Original Article

Opinions of Intensive Care Nurses about Family-Centered Care in Turkey

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Abstract

Background: Family-centered care is a philosophy of care that recognizes the family's central role in the patient's life and in the delivery of care. Family-centered care as a healthcare approach that respects the individual needs and values of families.
Objectives: The aim of the study was to evaluate opinions and practices of family-centered care of intensive care nurses in Turkey.
Methods: The data of this descriptive study were obtained online. In this study, it was aimed to reach all nurses who are members of Turkish Intensive Care Nurses Association (N:544). The study was completed with 233 intensive care nurses who answered the online questionnaire in full.
Results: Nearly half of the nurses reported that family-centered care was supported (58.8%) and families were allowed to participate in the care (44.6%). The percentage of those who collaborated with families in planning and providing care (38.6%) was low. Seventy-four percent of the nurses said that the days and hours of the visits were limited in the intensive care unit, while 62.7% found days and hours of the visits in their units adequate.
Conclusion: There is no consensus on family-centered care among intensive care nurses. Family centered care practices are not common in intensive care unit.

Keywords: Family-centered care, intensive care, nursing

Introduction

Family-centered care (FCC) is a holistic approach in which patients and families are treated as a whole in terms of physical, emotional, social, intellectual, cultural and spiritual aspects (Aykanat & Gozen, 2014;Coyne, Murphy, Costello, O'Neill & Donnellan, 2013). In the guide to FCC in Intensive Care Unit (ICU)s, the Critical Care Medicine Association defines FCC as a healthcare approach that respects the individual needs and values of families (Gerritsen, Hartog & Curtis, 2017). The philosophy of FCC care is based on the assumption that family is the primary strength and support in the care of the patient (Gerritsen, Hartog & Curtis, 2017; Mitchell, Chaboyer, Burmeister & Foster, 2009).

Critical illness and intensive care have a profound and traumatic impact on the health and well-being of patients and their loved ones. Previous reports suggest that many patients in the ICU are separated from their families and loved ones by widespread restrictive visitation policies that can negatively impact care and recovery (Tume & Latour, 2015; Liu, Read, Scruth, & Cheng, 2013; Bailey, Sabbagh, Loiselle, Boileau & McVey 2010; Dunst, Trivette, & Hamby, 2007; Fumagalli et al., 2006). The admission of a patient into a ICU in hospital can be stressful for the patient and family and can be exacerbated if the illness is severe, chronic, life-limiting, life-

threatening, or where resuscitation, intensive care, or death occurs (Foster et al. 2013).

Because of the complexity of ICU care, prior small studies have raised concerns that open ICU visitation policies could harm patients by increasing physiologic stress, interfering with timely and safe care delivery, violating on patient privacy, increasing exposure to infection, leading to caregiver exhaustion, and negatively impacting interactions with families (Tume & Latour, 2015; Liu, Read, Scruth, & Cheng, 2013; Bailey, Sabbagh, Loiselle, Boileau & McVey 2010; Dunst, Trivette, & Hamby, 2007). However, there are significant findings showing that supporting family members in the ICU can improve patient outcomes (Auerbach, Kiesler, Wartella, Rausch, Ward & Ivatury, 2005, Pochard et al., 2005).

In the traditional approach, the healthcare team controls how much the family can be involved in the care of the patient. In the family-centered care, the healthcare team guides the care together with the family by cooperating with them. When the traditional care is compared with family-based care, it can be seen that different approaches are exhibited such as strengthening the family rather than making up the deficiencies of the patient and the family, taking up a collaborative approach instead of a supervisory approach, guiding rather than establishing rules, involving the family instead of applying a visitor approach, and implementing more flexible approaches instead of strict visit rules (Davidson et al., 2017, Mitchell, Chaboyer, Burmeister & Foster, 2009; Auerbach, Kiesler, Wartella, Rausch, Ward & Ivatury, 2005).

