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Family Needs and Their Satisfaction in The Intensive Care Unit Hospital University Sains Malaysia (HUSM) Kubang Kerian Kelantan, Malaysia

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Abstract
A holistic approach to critical care nursing requires that the family be included in the plan of care. Once the patient has been admitted to the critical care unit, an assessment of the family provides valuable information for the preparation of the nursing care plan. Therefore, this study intends to gain information about the level of the family need and their satisfaction in the Intensive Care Unit Hospital Universiti Sains Malaysia (HUSM), Kubang Kerian Kelantan, Malaysia. A cross-sectional study design with 111 respondents was selected using convenience sampling. The inclusion criteria: The patient's family came to accompany them in the ICU ward; volunteer participate in this study. The questionnaire is divided into two sections: Part A: Demographic data and part B: Critical Care Family Needs Inventory (CCFNI) questionnaire was administered to all consenting relatives of ICU patients to determine the family needs. The frequency, mode, mean, standard deviation, and Pearson's correlation coefficient were measured. The correlation analysis revealed a significant positive correlation between family satisfaction and family needs. There was a significant correlation between family satisfaction and family need the p-value is .001. In an intensive care unit, family members' top five needs are support, proximity, comfort, information, and assurance. Support is presently in first place on the ranking. Family needs and satisfaction is commonly taken care of at ICU HUSM. The information gathered can be used to improve ICU services. Therefore, nurses must have trusting relationships with family members and be proactive to contribute to satisfaction.
Keywords: Family Needs, Satisfactions, Critical Care Nursing, ICU.

Introduction

Family members of dying patients play an integral role in patient care in the ICU. Families play a crucial role in the care of patients in the intensive care unit (ICU), giving history to doctors and nurses, performing as unofficial decision-makers, and helping with responsibilities such as reorientation (Stephana et al., 2022). Active family engagement in care of the patient,

communicating the patient's and families' values and goals and being involved in decision-making process are recognized as invaluable aspects when providing health care (Davidson, 2010). The ICU is also a stressful place for families (Foster & Chaboyer, 2003; Jones et al., 2004; Myhren et al., 2004; Pochard et al., 2005). Patient's families are expected to make unprecedented decisions and deal with many difficult situations (Sole, 2009). Heyland et al (2007) described the stresses confronting family members to include role changes, isolation from other family members, financial concerns, transportation problems, and the fear of losing their loved ones. These results from previous research show that family support has a major positive effect on the outcome of patients' illness (Abott et al., 2005). The family can be involved in the care of their loved one by participating in routine daily activities like feeding the patient, assisting with bathing, changing linens, providing pressure and back care, and turning the patient, as well as by becoming present during resuscitation and other invasive procedures (Al-Mutair et al., 2013).

A holistic approach to critical care nursing requires the family to be included in the plan of care. Once the patient has been admitted to the critical care unit, an assessment of the family provides valuable information for the preparation of the nursing care plan. Caring for the family is an important component of caring for the patient. This can be achieved when the family members are supported and involved in the care of the patient (Beeby, 2000). Furthermore, identifying factors of families' needs and satisfaction are both measuring and improving the quality of care. Thus, these studies will explore family needs and satisfaction in ICU. The impact of admission to ICU is often traumatic for the patient's family members and may result in a crisis within the family. As mentioned briefly, healthcare providers primarily identified personal and cognitive needs as the highest priority (Takman & Severinsson; 2006; Keenan & Joseph, 2010; Kinrade et al., 2010), whereas family members of critically ill patients admitted to the ICU identified information and assurance needs as their highest priority (Yang, 2008; Omari, 2009).

Literature Review

Family needs at the Intensive Care Unit

Having a loved one in the intensive care unit (ICU) can be a very difficult and stressful experience for families. In addition to concerns for the patient's medical condition, families may have their own needs that should be addressed during this time. Families need to be informed about the patient's medical condition, treatment plan, and prognosis. They may have questions about the care being provided, potential complications, and long-term outcomes. Families need to be able to communicate with the patient's healthcare team and receive updates on the patient's condition. They may also need support in communicating with the patient if they are unable to speak or are sedated. Families may experience a range of emotions during this time, including anxiety, fear, and grief. They may benefit from counseling or support groups to help them cope with their emotions and maintain their well-being. Research has shown that family-centered care in the ICU can lead to improved satisfaction and reduced stress for family members. This involves providing emotional support, clear communication, involvement in decision-making, and access to information about the patient's condition and treatment plan. It's essential to recognize that family members may have different needs and coping mechanisms, and it's crucial to address those individual needs to provide the best care possible.

