gay and lesbian couples.

In the nutshell “family” can be refer as two or more individuals who depend on one another for emotional, physical, and economical support. The members of the family are self-defined.

Hitchcock et al. 2010, defines family as a unique identified group comprising of two or more people whose relationship is characterized by special terms and may or may not be related through bloodlines or through blood but they operate in such as a manner as a family. In this regard, the definition does not insist on or excludes the blood affiliation ties but it incorporates the universal view of all the forms of family be it nuclear or extended. The nuclear consists of husband, wife and children (natural, adopted or both), extended which comprise of those members of the nuclear family and other blood related persons mostly from family of origin (Hitchcock et al. 2010).

Commission 2008, explains the major functions of the family as raising, nurturing, socializing and protecting the children. Supporting and improving the security of family members through the provision of emotional and physical support. Providing a logic of belonging and showing affection to both adults and children as well as identity in the social environment.

‘Family’ is defined also as a self-identified group of two or more individuals, who may or may not be related by bloodlines or law, but consider themselves a family (Bowden & Greenberg 2010, 5). ‘Family of origin’ is the family you were born into and ‘new families’ refers to adult children’s partners and their children.

Family systems theory proposes that families consist of several different systems and are entrenched in broader systems within society. For example, family systems consist of the sub-systems of the spousal or parental subsystem (dyadic subsystem), the parent-child subsystem and the mother-father-child subsystem (triadic subsystem). Each of these subsystems effects and is influenced by the other subsystem within a family system. In turn, a family system is prejudiced by the broader suprasystems in which it is nested,

such as the neighborhood in which the family lives or the school system with which they interact (Fine & Harvey 2006, 244).

Lodge et al. 2011, explains that, family can be expressed or thought of as an institution that provides a logic of belonging to members but not always linked by legal or biological relationships. This idea is because provision of belongingness does not only take place in the context of lawfully or biologically connected members or individuals (Lodge et al. 2011).

1.2 History of Family Nursing

Family health nursing has origins in society from ancient times. The historical role of women has been inseparably intertwined with the family, for it was the responsibility of women to care for family members who fell ill, and to seek herbs or medications to treat the illness. In addition, through “proper” housekeeping, women made efforts to provide clean and safe environments for the upkeep of health and wellness for their families (Bowden and Greenberg 2010).

During the era Nightingale, the development of families and nursing became more obvious. Florence Nightingale influenced both the establishment of locality nursing of the sick and poor, and the work of “health ministers” through “health-at-home” teaching. She believed that cleanliness in the home could eliminate high infant mortality and disease rates. (Lundy & Janes 2009). She encouraged family members of the fighting troops to come into the hospitals during the Crimean War to take care of their loved ones. Nightingale supported aiding women and children to achieve good health by promoting both nurse midwifery and home-produced health services.

In 1876, in a document entitled “Training Nurses for the Sick Poor,” Nightingale encourages nurses to serve in nursing both sick and healthy families in the homebased environment. She appears to have given both homebased health nurses and maternal-

child nurses the order to carry out nursing practice with the whole family as the unit of service (Kaakinen J, 2010, 8).

In colonial America, women continued the centuries-old traditions of development and sustaining the wellness of their families and caring for the ill. During the Revolutionary War, women called camp followers provided nursing care. These unqualified nurses performed many functions for the troops. During the Civil War (1861–1865), nursing of the wounded soldiers became more organized. Women formed Ladies Aid Societies,

1.3 Family Nursing Models and Approaches

Family nursing takes into consideration four approaches and how its been viewed and, at the same time, cuts across the individual, family, and community for the purpose of promoting, maintaining, and restoring the health of families. These approaches includes

- Family as a context
- Family as a client
- Family as a system
- Family as a component of the society

This framework in figure 1 shows the intersecting concepts of the individual, the family, nursing and society. The approaches have their basis from different areas in nursing, ranging from Maternal-child nursing, primary care nursing, mental health nursing as well as community health care nursing. All the approaches are reference point for nursing assessment and interventions and the kind of approach adopted by a nurse is determined by factors like situation of the family, the resources available to the nurse and the environment of the health care (Rowe Kaakinen et al. 2010, 9).

1.3.1 Family as a context

This method of family health nursing discharges its activity of assessment and intervention of the individual member concerning the family as a whole. Thus, the family is seen as the foundation for nursing an individual client. The family helps as a resource or aid to the health and illness of the individual or act as a stressor of the same (Rowe Kaakinen et al. 2010, 9).

This approach is often used in maternal-child nursing. The whole approach is built on the kind of family support an individual will get in association with professional nurses with regards to promoting their health and taking care of illness. The background information of the family is an enormous help to the nurse in assessing and determining the appropriate involvement to the consumer (Rowe Kaakinen et al. 2010, 9)

The question one should ask for example is that, will clients get help from any family member in taking their medication at night? On the other hand, who can prepare special diet food for client based on prescription? This is a traditional way of family nursing where by families are greatly involved in the health needs of an individual. In some cases, where an individual is very sick, amount of medications to be administered to the individuals are given to a family member beside him or her (Rowe Kaakinen et al. 2010, 9)

1.3.2 Family as a client

This approach to family nursing care is constructed on the assessment of the entire family members. The family here is seen as the client and treated as an individual. This means that every individual is included in the whole assessment and intervention. Therefore, each individual is assessed and health care is provided for all the members (Rowe Kaakinen et al. 2010, 10)

The approach is evident in the primary care hospitals in the community whereby primary care physicians provide health care from time to time to all the members of the family. Through this approach, the providing of health care to an individual call for the same to be given to the other member but not automatically the same intervention. This is because the ill-health of the individual also affects the other members in the whole family hence the need to incorporate them in the intervention (Rowe Kaakinen et al. 2010, 10)

Family care physicians normally use this method in the community sceneries. Important questions asked by physicians in this method to assess and intervene a health situation is how an intervention rendered to an individual affects the other family member. Example of how does every night need of medication affect the other member of the family? On the other hand, who is affected due to the diagnose of an illness in the family? Again how are family members coping with change of diet or preparing of different kinds of food due to new medication advice (Rowe Kaakinen et al. 2010, 10)

1.3.3 Family as a system

This is the third method to family nursing care and it outlooks the family as a system of interaction, intervention and assessment which goes beyond the family as a whole thus the interaction that occur between the members of the family becomes the approach point of focus for nursing interventions (Rowe Kaakinen et al. 2010, 10)

The family as a system approach focuses on both the individual and the family members at the same time. The approach operates on the idea that as a system, anything that happens to one part affects the other parts thus if one family member becomes ill, the situation affects the other members of the whole family. The important point here is the collaborations between members of the family (Rowe Kaakinen et al. 2010, 10)

Specialty of psychiatric and mental health nursing is one approach for the foundation of family system. The relevant questions asked in assessing and intervening a health

situation is how a health problem has affected the other members of the family or how an intervention implemented by a physician impact on the day-to-day living conditions of the other family members. E.g., How has the diagnosis of a disease of a family member affected the other family members? How are family members getting along since the change of family routines due to a member's ill health (Rowe Kaakinen et al. 2010, 10)

1.4 Family as a component of the society

This approach to nursing care is built on the impression that the family as an institution is part of the whole society as other institutions such as economic institutions, religious politics, and education. Henceforth the family is a basic unit of the society and forms a part of the broad system of the society. There are communications between the family and the other institutions in the society to receive and exchange information and undertake services for common benefits of all the units. This method of family nursing thus focuses on assessing and intervening a health situation based on the interactions of the family with the other institutions in the society. Thus, nurses and physician's assessment and interventions are based on these communications. The important questions asked here is how the family has been affected by the activity of other institution in the society such as joining a support group to help families with Cancer diseases (Harmon Hanson and Kaakinen, 2005).

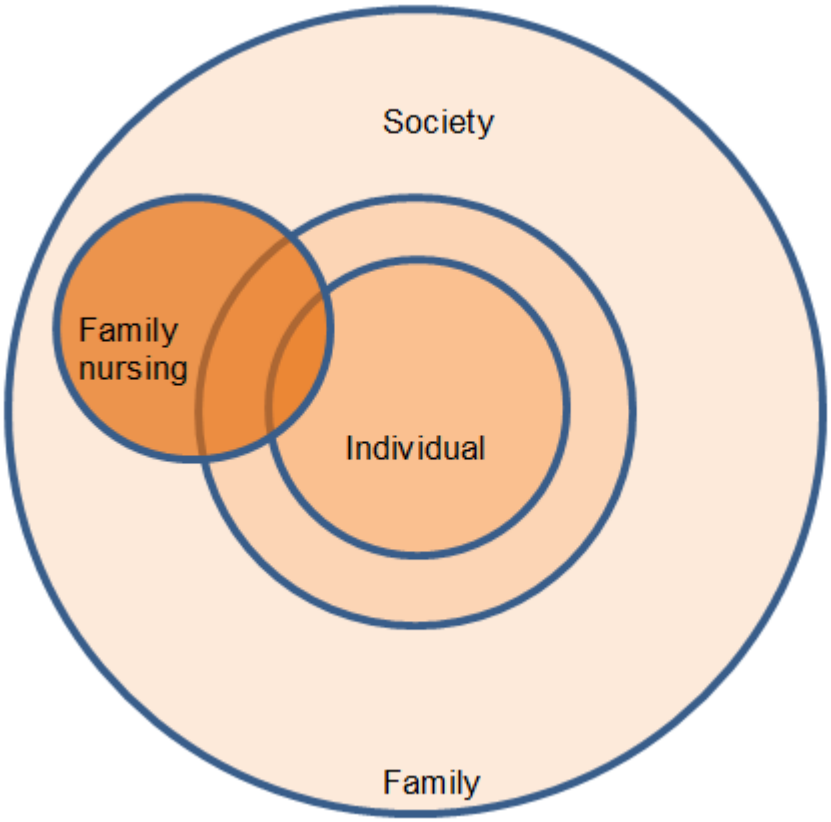

Figure 1. Family nursing conceptual framework (Rowe Kaakinen et al. 2010, 10)

In family as context-approach, the family is understood as context, the individual is perceived as foreground and the family as background; this is the traditional nursing focus. In this kind of setting, the family is seen as either a resource to the individual concerning their health or illness as seen from figure 1. This model is usually used in maternity and pediatric health care setting. (Kaakinen 2010, 10.)