Family-centered care has been accepted as the ideal philosophy around which to structure familys' involvement in intensive care in developed and developing countries (Coyne, Murphy, Costello, O'Neill & Donnellan, 2013). The family should be perceived as a contributor to the care, not as a visitor, and it should be ensured that the family can accompany the patient as they like (Davidson et al., 2017; Fumagalli et al., 2006). From the onset of taking the patient to ICU, the adjustment of the family to the ICU is ensured by giving the family information about ICU, the procedures performed, the equipment used, and the disease. In addition, with the help of FCC, the patient that will be discharged from the ICU is prepared for home care (Curley, Hunsberger & Harris, 2013).

Nurses should consider FCC as a basic need. The support of the family and their communication in ICU is provided by nurses. (Riley, White, Graham & Alexandrov, 2014; Mitchell, Chaboyer, Burmeister & Foster, 2009). Families come in contact with critical care nurses during times of transition and crisis, such as illness, injury, or death. During these periods of crisis, critical care nurses have the opportunity to enhance family strengths, detect dysfunctional patterns that may impede recovery, and enhance coping in both present and future family crises (Foster et al., 2013). Within the possibilities of hospital, it is necessary to allow family member to accompany and frequently visit their patients. In addition, it is important to give them detailed information, provide their safety, and provide the families coming from other cities with accommodation and transportation possibilities (Davidson et al., 2017; Riley, White, Graham & Alexandrov, 2014; Mitchell, Chaboyer, Burmeister & Foster, 2009).

Family centered care has been endorsed at the policy levels in developed countries. Yet, concern and some unknow remain about why FCC not yet been successfully implemented and why it is still not uncommon to hear patients and families evaluate their relationships with health care providers as uncaring, difficult, and intimidating. Research has reported that the FCC model of care continues to affect positive and negative health care experiences for the family, hospitalized patient, and health care professional in developed and developing countries (Davidson et al., 2017, Foster et al., 2013). Prior recognition and intervention studies to explore these FCC concepts have been reported, but limited data exist about the scope and variability of FCC and visitation policies and practices across the developing country. The aim of the study was to evaluate perceptions and practices of FCC of intensive care nurses in Turkey. Study conducted to determine policies in ICU in Turkey relating to visiting hours, informing families, and how families are incorporated into patient care, family participation in patient care in ICUs.

Materials and Methods

The data of the study, which has a descriptive design, were collected online between June and September 2017.

Sample and Settings: In this study, it was aimed to reach all nurses who are members of Turkish Intensive Care Nurses Association (N=544). The study was completed with 233 intensive care

nurses who answered the data collection form in full. The research questionnaire form was answered with 42.4%. Intensive care nurses from around the Turkey is a member of the Turkish Intensive Care Nurses Association. Nurses are voluntary members of the association.

Procedure

Data Collection Tools*:* The data were collected electronically with a questionnaire consisting of 47 questions prepared by the researchers (Boztepe & Kerimoglu Yildiz, 2017; Davidson et al., 2017; Lima, Monteiro, Sampaio-Nogueira & Martins-Melo, 2015; Aykanat & Gozen, 2014; Mitchell, Chaboyer, Burmeister & Foster, 2009). In the first part, there were 12 items questioning the demographic characteristics, working environment, and the education status of nurses. The second part had 35 items examining nursing practices and approaches to family-centered care in the intensive care units where the nurses work.

Data collection: The questionnaire was submitted to the online medium by one of the researchers. The research web link to the questionnaire was sent to intensive care nurses who are members of Turkish Intensive Care Nurses Association by e-mail. The nurses were sent three reminders at 30-day intervals to respond to the online questionnaire.

Ethics: At the outset of the study, the approval of the ethics committee of Istanbul University, Faculty of Medicine, non-invasive clinical research department was obtained (March 15th 2017/ethics board no.754). An explanatory statement relating to the purpose of the study was added to the online questionnaire form and the necessary permission for participation in the survey was obtained. The nurses were specified that they were free to agree or disagree to participate in the study. In addition, they were reminded that they had the option to terminate their participation at any stage, which intended to ensure the principle of autonomy. The use of human subjects in the study requires the protection of individual rights, so the relevant ethical principles such as "Informed Consent", "Volunteering" and "Protecting the Privacy" were fulfilled.

Data Analysis: The data of the study were evaluated using descriptive statistical methods (number, frequency, mean, standard deviation, minimum-maximum) in the SPSS version 21.0 package program.

Results

It was determined that majority of the participants were women (83.7%), the average age was 32.7 ± 7.22, and the average work experience was 7.79 + 6.0 years (Table 1).

When FCC practices in intensive care units were examined, it was found that 58.8% of the nurses supported the family-centered care, 44.6% allowed families to participate in the care upon request, 39.9% supported the family participation, and that 67% asked for permission from the patient family for all the interventions in the patient. Nurses was stated that no existed protocols about family-centered care in 68.7% of the intensive care units, visiting days and hours were fixed in 74.2%, and 69.1% had no accommodation possibilities for patients' relatives (Table 2).

According to the findings, 58.4% of the nurses thought it would be beneficial to participate in the care of the family, however, 28.8% of the İCU had family centered care. 62.7% found the visiting days and hours in their units sufficient. 44.6% of the respondents thought that flexible visiting hours could be applied in the intensive care unit (Table 3). Regarding the benefits, the nurses thought that the anxiety of the family and patient would decrease 70.4%, the family would be relieved seeing that all necessary procedures were performed 68.7%, family confidence in the care team would increase 62.7%, and that the family would cope better with mourning 53.2% (Table 4).

Discussion

The guide to FCC in ICU released in 2017 and literature emphasizes the importance of supporting FCC, establishing policies, and the documents providing families with information (Davidson et al. 2017; Karagozoglu, Ozden & Tok Yildiz, 2014; Mitchell, Chaboyer, Burmeister & Foster, 2009). In studies carried out to investigate the approach of intensive care nurses to FCC, more than half of the nurses (68.7%) reported that ICU had no protocols about FCC, while 38% stated that there were no documents providing information to the family. The lack of protocols and documents providing information is an important shortcoming for families in ICU. According to literature and guide to FCC in ICU, protocols should be established and documents providing families with information should be prepared.

Table 1. Socio-demographic and professional characteristic of nurses

Characteristics		Mean (SD)	Min-max
Age		32 (7.22)	19-58
Work experience		7.79 (6.0)	1-34
		n	%
Sex	Female	195	83.7
	Male	38	16.3
Marital Status	Married	132	56.7
	Single	101	43.3
Nurse education	Health High School	22	9.4
	Graduate	147	63.1
	Postgraduate	64	27.5
Hospital type	University	95	40.8
	Government	86	36.9
	Private	52	22. 3
Working intensive care unit	Emergency	6	2.6
	Internal Medicine-Surgery	25	15.1
	Pediatrics	48	20.6
	Neonatal	34	14.6
	Cardiology	10	4.3
	Cardiovascular surgery	17	7.3
	Anesthesia / Reanimation	83	35.6
Intensive Care Nursing Certificate	Yes	112	48.1
	No	121	51.9
Participation in training related to FCC*	Yes	65	27.9
	No	168	72.1

* Family-centered care (FCC)

Table 2. Family-Centered Care Practices in Intensive Care Units

Family-centered Care Practices	**Yes n (%)**	**No n (%)**	**Partly n (%)**
Is family-centered care supported?	137 (58.8)	21 (9.0)	75 (32.2)
Can families take part in the care whenever they like?	104 (44.6)	40 (17.2)	89 (38.2)
Is family participation encouraged at the level that the family demands?	93 (39.9)	69 (29.6)	71 (30.5)
Are families involved in the planning and delivery of care?	90 (38.6)	46 (19.7)	97 (41.6)
Are any changes made in the treatment and care according to the desires of families?	80 (34.3)	66 (28.3)	87 (37.3)
Is family permission obtained for each intervention in the patient?	156 (67. 0)	38 (16.3)	39 (16.7)
Are there protocols for family-centered care in intensive care unit?	48 (20.6)	160 (68.7)	25 (10.7)
Are the mechanisms for solving the ethical problems between families and the intensive care team sufficient?	38 (16.3)	140(60.1)	55 (23.6)
Can families easily reach the intensive care team when they want?	187 (80.3)	19 (8.2)	27 (11.6)
Are visiting days and hours restricted?	173 (74.2)	47 (20.2)	13 (5.6)
Are there documents in the unit providing families with information?	116 (49.8)	88 (37.8)	29 (12.4)
Are there accommodation facilities for patients' relatives?	51 (21.9)	161(69.1)	21 (9.0)