Another model for viewing family nursing practice, where family nursing is understood conceptually as the mix of theories and strategies from nursing, family therapy, and family social science, as seen from figure 2.

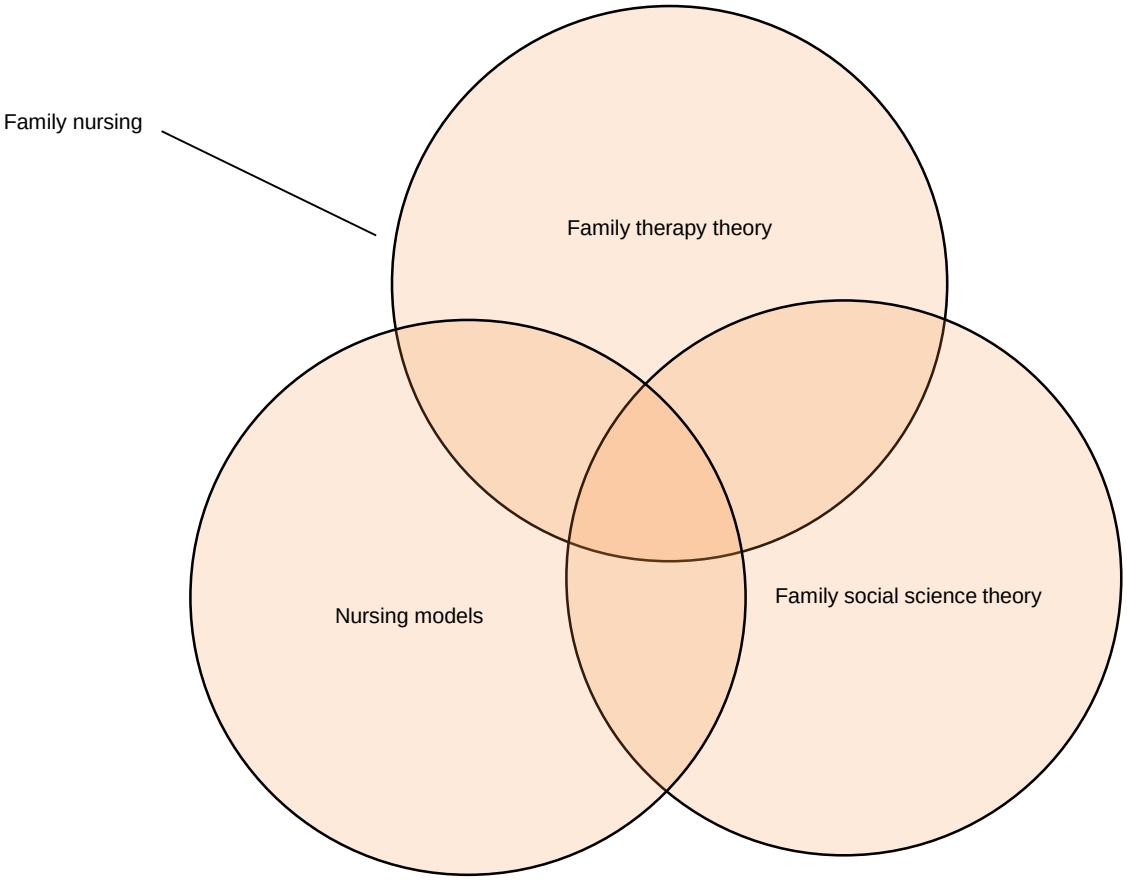

Figure 2. Family nursing practice. (Rowe Kaakinen et al. 2010, 11)

Family nursing continues to incorporate concepts from family therapy and family social science. They acknowledged that advanced experts in family nursing have a slenderer focus than generalists; however, they claimed that family assessment is an important skill for all nurses practicing with families. (Kaakinen 2010, 10).

This family nursing approach focuses at the same time on the individual and on the family. The core idea of this approach is that if a health issue affects one of the family members, it affects the whole family. This kind of approach is usually used in psychiatric and mental health nursing. (Kaakinen 2010, 10–11.)

In the family as component of society approach the family is seen as a component of society, as one of the many institutions in society. Family is considered as same kind of institution such as religious, health or economical institutions. As part of society, family interacts with the other institutions. This kind of approach can be seen in use in community health nursing. (Kaakinen 2010, 12.)

In addition to the previously mentioned models, one way of looking at family nursing can be seeing it as an interaction between the family and the nursing staff and as the co-operation that comes along with it. With this kind of approach understanding the basic questions of the family, hearing the wishes of the family and recognizing the coping methods of the family is vital. (Merimaa, 2012.) Another way of looking at family nursing can be seeing the whole family as an entity and providing the care for the whole unit. This kind of approach requires estimating the family needs and surveying the resources of the family. (Merimaa 2012, 10.) The different life situations and life events in families may require special attention in the family nursing approaches and models

2 FAMILY NURSING IN THE INTENSIVE CARE UNIT (ICU)

The critical/Intensive care unit is a specially designed and furnished facility, staffed by skilled personnel to provide effective and safe care for patients with life threatening or possibly life threatening health problems. The critical care activities require special and effective equipment as well as highly trained nurses, physicians, and other supportive services. However, the operation of critical care nursing is quite expensive and thus, require effective planning (Kuruvilla, 2008).

2.1 Family–Centered critical care

Family-centered care is a metaphysical approach for providing care to patients and their families. The basic principle of this philosophy is that patients are part of a larger "whole" of which we must be aware if we are to provide the best possible care (Tonetta-Stanker, 2009).

Family-centered care is care that demands a collaborative approach to care in which all members of the team support and value this attitude.

Providing care that is family centered means that one of the nurse has responsibility to help the family likewise the patient to endure the crisis of an illness, which means the nurse has an obligation to meet the three (3) basic needs of the family.

- The need for information
- The need for encouragement/support
- The need to be near the patient

The needs of family members of critically ill patients are well recognized: the need for information, the need for encouragement and support, and the nearness need of patient.

Despite a wealth of evidence supporting these basic needs, many critical care units continue to struggle with executing or upholding family-centered critical care (Tonetta-Stanker, 2009).

Family-centered care moves beyond a theoretical recognition of the significance of patients' family members in healthcare. A family focused unit views a patient's family as the unit to be cared for and organizes care delivery around the patient's family, as opposed to the more traditional patient-centered model (Cannon, 2011).

Providing family-centered care is not a simple endeavor. My experience indicates that divisions that are successful in embracing a family-centered approach typically have characteristics such as strong leaders, a caring staff, and the support of a dedicated multi-disciplinary team. Promoting a family-centered environment takes time and tolerance (Henneman and Cardin 2006)

2.2 Patient in the Intensive Care Unit

Patients in this unit are in a critical condition and physical wear and because of this; they require great level of monitoring and care. Normally patients are admitted as a result of Injury, multiple organ failure diseases such as shock, coma, heart attack, acute respiratory problems, and complications of surgery. These are special case problems and thus need special attention (Cannon, 2011).

Critical care units can be grouped into three main stages depending on the availability of staff and other support equipment and facility at the hospital. The first level is either combined or disconnected from the general ward and patients admitted in this unit are those who need special observation after undergoing a surgery. The nurse to patient ratio is 1:3 and health personnel are not present in the unit at all times (Kuruvilla 2008.).

The second level of intensive unit is able to provide mechanical ventilation for a longer period but lack chance to detailed support activities. Nurse patient ratio is 1:2, junior medical staffs are always present in the unit, and consultancies are available. The unit has also educational programs (Welker and Shiel 2007).

The third unit is very detailed and comprehensive, which is the main teaching and transfer center with cardiothoracic, and neurosurgical facilities. The nurse patient ratio is 1:1 and medical staffs in the unit are always present. This unit has an investigation and teaching responsibility (Welker and Shiel 2007).

The Intensive Care Unit (ICU) is an "extreme" area and can create a great deal of difficulty and stress for patients and families. Effective and appropriate communication is an important part of the healing process, not only for the patient, but also for the family (Welker and Shiel 2007).

The majority of critically ill patients receive sedative and/or analgesic medications to battle the pain and anxiety and improve their tolerance of the ICU environment (Fuchs and Von Rueden, 2008). Sedative and analgesia drugs may perform a role in subsequent mental impairment in the ICU setting (Sessler & Varney 2008).

The risk of having no recall and a longer stay in an ICU is as a result of heavy sedation increases and the risk of delusional memories. ICU patients may also have few memories of the ICU, dreams or hallucinations (Olsen et al. 2009)

2.3 Qualities of nurses in the intensive care unit

The qualification for a person or a nurse to work in the intensive care unit follows specific requirements, which are met by majority of nurses. These are generally registered nursing with license in the country of authority or sponsorship, who is not under any discipline or a legal injunction by a nursing council to work, and has no conditions involved

to the license that should be met in certain control. Due to the nature of the activities at the intensive care unit, there are few needed required skills and qualities desired by some hospitals and nursing institution. (Welker and Shiel 2007).

Directors and other heads of ICU's interview nurses concerning their ability and characters before hiring or assigning them to work in the ICU. This brought about many different characters to look out for, such as good personal organization and the ability to work in a fast-paced environment. Besides, being able to think and come out with an idea in a challenging circumstance, a background history of working in an ethically disciplined manner is valued. The other significant factor for all applicants applying to work in the ICU are those with good clinical skills and references (Landrum 2012).

Therefore, critical nurses in all ranges have the following potentials: confidence, organized, compassion, talented, respectful, and being able to handle pressure and work in challenges, caring and above all else, the desire to learn more from different avenues and people (Landrum 2012).

A critical care nurse once hired is not left alone but made to study under an experienced person who teaches critical nursing technique. A lot of orientation have to be done to assist the nurses and acquaint them with new methods and procedures. Apart from all these, education and training must be unabated to keep them abreast with new techniques and methods, up to date skills and competency (Landrum 2012).

In some countries, ICU nursing workers can obtain certificates of specialization after taking some courses or exams about ICU practices to prove great level of competency and skills in working at the ICU with their certificates. An example is the Certified Critical Care Registered Nurse (CCRN) in the United States of America, which is acquired through examination on practice analysis in critical care.

2.3.1 Health of the critical care Nurse

The area of critical care nursing is very demanding and requires a lot from nurses. As a result, the nurses own health may be affected especially in the area of stress and depression hence; they have adrenaline highs and lows than other nurses in other sectors. Therefore, there is the need for nurses in the ICU to be able to handle their health status very well so that they can deliver very effectively to the patients in their care. (Landrum, 2012).

The following have been identified as means by which ICU nurses can deal with stress;

- Eating well balanced food and drinking a lot of water
- Exercise regularly and acts flexible
- Have enough hours of sleep for about 7 - 8 hours daily
- Get sufficient time for home life, spend able time with family members and friends
- Maintain positive attitude
- Engage in hobbies outside of work
- Counseling should be pursue if needed to handle grief and sorrow.
- Discuss anxieties about patients, co-workers and other health workers with the Nurse manager
- Be numerous and happy (Landrum, 2012).

All these techniques and strategies are important in keeping the nurse active in his /her health and that has very positive bearing in the quality of care of the nurses to render to their patients in the ICU. Apart all the factors named above, ICU nurses must regularly see their own doctors or physicians for immunization on various diseases due to their regular contact with patients (Landrum, 2012).

Family or relative wants in an Intensive Care Unit (**ICU**) has always posed a challenge to healthcare workers especially nurses and doctors. This is because the family members relied heavily on the healthcare workers for information on the patient's condition and development as the patient himself/herself was not able to talk or receive any communication from the healthcare workers as well as the family members due to their medical condition (Hashim & Hussin 2012).

The intensive care unit (**ICU**) is a dynamic health care scenery. The critical care perspective is recognized as being a stressful experience for intensive care patients as advanced technical equipment and continual checking is connected to the critically ill patients. This is a difficult time for the families as they are scared of losing their loved ones (Olsen et al. 2009).

Families that have a seriously ill family member in an intensive care unit (**ICU**) face a demanding situation threatening the normal functioning of the family. Specific characteristics for the **ICU** situation are the sudden beginning of illness and the traumatic experience it causes for the family (Söderström et al. 2009). This may lead to a temporary family crisis, i.e. the pressure becomes so severe that the family system is immobilized and incapacitated. In such a situation, families have to use their capabilities and strengths during and after an **ICU** stay to facilitate changes in the patterns of family functioning in order to adapt to the new situation (Boss 2002).

Family members play numerous essential roles in the medical care of patients in the intensive care unit (**ICU**). These roles include acting as a alternate decision maker, being a caregiver, advocating for patient wishes, assessing patient suffering, communicating information between patients and clinicians, and being a source of hope and comfort (Wilson et al. 2015).

Because of the family's key roles in patient assessment, support, and decision-making, providing "family centered" care is a key component of providing "patient centered care". Effectively engaging and communicating with families are an essential skill that **ICU** clinicians (physicians and nurses) must develop, master, and seek training for as much

like any other skill in the **ICU** (Shanawani et al. 2008). Unfortunately, many studies show that the ability of **ICU** clinicians to communicate effectively with families is not optimal (Fox, 2014). Physicians have low rates of assessing family member understanding and assessing their preferred roles in decision-making.

2.4 Nursing interventions for families

According to (Wright & Bell 2009) nursing intervention is any action or response of the clinician. This includes the clinician over therapeutic actions and internal cognitive effective response that occurs in the context of a clinician client relationship offered to effect individual, family, or community functioning for which he or she is accountable. It can also be termed as roles of nurses in the **ICU**.

2.4.1 Recommendations on circumstance for nursing intervention.

A family member with illness that poses great threat to the other family members for instance, a coma patient can cause great mental health disturbance to the children.

Situation where a family member can add to the severity of the symptoms of the other family member in the intensive care unit. Example failure of family members to visit their relative in the intensive care unit (Wright & Bell 2009).

The first time in which such sickness is diagnosed in the family, family members would not have any former idea, knowledge or experience to give to clinicians for effective diagnoses. This calls for assistance and support (Wright & Bell 2009).

When a family member's condition worsens, it extremely affects others and calls for encouragement and the rebuild of the family. When a family member dies, though it may bring relief to the family, it creates vacuum to the family concerning the patient's death. When a family member dies, though it may bring relief to the family, it creates vacuum to the family the deceased in terms of the role being played by the family members (Wright & Bell 2009).

All available information and data collected by the nurse with regard to a particular patient, makes up the assessment (Gulanick & Myers 2011). This is as a result of methods such as interview, observation and personal report by the patient or family member as well as historic information about the patient laboratory diagnoses, critical listening and analysis and physical assessment. There is interventions that follows the assessment and it is the actual implementation of the plans and actions based on what is diagnosed. (Gulanick & Myers 2011).

Family assessment is important in other to provide and support family to handle illness and difficulties admitted in the **ICU**. An important and widely used model for assessment is the Calgary Family Assessment model that has three main areas namely: the structural, development and functional. Thus, it rest on health care providers to identify which area will be relevant to the family. Families who benefit much from this model are those who experience emotional, physical and spiritual sufferings caused by a family members ill health.

The three main structural agreements are internal (family, composition, and gender orientation), external (extended family and the larger system) and context (Environment, social class, and religion). The structural assessment tools are helpful in understanding a particular family structure and its contact with individuals and Organizations (Srivastava 2007).

The Development deals with the stages, the tasks and the attachments and finally the function deals with expressiveness (emotional communication, verbal communication, nonverbal communication) and instruments (activities of daily living) (Srivastava 2007)

2.5 Promotion of family nursing in the ICU

2.5.1 Spiritual care:

The spiritual state of a family member in the intensive care unit is very necessary at that moment of the person's life. Spiritual care nursing defined by (Sawatzky & Pesut 2005) as "an natural interpersonal ,self-sacrificing and integrative expression thus contingence on the nurse's awareness of the superior dimension of life that reflect the patient's reality" they explain that the importance of giving spiritual care is an avenue for nurse-patient interaction rather than just following a set of rules and principles in nursing.

In addition Van Leeuwen et al. (2006) presents that spiritual issues in nursing has no definite methods and applications. More often than not, the nurse's awareness about spirituality helps in playing important role when dealing with spiritual needs of patients in **ICU**. Other factors such as age, culture, up bring, education and spiritual activities of the nurse are also importance in offering spiritual care in nursing practice.

It was found that there is a confusion over the notion of spiritual care because the nurses have inadequate knowledge and experience of such care.Therefore nurses' education is designed to promote the nurses' spiritual development. Nurses should see to the spiritual needs of the patient regardless of their religious affiliations, this is because one of the nursing's objective is to aid patients to experience fullness in their body, mind and spirit as well as gaining a meaning understanding of reasons for living life (Monareng, 2013).

Lundberg & Kerdonfag (2010), identify the following ways of giving spiritual care to patients and families in the intensive care unit.

2.5.2 Mental Support

An important aspect of spiritual care is the provision of mental support to both the patients and the family members when the patients are in critical condition. This is because the admission of a member in the ICU brings stress to both the family and the patient and if not dealt with can lead to depression (Lundberg & Kerdonfag 2010).

The provision of mental support takes the form of the nurse being present, listening to family members complains, showing empathy and touching as well as speaking words of encouragements and engaging family members and the patient in the patient's care plan and patient's interventions (Lundberg & Kerdonfag 2010).

2.5.3 Religious practices and cultural beliefs

In the survey conducted by the nurses, it came to conclusion that the religious practices and cultural beliefs of patients and families in the **ICU** enables them to go through that period of difficulties as well as helping in the healing and recovery and in worse conditions, face death peacefully (McEwen, 2005)

There are different ways by which religious practices and cultural beliefs can be applied in the **ICU** to either help in recovery or dying peacefully. Placing an image of an object of worship of the patients, bed in the **ICU** brings some comfort and hope to the patient (McEwen. 2005)

Some nurses also explain that part of their nursing activities had been playing a tape of a sermon or a prayer by a religious leader of the patient provided an huge peace, harmony and comfort to the patient. When nurses themselves share in the religion and cultural beliefs of the patient and provide these religious interventions, it brings happiness, comfort, security and hope to the entire family and the family expresses profound gratitude to the nurse for administering such an intervention (McEwen, 2005).

2.6 Interacting with the patient and the family

In the survey conducted, majority of the nurses indicated that, another form of the spiritual care is repeatedly talking to the patient and the family. They opined that , many patients in the **ICU** with intubations cannot speak and therefore nurses have to rely on nonverbal means of communication such as using signs and writings on a piece of paper. They expressed that listening and speaking with both the patient and the families' forms part of spiritual care given by nurses as friendship and trust are built and emotional support given. It also explained by some of the nurses that giving specific information about the nursing care and the treatment given to a patient had positive impact on the whole nursing care plan .e.g. Patients agree to treatment plans which sometimes involves arranging meetings between patients' families and physicians (Carta & Clark. 2016).

2.7 Communication and emotional support

Communicating and supporting the patient emotionally is an important factor in promoting healthcare in the **ICU**, talking to and encouraging the patient and family members in many times is very good for their health status. Likewise helping build their self-esteem of quick recovery and using kind, comforting and friendly words to help them leave their present situation in the **ICU** is an important attitude and skills that nurses in the **ICU** adopt to support their patient (Carvalho et al. 2012)

2.7.1 Assessing and treating sleep problems

One of the ways that health givers promote family nursing in the **ICU** is by intervening in the sleeping problems of family members whose love ones had been admitted in the **ICU**. Good sleep has positive impact in the emotional and physiological health of the family caregivers. However most family caregivers whose loved ones are admitted in the **ICU** do not have adequate sleep due to the fact that when a loved one is being admitted in the **ICU.** Stress, anxiety, fear and uncertainty contributes to sleep loss and feeling of exhaustion in the family members before and after discharged from the hospital (Day et al. 2013).