Are families prepared for home care following the discharge?	205 (88.0)	8(3.4)	20 (8.6)
Do families have the chance to call the intensive care team during home care?	126 (54.1)	57 (24.5)	50 (21.5)
Is there a room for families to fulfill their rituals/prayers?	131(56.2)	50 (21.5)	52 (22.3)
Are families whose patient is at the terminal stage supported during their loss/mourning period?	170(73.0)	19 (8.2)	44 (18.9)

Table 3. Views of intensive care nurses about family-centered care

Opinions of Nurses	**Yes n (%)**	**No n (%)**	**Partly n (%)**
Can family participate in care in intensive care unit?	125 (53.6)	15 (6.4)	93(39.9)
Do you think the participation of the family in care is useful?	136 (58.4)	16 (6.9)	81 (34.8)
Do you think family-centered care is practiced in your unit?	67 (28.8)	79 (33.9)	87 (37.3)
Can families monitor the medical procedures applied to the patient in intensive care?	56 (24.0)	115(49.4)	62 (26.6)
Are the visiting days / hours appropriate / adequate in the intensive care?	146 (62.7)	62 (26.6)	25 (10.7)
Is it possible to apply flexible visiting hours in the intensive care unit?	104 (44.6)	57 (24.5)	72 (30.9)
Are the patient relatives informed adequately?	166 (71.2)	29 (12.4)	38 (16.3)
Are the values. cultural preferences and opinions of families respected adequately?	174 (74.7)	33 (14.2)	26 (11.2)

Table 4. Nurses' Opinions Effects of Family-Centered Care in Intensive Care Units

Negative Effects of Family-Centered Care *	**n (%)**
It will increase risk of infection.	76 (32.6)
It will restrict the workspace.	61 (26.2)
It will cause stress in healthcare team.	58 (24.9)
It will affect the family psychology adversely.	53 (22.7)
It will increase the employee workload.	57 (24.5)
It will limit the privacy of other patients.	51 (21.9)
Family members can sue in case of failure.	33(14.2)
Patient reactions will increase. / Patient care will be impacted negatively.	28 (12.0)
Families can misjudge what they see.	24 (10.3)
Not suitable for the structure of Turkish society	24 (10.3)
The technical skills of the team will be adversely affected.	23 (9.9)
Positive Effects of Family-Centered Care *	
Anxiety of the family/patient will decrease.	164 (70.4)
The family will be relieved as they see all necessary procedures are carried out.	160 (68.7)
The family will trust the care team more.	146 (62.7)
The family will handle the mourning period better.	124 (53.2)
Practices that the family is permitted to do to the patient*	
Feeding	204 (87.6)
Accompanying	163 (70.0)
Changing clothing/diapers	143 (61.4)
Bathroom / hygienic care	125(53.6)
Aspiration	55 (23.6)
Enteral drug administration	54 (23.2)
Accompanying the patient during examination. x-ray	49 (21.0)
Accompanying the patient during treatment	44 (18.9)

*More than one option was marked.

Nearly half of the nurses in the study group reported that FCC was supported (58.8%). In a study conducted to determine policies in intensive care units in France relating to visiting hours, informing families, and how families are incorporated into patient care, family participation in patient care in adult ICUs were found low (Soury-Lavergne et al., 2011). In a study conducted at a pediatric clinic, it was determined that parents wanted to be with their children during interventions, but nurses did not want family involvement (Boztepe & Kerimoglu 2017; Lima et al. 2015; Sarikaya Karabudak, Ak & Basbakkal 2010). Even though the benefits of family-based care have been approved many years, it can be assumed that the practices are still not at the desired level.