The impact of sleep loss on the physical and the emotional health of individuals and the effect that the reduction in stimuli, relaxation and a healthy sleep routines can have on a caregiver's ability to minimize sleep loss. Inadequate sleep has been associated with health challenges like heightened heart rate as well as cortisol and an adverse effect to the nervous system. Moreover, long-term effect of inadequate sleeping is impairment of the glucose metabolism and weakening immune system. There is also sign of stress and depressions and finally leading to poor quality of life (Carta & Clark. 2016).

Many identified factors that cause lack of sleep impediments are from television, radio, noisy environment, disruption of daily routine and physical activities as well as eating habits that cause sleeplessness (Day et al. 2013).

In combating sleeplessness, they explained that a sleep evaluation questionnaire be used to help caregivers identify the various factors that causes the sleeplessness and then appropriate intervention developed to handle such cause. Three main behavioral techniques were identified to deal with this challenge (Day et al. 2013).

2.7.2 Stimulus reduction

This method aims at reducing the factors that causes the sleep adequacy include environment, chemical, physical and emotion. Each factor causes the caregiver to be awake. Some of these factors that find themselves in the bedroom include television, radio, computer and tables used for activities disrupts sleep as such therefore caretakers are guided to know what disrupts them and keep those out of the bedroom. In addition, chemical activity like drinking caffeine, which causes sleeplessness should be avoided. Also physical activity done early before sleep promotes good sleep and reduce emotional stimulants like stress and fear through counseling (Day et al. 2013)..

2.7.3 Relaxation

Although anxiety and fear are to be expected when a family member is critically ill, acknowledging these feelings and practicing relaxation techniques can reduce the impact that the feelings have on a sleep. Often caregivers say it is hard to fall asleep because they cannot stop thinking about things or because thoughts keep running through their mind (Skoog et al. 2016

In instances such as these, family caregivers can be encouraged to do any of several activities such as, get out of bed and write down their thoughts (journaling); practice thinking about a quiet, comfortable, relaxing place (visual imagery); and repeat the same word over and over (e.g., river) while concentrating on making their breathing the same length on inspiration as on exhalation (meditation). Any of these activities will help “quiet” the mind, allowing the caregivers to fall asleep faster. Incorporating relaxation techniques into the bedtime routine can condition the mind and body for sleep (Skoog et al. 2016)

2.8 Healthy Sleep Routines

Sleep is a basic physiological need of all living beings and the body responds best if it is on a predictable schedule. Sleep is just one of many biological functions that is regulated

by daily pulses. The hypothalamus acts as a biological chronometer to regulate the alteration between sleep and wake states as dictated by internal and external time cues. The light-dark cycle is the most important of these cues. Social interactions, work schedules, and meal times are other extrinsic time cues that contribute to regulating sleep-wake cycles. Internal time cues can also markedly affect sleep. For instance, the time to fall asleep is inversely associated to the duration of the previous period of wakefulness with prolonged sleep loss. This initiative to sleep can be over ridden, resulting in a disruption of the sleep-wake cycle. Although most family caregivers want to stay at the hospital “all hours,” it is important to encourage them to keep a regular sleep-wake schedule. Family caregivers should be encouraged to go home and sleep in their own beds. By reassuring a patient’s family members that they will be notified if any change occurs in the patient and allowing them access to their loved one whenever they are at the hospital, nurses give the family caregivers permission to focus on self-care (Skoog et al. 2016)

2.8.1 Anxiety

One of the problems encountered by family members whose love one is in the intensive care unit is anxiety. Higher levels of anxiety in family members are very intense even when their relative has been discharged. Nurses use facilitated sense making theory in order to help family with anxiety. This theory is based on the idea that family members make sense of the ICU and find their new duties as caregivers. The aim of this theory is to enable family members to cope with the critical illness of their love ones. Family members are engaged in sense making process through varieties of nursing interventions such as:

- Helping the family members to understand the ICU environment
- Fulfilling the family members need for information

- Guiding them on how to visit
- Directing activities to be performed at the bed side
- Providing family support.

(Skoog et al. 2016)

Family members with a relative in the Intensive Care Unit (ICU) faced a crisis period due to the stress and nervousness invoked by the admission to this unit known for its high mortality rate. Admission to the ICU is mostly unplanned and the patients were usually deemed to be in a critical condition (Hashim and Hussin 2012).

It is important for nurses to meet the needs of family members, as they are advocators for the patients who were unable to decide on the care given their critical condition. Satisfied family members' gives support to the care intervention of the patient and helped improved patient outcomes (Hashim & Hussin 2012).

Nurse are on hand to provide the important needs via good communication and communication should be voluntarily provided as most times family members were uncertain what to ask.

The positive experiences of the patients include sense of safety due to family closeness and security promoted primarily by nurses, while negative experiences included sleep problems, pain, and anxiety and impaired cognitive functioning.

This research also emphasizes the importance of people being nearby which sometimes could be family, nurses and friends.

Other studies show that families promote a feeling of support and security to the patients (Williams 2005).

2.8.2 Ethical challenges

Critical care nurses encounter moral issues on a daily basis and the neglect of these issues at the individual and organizational level often leads to the harm to patients, poor morale to staff, moral distress, increase operational and legal cost, negative public

reaction and loss of public trust in the profession. Studies conducted show some ethical issues in the **ICU**.

An ethical dilemma explained as a problem confronting one with a choice between options that seem equally favorable. For example, a person in a continuous vegetative situation, one might face the decision between prolonging what appears to be a life with no quality and little or no reasonable hope of cover, and allowing the patient to die in his or her own. (Lachman, 2006)

2.9 Conflict between health care team and patient's family

There is a clash in the ICU over assumed futile medical treatment between the two groups that distorts the purpose and the goal of care of achievable outcomes. The ICU team see that a patient may never regain consciousness and that a further medication may lead to more harm without any benefit but family of the patients see the purpose and benefit of his continuous life support. Patient's living will have been completed with an awareness of cancer and as such family member feels that removing the life support of their loved ones is a denial and sabotage of his wishes communicated in both conversation and in writing. Even though he or she cannot do anything to alter the condition of the family member, there is a feeling of a sense of responsibility to safeguard the choices of the patient (D. Urden et al. 2016).

2.9.1 Patient suffering and nurse distress

Attention and monitoring of patient's suffering and reaching a consensus or settling the grudge on the futility of a medication is an important ethical and palliative care issue. Nurses in the **ICU** more often than not experience much moral distress with the commonest scenarios being the feeling of pressure to provide life-sustaining treatment to

dying patients. The provision of medication that prolongs the death of the patient however the patient will not make it; as such, the treatment is futile.

Due to the continuous presence of nurses at patient's bedside, they witness the intense suffering of patients. Again, they are responsible for carrying out orders that does not come from them and seeing them as not appropriate or in some cases harmful to the patient. Imposing these treatments on patients that they would not have chosen for themselves or their family members' causes moral distress to the nurses during the application. (Hartjes 2015).

Most often, critical care nurses experience moral distress whereby they know the ethically appropriate thing to do but are unable to do or act contrary to the personal and professional values and this is because of lack of direct involvement in end of life decision making. Open discussion with the ICU team as well as the family and the patient on the issues of the wishes and concerns of the patient reduces moral distress. Knowledge of the ethical, legal and palliative principles involved in such decision-making will make their participation in the decisions more valuable. (D. Urden et al. 2016)

2.9.2 Conflicts between faiths based care and standard care

Most often, there are conflicts between faith based care and standard medical care. Religion is a guide for morality for many people but it does have some limitations in the multicultural environment. Since most religions establish moral principles in a dogmatic, commandment like form, there usually is no room left for rational consideration. Thus when facing a dilemma most religious morality may be found to be lacking the proper intellectual tools for handling these hard cases. (Lachman 2006)

2.9.3 Developmental ideas

Most family members who have their patient at the **ICU** are not able to get proper sleep due to the change of environment and other factors like anxiety. The visitors lodge should be built in such a way that, it would make it look like the home environment to make the family members feel a little bit at home.

Information must be available to the family of the **ICU** patients and by this, a special site on the hospital website could be open where all the information of the patient could be displayed for the authorized family only to see so that they can monitor what is going on everywhere in order to ease unnecessary tension. They can also think about medication at home before coming to see the physician to discuss the way forward. This reduces stress as family members are sure that their loved one is been properly cared for.

3 FAMILY OF THE INTENSIVE CARE UNIT PATIENTS

The admission of a patient to an ICU is recognized as being a stressful experience for families. In this study, the researcher considers family to include family members as well as close friends. Family needs and concerns within the critical care context have been explored from the review perspective (Mallampalli et al. 2005). The results from these studies indicate that the family needs hope, adequate and honest information and an assurance that the patient is properly cared for. Families of critically ill patients want to be close to the patient and have a flexible visiting policy. However, these studies have primarily focused on the needs of families in an ICU and lack a differentiation in needs among the family members (Alvarez & Kirby 2006).

Also family members would like to sleep well when staying overnight having gone through the daily routines for caring for their patients; they would like to have enough sleep so that they can have sustenance and new strength to continue care of their love one. Again, family members need physical comfort in terms of conducive place of sleep free from distraction, comfortable bed, well-ventilated place, and enough space for free movement are all important to promote the physical comfortability of the family of the **ICU** patient (Alvarez & Kirby 2006).

Another important need of the family is to be able to participate in the physician's routine i.e. They would like to get an informed knowledge about the health status of their love one during doctor's visitation, and progress of their love one or any new treatment for the patient. (Jocob et al. 2016)

Findings indicate that the family provides a vital source of emotional support to patients and seem to make a very valuable contribution to patients' care and recovery in an **ICU** (Williams 2005).

3.1 Social Support

An external event like serious illness that is harmful can provoke stress reactions which both the patient and the patient's family need to cope with. However, social support can reduce such mental distress and lower the likelihood of illness. Social support is considered the most important form of support when coping with stressful experiences.

According to (Olsen et al. 2009) social support is categorized into emotional and informational support. Emotional support reassures a person that he or she is a valuable individual about who people care. Informational support can help a person to understand a stressful event better and determine what resources and strategies are required in the particular situation. However, sometimes-family members may fail to understand what kind of support they actually needed. Too much or too insistent social support may increase the stress experience. Those providing support could also be affected negatively by the stressful event (Olsen et al. 2009).

3.2 Family Nurses needs in ICU

The needs of families in **ICU** have been the center of family-related research in this context since the late 1970s. Much of the research is centered on the importance of families' needs, as identified in Walter's seminal study (Walters 1995) and the subsequently developed Critical Care Family Needs Inventory (CCFNI). Now universally accepted, we know that families of critically ill patients require honest, accurate and up-to-date information; they want to be close to the patient; they want to be notified of any changes in the patient's condition and they want to be assured that the patient is being well cared for (Wong et al. 2015). **ICU** nurses may have a good knowledge of what families' need, but this might not be translated into clinical practice. Consequently, studies have found that unmet families' needs have a negative impact on family satisfaction in **ICU** (Buckley & Andrews 2011).

3.3 Family and nurse's interactions and communication in the ICU

Studies have shown that some family needs are met by their experiences, interactions and relationships with staff such as through the communication and delivery of information (Blom, et al. 2013).
The ease of communication with staff and the use of everyday language help families to feel confident that their family member is well looked after in ICU. In addition, caring and interactions provide comfort and help allay fears (Williams 2005).
Non-verbal interactions such as eye contact and facial expressions also provide comfort and reassurance (Fry & Warren 2007).

Nurse behaviors that demonstrate a commitment to the family and patient, such as treating them as people, displays of empathy and sharing of information, encourages a connection that reassures and supports families' nurses. When nurses discourage family involvement, fail to acknowledge the family or demonstrate task oriented attitudes towards care of the patient, family nurses express distress and feel excluded (Wong et al. 2015).

Earlier research done in this field indicates that nurses use strategies to hinder the staff family relationship, by distancing themselves from the patient and the family, at the expense of focusing on the technological aspects of the patient's care.
In other research found that nurses, who value the technical and medical aspects of their role and are unable to provide families with comfort or support, represent non-inviting interactions.
In contrast, they also found that nurses who value the development of good relationships with families and feel confident about supporting them characterize 'inviting' interactions. Later, the same authors interviewed families, observed their interactions with staff, and concluded that initial interactions had an impact on the families and influenced further

interactions families had with staff. Unambiguous information and open communication that lead to mutual understanding was important for family nurses to adjust to the system and affected whether they felt consoled or insulted (Söderström et al. 2006).

3.4 Tips for Intensive Care Unit (ICU) Patients and Families

The Intensive Care Unit (ICU) is a very "intense" area and can create a great deal of tension and stress for patients and families. Effective and appropriate communication is an important part of the healing process, not only for the patient, but also for the family.

- Provide a small board for the patient to write on. Many patients can write just enough so you know what they want. The hospital should provide this.
- Speak in a calm, clear manner. Make short positive statements. Many family members undertake because their loved one is on a ventilator where they cannot hear and so they speak loudly.
- Do not ask the patient questions that could not be answered. Use a board so the patient can point to a word such as "pain," this allows your loved one to make his need know. Most **ICU's** have these boards available or will make one for you. It is unusual for patients to be angry, frustrated, or not be interested in communicating. Be patient with them, the frustration level will decrease and perhaps another method of communication will work better for them.
- Simple hand gestures may work as well, such as thumbs up = "good"; and thumbs down = pain" or "I need something."
- Orient your loved one to the surroundings, for example, the date and time of day. You may want to make a sign each day with the date on it and place it where they can easily see it (for example, on the wall at the foot of their bed). Describe what the different noises are to help ease any fear or anxiety they may have about them.
- Hold your loved one's hand or touch them gently (be sure to check with the ICU staff first). For example, rubbing lotion on their hands or feet may not be allowed.

- Read your loved one's favorite prayers, books, poems, stories, or bible verses if a christian.
- Allow music to be played in the ICU when appropriate. Again, be sure to check with the **ICU** staff for guidance.
- Ask the critical care staff to explain to you what the status of your love one is, so you understand what is going on and why.
- Do not discuss any unpleasant matters in your love one's room. If your love one's condition is critical, discuss this or other problems outside the room. For example, do not discuss financial matters, or family disagreements, etc.
- Request your church Chaplain, the hospital Chaplain, or a social worker if you feel you need further support for yourself or for your loved one during the hospitalization.
- Consider setting up a family visitation schedule to spend time at the hospital, this prevents one person from becoming exhausted.
- Consider setting up an information update on the family answering machine so family and friends can get frequent updates on your love one's condition. Multiple phone calls to the Critical Care Unit staff can be time consuming and the staff wants to be at your loved one's bedside.
- Allow your loved one periods of rest, this is a critical part of the healing process. Just sit quietly at the bedside, speak only if your loved one wakes up. Offer support and comfort (Welker & Shiel 2007)

3.5 End of life care (EOLC)

End of life care is defined as the act of helping persons facing imminent or future death to ascertain the best quality of life possible till they come to the end of their life regardless of their medical diagnosis, health conditions or ages (Izumi et al, 12, Noome et al). Thus caring for people at the point of death. The mortality rate in the **ICU** is approximately between the percentage of 15 to 24 worldwide and studies show that, there is a rise in the use of the **ICU** for the last 30 days of a person’s life (Tenol et al. 2013).

Identifying an appropriate intervention for a particular patient in the **ICU** is one of the key nurse competences. However, coming out with the right intervention by end of life intervention is difficult in the field of critical care medicine which involves highly complex therapeutic and nursing procedures. Studies conducted show the following activities as being frequently used for **EOLC** in the **ICU** (Tenol et al. 2013).

Biological Dimension: This involves events like assisting the patient with basic care scheduling feeding to another time when patient is tired giving culturally accepted food, identifying the patient's care in order of importance and monitoring of the physical or mental continuous breakdown. In addition, it includes providing frequent rest time and reducing discomfort when possible (Tenol et al. 2013).

Social dimension: This dimensions deals with the patient's relational and personal activities. It involves respecting the privacy, supporting the family's effort to be near the patient at all times, respecting specific request by the family and the patient, involving the family in the care decisions, being close to frightened patient (Tenol et al. 2013).

Psychological dimension: This deals with the patient and the families' mental health status, which involves activities like monitoring patient for anxiety, being a good listener to individual feelings, supporting patient and family through stages of grief and also monitor mood changes, assuring both patients and families of nurses' support and availability (Tenol et al. 2013).

Spiritual dimension: The activities here includes providing privacy and quiet times for spiritual activities arranging visits by individual spiritual advisers. Discussing about the issue of death (Tenol et al. 2013).

4 AIM AND OBJECTIVE

The aim of this literature review is to systematically review the presence or identify the needs and the role of family members having a relative in the ICU and the nurse and the impacts it has to the patients. The purpose is to conduct a comprehensive description and define roles and responsibilities played by family nursing in the Intensive Care Unit (ICU).

4.1 Research Questions

How are nurses/patients going to communicate with family members or loved one in the intensive care unit? What special assistance can the family members offer to the patients or love one in the ICU?

5 DATA COLLECTION METHOD

5.1 Systematic Literature Review

In this study, a systematic review of literature is used as the methodology. A review of literature means an organized, critical collection and evaluation of important published literature that supports a study. The major purpose of a literature review is to form an extensive, systematic, and critical review of the most important published scholarly literature on a particular topic. (LoBiondo-Wood & Haber 2014.) This literature review consist of known and unknown about a certain research problem pinpointing on the present research at hand (LoBiondo-Wood & Haber 2014.)

During the process, as research sources are identified and located, keywords are selected and searches were done. The research literature is read, summarized and body of knowledge is gathered. This literature review document the current knowledge of selected topic and indicate the findings that are ready for use in practice and also deliver the current knowledge of the topic under interest and determine the knowledge of phenomenon by the comparison and combination of the findings (Burns and Grove, 2005).

Literature review could be conducted based on the three following steps

1. Using current edited educational textbooks
2. Identifying suitable research sources and
3. Locating the terms identified.

The main features of a systematic review is that reviewers follow a strict procedure to ensure that the review process undertaken is systematic by using unambiguous and rigorous methods to identify, critically appraise and combine relevant studies in order to answer a predefined question (Burns and Grove, 2005).

5.2 Target Group and Perspective

The research focuses on both male and female adults or young admitted in the ICU, relatives of the patients admitted in the ICU and nurses. The search acknowledged the importance of family members providing adequate support to their family patient and identifying their needs in times of crisis, in order to ease the effects of the crisis to the family in the ICU (Hashim and Hussin, 2012).

It is important for nurses to meet the needs of family members, as they were advocators for the patients who were unable to decide on the care given their critical condition. Satisfied family member gives support to the care intervention of the patient and helped improved patient outcomes (Hashim and Hussin, 2012).

6 DATA SEARCHING PROCESS

A systematic literature review was used to do the engine searches and the following data was gathered from the nursing database.

- MedLine
- Cinahl EBSCO*host*
- PubMed
- Science Direct
- E-Journals
- Use of peer reviewed articles not less than 10 years old
- Textbooks internet sources not less than 10 years old

The database search engines above were used. The limitations for all literature searches were: Abstracts, Full text of the article, English language and the articles published from the year 2005 to 2016.

Searched was systematically done on the Cinahl database using Cinahl headings such as:

I. Family and I obtained 15,701 articles
II. ICU, 16,308 articles were obtained
III. 39 articles were hits after the two searches were combined.
IV. I narrowed the search strictly to articles from 2005 to 2016 and 10 articles were hit and used for thesis.

The search on PUBMED was conducted by using the mesh with the following keywords:

I. Family nursing/member and 14,027 were hit

II. The articles were further filtered and centered to articles published in the last 10 years and I hit 30 articles.

After reading through the articles, only seven (7) were relevant and used for the study.

Most of the study information were obtained from Science Direct, which involved detailed scientific articles. The search on science direct gave 350 articles and books and after narrowing them to articles from (2005 to 2016), six (6) textbooks were hits and 31 articles were relevant and used in the thesis.