The nurses in study group identified the negative aspects of family-centered care as increased infection risk, limitation of the workspace, creating stress in the healthcare team, and increasing workload. It is stated in the literature that the presence of family members in intensive care units causes stress to the team (Stayt, 2007) and the healthcare team does not prefer family participation as the level of intervention increases (Sarikaya Karabudak, Ak & Basbakkal 2010, Stayt, 2007). In a qualitative study carried out in the UK and Australia investigating the opinions of nurses on FCC practices, nurses stated that a constant visitor flow into the ICU would affect patient care, and meeting the needs of patient relatives in the ICU (information needs, questions about nursing practices) would increase the workload (Kean & Mitchell 2013). Coyne et al., (2013) showed that nurses support FCC but perceive the design of the health care system and parent–professional collaboration as barriers to FCC practice. The justifications that the nurses in this study have relating to adverse effects of family-centered care were in line with those of similar studies and the related literature.

The nurses in study stating that family participation in the treatment was beneficial reported that family participation would help decrease family and patient anxiety, the family would be relieved seeing that all necessary procedures were being done, the trust to the treatment group would increase, and that families would cope better with mourning. Studies reporting positive results of family-centered care are more than those reporting the negatives. It was determined that accompanying the patient in intensive care had a positive impact on the patient's recovery process (Bailey et al., 2010), the patient had early mobilization, suffered less pain, and were discharged earlier (Fumagalli et al., 2006). In a meta-analysis investigating the relationship between family-centered care and parent, child behavior and functioning, 47 studies with 11,000 participants from 7 different countries were reviewed and the majority of the studies were found to report positive results, and there were very few negative findings (Dunst, Trivette & Hamby, 2007). It was declared in these studies that with the family-centered care, patient and family satisfaction increased, the family experienced less anxiety, and families respected the healthcare team more and understood the care better (Davidson et al., 2017, Tume & Latour, 2015; Kirchhoff & Dahl, 2006, Fumagalli et al., 2006, Heyland et al.,2002). It was determined that nurses thought family members were better able to understand the complexity of the ICUs when they saw the medical procedures and daycare, and they would help patients' daily life activities more (Riley, White, Graham & Alexandrov, 2014).

The practices that nurses allowed families to do in ICUs were feeding, accompanying the patient, changing clothes, bathing and, giving hygienic care. In the family-centered approach, it is recommended that families can be involved in daily care, and all interventions to patients, including those involving resuscitation (Davidson et al., 2017), and family access to the intensive care unit should be increased (Davidson et al., 2017, Auerbach, Kiesler, Wartella, Rausch, Ward & Ivatury, 2005, Pochard et al., 2005). The family can meet the daily requirements of the patient such as massage, full bath, eye care, oral care, shaving and hair brushing (Kingsinger, 2015). When the family is trained, they can even perform invasive procedures. The main principle in the participation of the family is that the practices should be within the capacity of the family and at the requested level.

It was found that the days and hours of visit were restrictived in ICU. In many developed country, it is known that restrictive visiting policies are still practiced in ICUs (Soury-Lavergne et al., 2011; Institute for Patient- and Family-Centered Care, 2010; Kirchhoff & Dahl. 2006). It is reported that adult ICU have applied the 70% restrictived visiting method (American Association of Critical-Care Nurses, 2015). Prior reports suggest that restrictive ICU visitation