From the Seinäjoki Medwest library, six (6) textbooks were obtained and 11 other textbooks were obtained from internet sources, which were relevant and used in the thesis. Total of 17 textbooks were used. Figure 3 illustrates the summary and pathway of choosing the material.

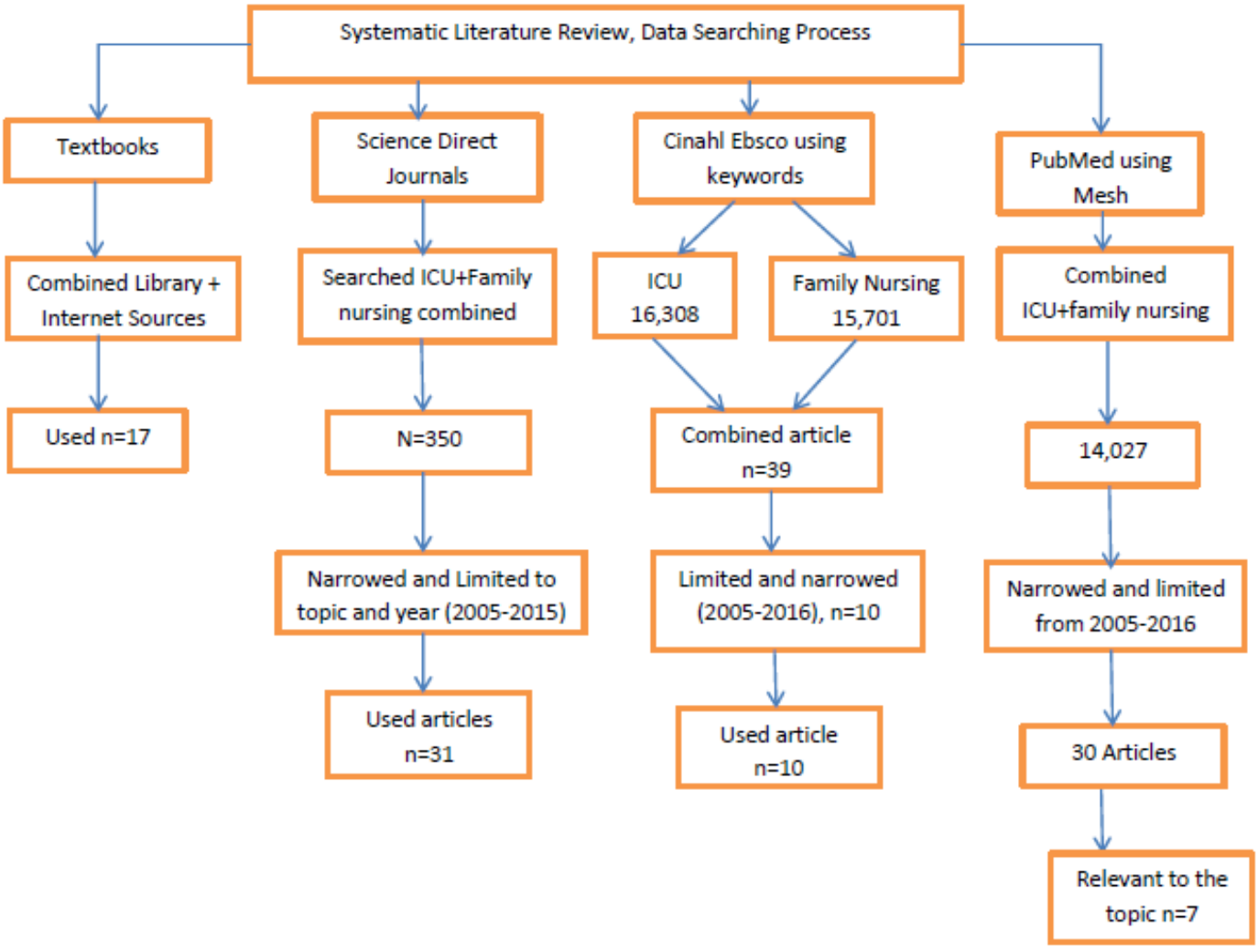

Figure 3. Pathway for material searching

6.1 Key words used for the data searching

- Intensive Care Unit (ICU)
- Critical Care Nursing (CCN)
- Family
- Family Nursing
- Family health promotion
- Family Centered Care
- Family needs
- End of life care

6.2 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria facilitate a literature search by minimizing the relevant articles to a manageable number. The criteria are specified before the formal literature search starts and maintaining the guarantees of the validity of the study (Enmarker et al. 2011). Inclusion criteria are criteria or characteristics that a subject must have to be included into the bigger entity and exclusion criteria are criteria or characteristics that according to which a subject may be excluded from the bigger entity. The chosen inclusion and exclusion criteria ought to be reasoned in a valid way.

The inclusion and exclusion criteria of this literature review were chosen to provide the wanted information and knowledge about the subject under study. Researches are chosen to the inclusion regarding their quality and relevancy to a selected problem. Peer-review articles written in English language covering a wide range of geographical locations (Europe, USA; Asia, Australia and South America) published between 2005 and December 2015 and with the focus on family nursing in the ICU. Research articles included all types of material such as literature reviews, editorials published in nursing journals, research studies as well as class notes and textbooks.

In the present review, articles that were not published in English were excluded because of the language barrier. I did not focus on family nursing in any hospital department other than the ICU.

Research articles that did not match the aims of the present literature review, articles focusing on family nursing in pediatrics, and obstetrics were excluded to streamline my study. Any published papers written before the year 2005 and the studies done in Africa were excluded. The criteria is illustrated in the **table 1**, below.

Table1. Inclusion and Exclusion Criteria

Inclusion	**Exclusion**
Current articles not more than 10 years old	Articles more than 10 years old
Articles used not limited to only in Finland and other EU countries	Articles limited to only Finland and other EU countries
Educational textbooks not more than 10 years were used	Educational textbooks more than 10 years
Articles with full text	Non-full text articles

Title containing one or more keywords	Titles containing no keywords.
Articles focusing on family nursing in the ICU	Not focusing in the ICU
Written in English Language	Written in language other than English

7 DATA ANALYSIS (INDUCTIVE CONTENT ANALYSIS)

According to Lo-Biondo-Wood & Haber (2006, 561) content analysis is a technique for the objective, systematic and quantitative description of documentary evidence. Content Analysis is applied in this final project. It is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action.

The aim is to produce a condensed and broad description of the phenomenon question. Content analysis is a method that may be used with either qualitative or quantitative data and in an inductive or deductive way. Qualitative content analysis is commonly used in nursing studies but little has been published on the analysis process and many research books generally only provide a short description of this method.

Another difference is that qualitative content analysis entails a data reduction process by focusing on selected aspects of data. Data reduction is achieved by limiting “analysis to those aspects that are relevant with a view to my research question (Timmermans & Tavory 2012).

Data analysis was made to facilitative factors between nurses and families' communication that consisted of spiritual care, emotional support, participation, notification and consultation and barriers that were misunderstandings regarding treatment of the patient in the ICU.

The challenges that emanated from nurse/patients communication was bridged by the family member in the ICU. The analysis of the literature review was guided by content analysis, which included detailed search and summarizing of selected articles in a way than the initial review for inclusion. The data analysis stage includes four areas: data reduction, data display, data comparison, and conclusion drawing and verification. Having family members together for a family conference to provide patient feedback allowed staff to respond to questions raised and other family members getting similar information form one source (Davidson 2009).

The setback would be the difficulty of getting the numbers of family members as each would have responsibilities and visited different times, unless for decision on critical

issues like surgery or impending death. From the review, a deep and holistic research was done through the collection of articles, previous thesis and narrative materials (Davidson 2009).

Figure 4. illustrates the abstraction process of the topics used in writing this thesis

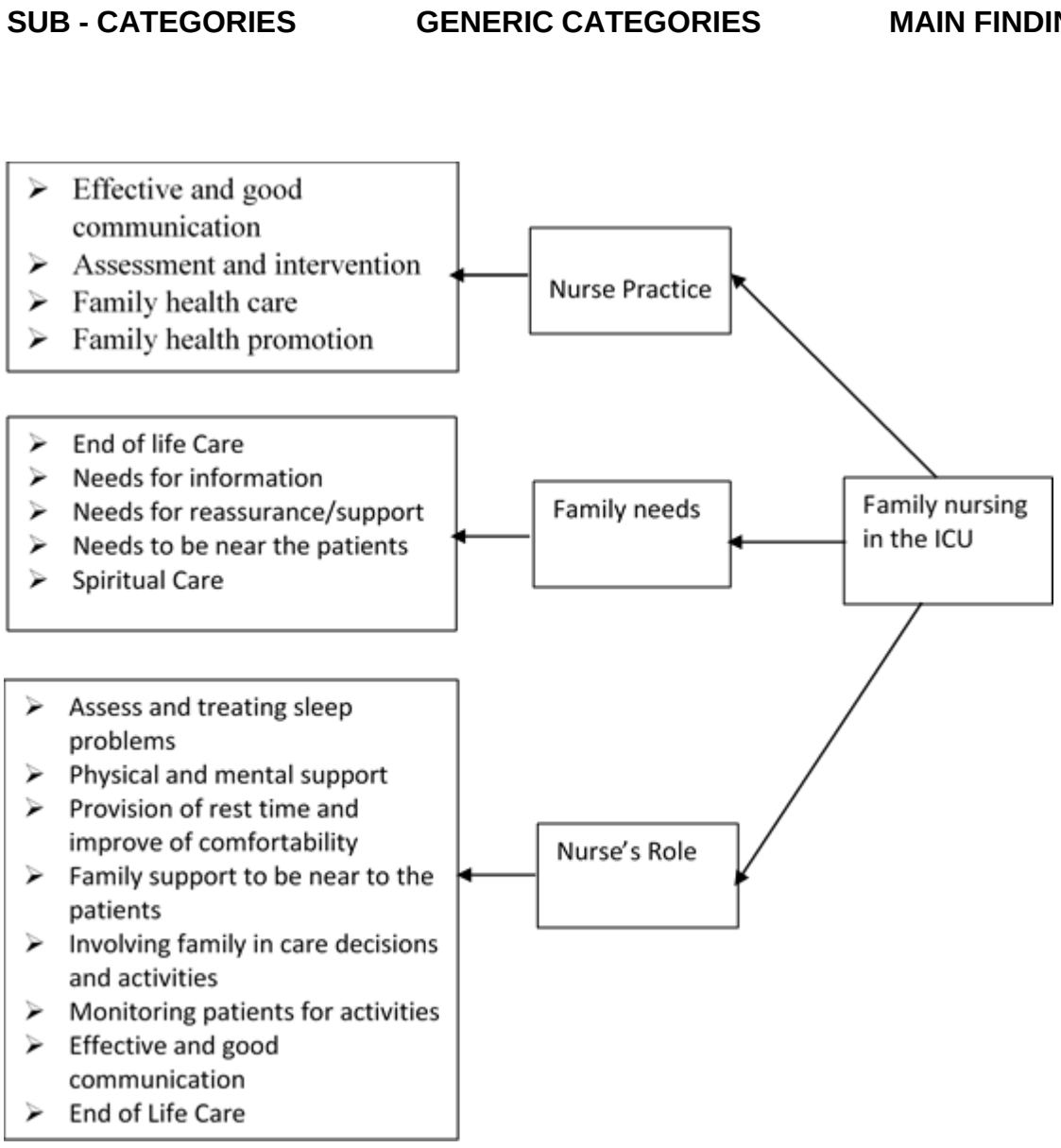

Figure 4. Abstraction Categorization Process

8 RESULTS

A family member of a patient in ICU experiences stress, uncertainty, and emotional turmoil. This condition results in a behavior we labeled hovering. As the preliminary shock decreases, family members begin to refocus, seek information and to trail the patient's care and prognosis. Family members' energies are finally focused toward garnering resources both for themselves and for the patient. Figure 4 explains these processes of four categories: hovering, information seeking, tracking, and the gathering of resources. Hovering is an initial sense of confusion, stress, and uncertainty. Information seeking is a tactic used both to move out of the hovering state and to identify the patient's progress. Tracking is the process of observing, analyzing, and evaluating patient care and status and the family's own satisfaction with the environment and with caregivers. The garnering of resources is the act of acquiring what family members perceive as needed for themselves or their relative. Figure 5 illustrates model of families' experiences in ICU for each stage and nurses interventions.

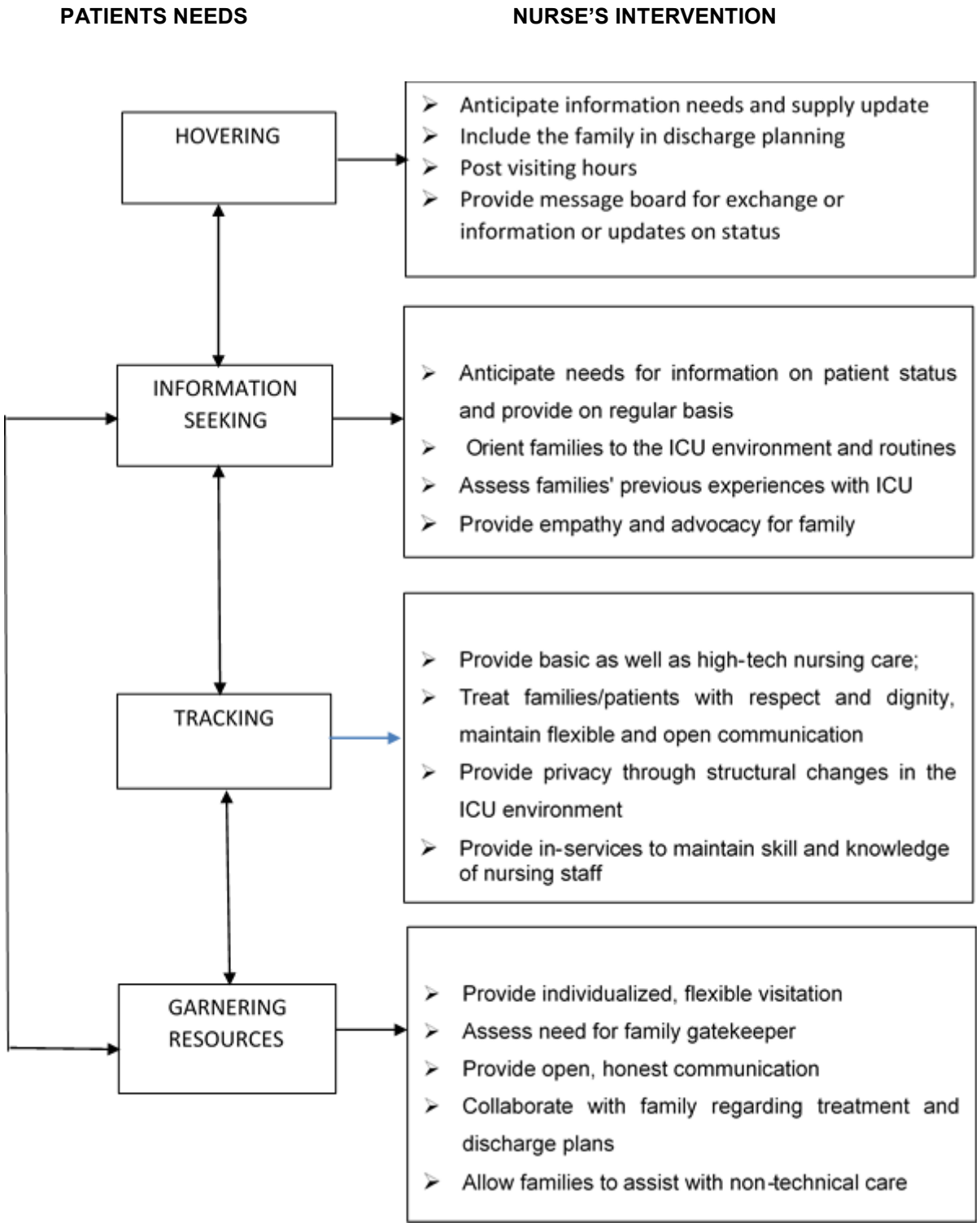

Figure 5. Model of families' experiences in ICU for each stage and suggested nurses interventions

Both Family and the patients in the ICU have special needs that needs attention. The table below shows the results of the main areas of care and intervention and the roles played by the family members and the ICU nurses.

Table 3. *The roles played by the family members and the ICU nurses.*

Area / Dimension	Roles of the family	Roles of the ICU nurse
Biological Dimension	Assisting the patient with basic care. Giving culturally accepted food.	Scheduling feeding to another time when patient is tired. Identifying the patient's care in order of importance and monitoring of the physical or mental continuous breakdown. Providing frequent rest time and reducing discomfort when possible.
Social Dimension. This dimensions deals with the patient's relational and personal activities.	Being close to frightened patient. Involving in care decisions and activities. Being a good listener to the patient and attending to the basic needs.	Respecting the privacy of the patient. Supporting the family's effort to be near the patient at all times Respecting specific request by the family and the patient.

		Involving the family in the care decisions and activities.
Psychological dimensions This deals with the patient and the families' mental health status	Being available to listen to patients needs and requests. Heeding to the request of patients.	Monitoring patient and family for anxiety. being a good listener to individual feelings. supporting patient and family through stages of grief and also monitor mood changes. Assuring both patients and families of nurses' support and availability.
Spiritual dimension.	Arranging visits by individual spiritual advisers. Giving spiritual encouragement if possible.	Providing privacy and quiet times for spiritual activities Discussing about the issue of death.

8.1 Discussion of results

Both the family members whose patient is in the ICU and the nurses' have variuos role to play for the effective management of the patient. The functions performed are grouped into four main dimensions namely the biological, social, psychological and spiritual. These are the major care areas where the patient falls within. However, the ICU nurses' role are both to the patient and the family members because as realized earlier, family members go through some challenges as a result of the admission of their member in the ICU. The needs of the family members therefore fall within the four main dimension of the activities in the ICU. Thus, they also receive biological, social and Psychological care intervention administered by the ICU nurses.

In some cases, both the nurse and the family members jointly perform the roles and therefore great collaboration between the two is very important and this runs through all the four major dimensions. Effective communication and frequent interaction are very essential for an effective intervention to both the patient and the family members.

8.2 Ethics and Reliability

The data collected in this study was from already well-known scientific sources and thus their validity, reliability and ethical considerations were of the utmost standard possible. Plagiarism was evaded at each stage of the thesis writing process by maintaining and recognizing the sources used, quoting them in the text and further showing them in the bibliography. Subsequently the thesis consists of other original research, third party participants or questionnaires; therefore, there is the need to refer the sources in the bibliography.

This study was done conforming to Seinäjoki University of Applied Sciences approved thesis guidelines for bachelor's degree programmes.

9 CONCLUSIONS

These studies support the suggestion that family nursing in the intensive care unit (ICU) increases parents' satisfaction and coping. Families nursing experience a sense of uncertainty that is eventually resolved by seeking information and resources. Health care professionals can minimize the stress associated with hospitalization of relatives in the ICU by anticipating and addressing the family's needs for information and resources.

All the family needs informed in this study need nurses to communicate with the family members in order to meet them. Needs related to the patient and his/her outcome presided over needs of the family members. Also by implementing specific cost-effective strategies to increase family access to the patient, to improve communication with the physician and the health care team, and to create a family-friendly environment, critical care RNs can meet family member needs and improve the quality of nursing care.

Chapter two will review the literature relating to stress in ICU nurses; the needs and experiences of families of critically ill patients; and the experience of nurses as family members

More over some hospital did not have a proper waiting room with basic amenities, but this was considered unimportant.

In other way, the hospitalization of a family member in an intensive care unit can be a very stressful time for the family. Family bedside rounds is one way for the care team to inform family members, answer questions, and involve them in care decisions. Few studies have examined the experiences of family members with ICU bedside rounds (Cody J. S. 2015).

However, further research is needed to determine the benefits of family presence and prevent barriers to true implementation.