policies can negatively impact patients and their loved ones. However, visitation practices in ICUs, and factors associated with them, are not well described (Liu, Read, Scruth, & Cheng, 2013). In a study in France with 222 adults and 41 pediatric intensive care unit nurses (n:731), it was proposed to limit visit hours in adult intensive care units, as opposed to pediatric intensive care units. Although 81% of the nurses in this study reported that the 24-hour visit policy would contribute to the development of family relationships, it was determined that only 7% of the ICUs had a 24-hour visit policy (Soury-Lavergne et al., 2011). Visitation restrictions can thus further contribute to patients' and families' experiences of ICUs as disorienting places that enforce separation during challenging periods of critical illness and recovery (Liu, Read, Scruth, & Cheng, 2013). Such issues as loss of control, feeling guilty due to illness, and not allowing visits and family participation in patient care can increase the problems of the patient in the intensive care unit and the family (Davidson et al., 2017, Auerbach, Kiesler, Wartella, Rausch, Ward & Ivatury, 2005, Pochard et al., 2005, Unver, 2003**)**. Recent data suggest that open visitation policies do not adversely impact patient outcomes and represent only a moderate, and acceptable, intrusion on patient care (Liu, Read, Scruth, & Cheng, 2013**).** For this reason, it is recommended that families can be involved in all interventions to patients, family access to the intensive care unit should be increased (Davidson et al., 2017; Auerbach, Kiesler, Wartella, Rausch, Ward & Ivatury, 2005; Pochard et al., 2005, Unver, 2003). Although family is an essential unit of society, many ICUs continue to limitations on families' access to their loved ones. In recent years, less restrictive visiting policies have been implemented in critical care units. As these policies are popularized, nurses have greater freedom to individualize family visiting and to take advantage of the support family members provide for each other.

in study group, 44.6% of the nurses reported that a flexible (open) visit should be used in the ICU. Family presence is backed both by data and the guidelines of multiple professional societies. Flexible visitation policies and regular reports on patient status answer some of the significant needs of families with loved ones in the ICU. Flexible visits are reported to reduce the anxiety, agitation and stress of the patient (Davidson et al., 2007; Fumagalli et al., 2006). The Multidisciplinary Experts Board reviewed more than 300 publications between 1980 and 2003 and pointed as a result that open and flexible visits increased communication and reduced stress (Davidson et al., 2007; Baharoon et al., 2014) found in their study comparing flexible (open) and restricted family visits found that there were no differences for families in terms of information or comfort. Further study into the impact of ICU visitations on care and outcomes remains necessary to standardize practice. It is necessary to increase of publications providing information on the subject so that nurses can reach a consensus related to flexible visits.

The intensive care nurses in this study group reported that family values, cultural preferences, and opinions were sufficiently respected (74.7%) and that families were provided an environment for performing their traditional rituals/prayers (56.2%). It is reported in Clinical practice guidelines for support of the family in the patient-centered ICU that a counselor or religious officer may be offered to the patient and family for meeting their spiritual needs (Davidson et al., 2017**)**. Developed countries have solved problems related to spiritual care needs. In developing countries, the needs of patients and families for worship are not sufficiently met. It seems that the spiritual care needs of especially minority patients and families are not met. When intensive care nurses focus on the critical problems of patients, they can forget the needs of families. FCC and spiritual care needs should be adopted as an institutional policy and these needs should be taken into account when structuring ICU.

Implications for Practice: Lack of knowledge or understanding has been frequently offered in previous studies as a reason for nurses difficulty with FCC. The current literature reflects the questions of developed countries. Family-centered care is a new discussed in Turkey. This study is important for a developing country which reflect the views of nurses in Turkey.

This research shows that nurses support the philosophy of FCC, but are unable to apply all the elements in practice because of organizational barriers, lack of resources, and hospital design. It illustrates how poor resources, inadequate facilities and inadequate support can hinder nurses' abilities to implement FCC satisfactorily. Supporting nurses' efforts to

implement FCC in their everyday practice requires specific hospital policies, supportive management practices, and family-friendly facilities.

The impact of flexible visiting policies on patient and family outcomes should not be forgotten and flexible visits should be adopted when visiting policies are established for intensive care units.

Conclusion: Family-centered care applications in intensive care units are not at the desired level. The majority of ICUs had restrictive visitation policies. There is no consensus among intensive care nurses concerning family-centered care. Wide variability in visitation policies suggests that further study into the impact of ICU visitations on patients and families are likely to influence and improve future practice.

Limitations: The survey was conducted only in intensive care nurses who are members of Turkish Intensive Care Nurses Association. Our findings should be interpreted in light of the study's limitations.

Future research into FCC concepts from a health care provider, family, and patient's perspective needs to explore the similarities and differences of how family–nurse interactions and relationships shape positive and negative critical health care experiences from different countries, contexts, and health care settings.

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