BIBLIOGRAPHY

Alvarez, G. & Kirby, A. 2006. The perspective of families of the critically ill patient: their needs. Current Opinion in Critical Care, 12(6), pages 614-618.

Anon, 2016. Intensive Care Unit. [online] Available at: http://www.surgeryencyclopedia.com/Fi-La/Intensive-Care-Unit.html [Accessed 3 May 2016].

Auerbach, S., Kiesler, D. & Rausch, S. 2005. Optimism, Satisfaction With Needs Met, Interpersonal Perceptions of the Healthcare Team, and Emotional Distress in Patients' Family Members During Critical Care Hospitalization. Association of Critical Care Nurse, 14(3), pages 202-210.

Blom, H., Gustavsson, C. & Sundler, A. 2013. Participation and support in intensive care as experienced by close relatives of patients, A phenomenological study. Intensive and Critical Care Nursing, 29(1), pages 1-8.

Boss, P. 2002. Family stress management. Thousand Oaks, Calif.: Sage Publications.

Bowden, V. and Greenberg, C. 2010. Children and their families. Philadelphia: Lippincott Williams & Wilkins.

Buckley, P. and Andrews, T. 2011. Intensive care nurses knowledge of critical care family needs. Intensive and Critical Care Nursing, 27(5), pages 263-272.

Carta and Clark. 2016. Assessing and Treating Sleep Problems in Family Caregivers of Intensive Care Unit Patients. the journal for high acuity , progressive and critical care nursing, pages 16-23.

Carvalho et al. 2012. The nurses' perception regarding health promotion in the ICU.

Cannon, S. 2011. Family-Centered Care in the Critical Care Setting. Dimensions of Critical Care Nursing, 30(5), pages 241-245.

Commission, F. 2008. The kiwi nest: 60 years of change in the New Zealand Families. Wellington: family commission.

Davidson, J. 2009. Family-Centered Care: Meeting the Needs of Patients' Families and Helping Families Adapt to Critical Illness. Critical Care Nurse, 29(3), pages 28-34.

Davidson, J., Powers, K., Hedayat, K., Tieszen, M., Kon, A., Shepard, E., Spuhler, V., Todres, I., Levy, M., Barr, J., Ghandi, R., Hirsch, G. & Armstrong, D. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. Critical Care Medicine, 35(2), pages 605-622.

Day, A., Haj-Bakri, S., Lubchansky, S. & Mehta, S. 2013. Sleep, anxiety and fatigue in family members of patients admitted to the intensive care unit: a questionnaire study. Critical Care, 17(3), pages 91.

Department of Nursing Science, University of Vienna, 2009. Family Friendly Intensive Care Unit. Needs and Need Satisfaction of Critical Care Family Members. Vienna: Prof. Mag. Dr. Hanna Mayer.

Denham, D. S. 2012. Family Health: A framework for Nursing. Ohio: Ohio university press.

Fine, M. and Harvey, J. 2006. Handbook of divorce and relationship dissolution. Mahwah, N.J.: Lawrence Erlbaum.

Fox, M. 2014. Improving Communication With Patients and Families in the Intensive Care Unit. Journal of Hospice & Palliative Nursing, 16(2), pages 93-98.

Fry, S. & Warren, N. 2007. Perceived Needs of Critical Care Family Members. Critical Care Nursing Quarterly, 30(2), pages 181-188.

Fuchs, E. & Von Rueden, K. 2008. Sedation Management in the Mechanically Ventilated Critically Ill Patient. AACN Advanced Critical Care, 19(4), pages 421-432.

Gulanick & L.Myers. 2011. Nursing care plans: Diagnoses, intervantion and outcome (7th p.). Missouri: Elsevier Inc.

Hanson, S. 2005. Family Nursing: Challenges and Opportunities: Whither Thou Goeth Family Nursing. Journal of Family Nursing, 11(4), pages 336-339.

Hartjes, T. 2015. Palliative Care in Critical Care, An Issue of Critical Care Nursing Clinics (Osa/vuosik. 27). New York: Elsevier Inc

Hashim, F. & Hussin, R. 2012. Family Needs of Patient Admitted to Intensive Care Unit in a Public Hospital. Procedia - Social and Behavioral Sciences, 36, pages 103-111.

Henneman, E. and Cardin, S. 2006. Family-Centered Critical Care: A Practical Approach to Making It Happen. Critical Care Nurse, 22(6).

Hitchcock,Schubert & Thomas. 2010. Community Health Nursing :Caring in action. U.S.A: Delmar Learning.

Izumi et al. 2012. Defining end of life care from perspective of nursing ethics. Nurs ethics, pages 608-618.

Jocob et al. 2016. Needs of patients family members in an intensive care unit with a continuous visitation. American journal of critical care, no.25.

Jacobowski, N., Girard, T., Mulder, J. and Ely, E. 2010. Communication in Critical Care: Family Rounds in the Intensive Care Unit. American Journal of Critical Care, 19(5), pages 421-430.

Kaakinen, J. 2010. Family health care nursing. Philadelphia: F.A. Davis Co.

Kleinpell, R. & Hudspeth, R. 2013. Advanced Practice Nursing Scope of Practice for Hospitals, Acute Care/Critical Care, and Ambulatory Care Settings. AACN Advanced Critical Care, 24(1), pages 23-29.

Kuo, D., Houtrow, A., Arango, P., Kuhlthau, K., Simmons, J. & Neff, J. 2011. Family-Centered Care: Current Applications and Future Directions in Pediatric Health Care. Maternal and Child Health Journal, 16(2), pages 297-305.

Kuruvilla, J. 2008. Essentials of Critical Care Nursing. New Delhi: Jaypee brothers medical publishers LTD

Landrum, M. A. 2012. Fast Facts for the Critical Care Nurse: Critical Care Nursing in a Nutshell. New York: Springer Publishing company

LoBiondo-Wood, G. and Haber, J. 2014. Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice. Journal of Nursing Regulation, 5(1), page 560.

Lodge, Moloney & Robinson. (2011). Domestic and Family Violence:A review of the literature,A report for the department of human services. Melbourne: Australian Institute of family studies.

Lundberg & Kerdonfag. 2010. spiritual care provided by nurses in intesensive care units. journals of clinical nursing, pages 1121 -1128.

Lundy, K. and Janes, S. 2009. Community health nursing. Sudbury, Mass.: Jones and Bartlett Publishers.

Mae Harmon Hanson, S. & Rowe Kaakinen, J. 2005. Family Health Care Nursing Theory, Practice, and Research. 3rd ed. Philadelphia: F.A. Davis Company, pages 215-242.

Mallampalli, A., Dowling, J., Lederer, M. & Guntupalli, K. 2005. THE UNMET NEEDS OF CRITICAL CARE FAMILIES AS PERCEIVED BY THE ICU TEAM. Chest, 128(4), pages 185S-b-1-185S-b-2.

McEwen, M. 2005. Spiritual Nursing Care. Holistic Nursing Practice, 19(4), pages.161-168.

Merimaa, E. 2012. How patients and their family members, need of support and counselling can be assessed by written measures. Undergraduate. Tampere University of Applied Sciences.

Monareng, L. 2013. An exploration of how spiritual nursing care is applied in clinical nursing practice. Health SA Gesondheid, 18(1).

Noome, M., Beneken Genaamd Kolmer, D., Van Leeuwen, E., Dijkstra, B. & Vloet, L. 2016. The nursing role during end-of-life care in the intensive care unit related to the interaction between patient, family and professional: an integrative review. Scandinavian Journal of Caring Sciences,

Olsen, K., Dysvik, E. & Hansen, B. 2009. The meaning of family membersâ€™ presence during intensive care stay: A qualitative study. Intensive and Critical Care Nursing, 25(4), pages 190-198.

Perrin, K. 2009. Understanding the essentials of critical care nursing. Upper Saddle River, N.J.: Pearson Prentice Hall.

Ryttylainen, K. 2008. Family health promotion, Culture and welbeing. Jyvaskyla: Jyvasjylan university press.

Sawatzky R & Pesut B. 2005. Attrbute of spiritual care in nursing practice:. journal of holistic nursing 23, pages 19-33.

Skoog et al. 2016. The impact on family engagement on anxiety levels in a cardiothorasic intensive care unit. American Association of Critical nursing, 36 .

Söderström, I., Saveman, B. & Benzein, E. 2006. Interactions between family members and staff in intensive care units—An observation and interview study. International Journal of Nursing Studies, 43(6), pages 707-716.

Söderström, I., Saveman, B., Hagberg, M. & Benzein, E. 2009. Family adaptation in relation to a family member's stay in ICU. Intensive and Critical Care Nursing, 25(5), pages 250-257.

Srivastava, R. 2007. The Healthcare Professional's Guide to Clinical Cultural Competence. Toronto: Reed Elsevier Canada Ltd

Teno, Gozalo, Bynum, Leland, Miller & Morden. 2013. Change in ife care for Medicare beneficiaries site of death, place of care, and health care transitions in 2000, 2005, and 2009. Journal of American Medical Association, pages 470 -477.

Timmermans, S. & Tavory, I. 2012. Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis. Sociological Theory, 30(3), pages 167-186.

Tonetta-Stanker, S. 2009. Providing patient- and family-centered end-of-life care in the ICU. Nursing Critical Care, 4(5), pages 54-55.

Welker, M. & Shiel, W. 2007. Intensive Care Unit (ICU): Tips for Patients and Families by

MedicineNet.com. [online] MedicineNet. Available at: http://www.medicinenet.com/script/main/art.asp?articlekey=79623 [Accessed 5 Nov. 2015].

Williams, C. 2005. The identification of family members' contribution to patients' care in the intensive care unit: a naturalistic inquiry. Nursing in Critical Care, 10(1), pages 6-14.

Wilson, M., Kaur, S., Gallo De Moraes, A., Pickering, B., Gajic, O. & Herasevich, V. 2015. Important clinician information needs about family members in the intensive care unit. Journal of Critical Care.

Wong, P., Liamputtong, P., Koch, S. & Rawson, H. 2015. Families, experiences of their interactions with staff in an Australian intensive care unit (ICU): A qualitative study. Intensive and Critical Care Nursing, 31(1), pages 51-63.