Abraham Maslow in his book, Motivation, and Personality proposed by Maslow's hierarchy of needs which are physiological needs, safety needs, love and belongingness, self-esteem, and self-actualization. An ICU stay is also stressful for the patient's relatives (Jezierska et al., 2014) and can lead to feelings of anxiety and power lessness (Margaret & Geraldine, 2010).The recognition of families' needs was assurance, needs for of information, needs for comfort, support and needs for proximity which refer to personal contact and remaining near to the ill relative (Al-Hassan & Hweidi, 2004). The needs associated with information, assurance and remaining near to the ill relative are the greatest needs of family members of critically ill patient. According to Al-Hassan & Hweidi (2004) in a study on Jordanian families showed that needs for comfort and support were less important among the five needs described in the *Critical Care Family Needs Inventory* (CCFNI).
In the intensive care unit (ICU), close relatives are regarded as crucial since they may provide personal knowledge about the patient who is critically sick (Söderström et al., 2003). Meanwhile, De Jong & Beatty (2000) in their study on intervention support found that appraisal supports by allowing the family to visit the patient, as well as emotional support from the family are second most important support after information support. De Lima, Rocha, Scochi & Gallery (2001), stated that the families felt more comfortable and confident if the hospital focuses on the patient's treatment rather than the patient's disease. They also wanted consent to be involved in the care of their ill relative.

Communication is the main medium for the nurse to convey information to the family. An effective communication will be able to form a close interpersonal relationship and trust with the patient's family. The nurses can identify the real needs of the family once they obtain confidence from the family through the interview or their body language. The nurses also should be responsible in helping the families to empower themselves in coping with the critical situations so that they can face the situation effectively. Information provided by the nurses indirectly caused the family to feel they were given assurance and hope. Apart from that, the crisis burden borne by the family can be eased by allowing the family to continue the role of parenting, by ensuring their comfort during the period of hospitalization, and by giving them long-lasting psychological support.

Heyland et al (2007), suggested that there be training programs in communication, especially for physicians, since every study indicated that communication was an unequivocal source of either satisfaction or dissatisfaction. To assist in attempts to increase satisfaction with medical services, Wasser et al (2005), developed the Critical Care Family Satisfaction Survey to measure patient satisfaction. The survey was built around the following five subscales, which were derived from the measures of the CCFNI of (Molter, 1995), assurance; information; proximity; support; and comfort. Other specific strategies were researched, all aimed at producing greater satisfaction for family members. Peterson (2005) outlined an effort at education in the Duke University Health System, where the staff developed a special pamphlet for the families of those undergoing coronary bypass surgery, although staff members thought that their experience indicated something similar could be used for any illnesses requiring patient care in an ICU.

Lautrette et al (2007), found that communication with family members is an important part of the critical care nurses' responsibilities; yet other responsibilities may prevent the nurse from being present at the time that communication would be most valuable. Volunteers were

recruited from the volunteer program of the hospital and were assigned to a critical care nurse who trained them and acted as a mentor. The volunteers were then available in the family waiting room area and served as a bridge between the family and the nurse. They listened to questions, were usually able to elicit answers in a reasonable amount of time, and frequently served as sympathetic listeners to alleviate families' concerns. The favorable reception of the volunteers was transferred to the critical care nurses, who were then perceived as more involved and empathetic with families.

Methodology

A cross-sectional study design with 111 respondents was selected using convenience sampling at ICU in Hospital University Sains Malaysia (HUSM), Kelantan. The inclusion criteria: The patient's family came to accompany them in ICU ward; volunteer participate in this study. The exclusion criteria: Respondents who do not volunteer to participate. The questionnaire is divided into two sections: Part A: Demographic data: 10 items and part B: Critical Care Family Needs Inventory (CCFNI) questionnaire was administered to all consenting relatives of ICU patients based on a five-point Likert scale (1: Poor; 2: Fair; 3: Good; 4: Very good and 5: Excellent). The frequency, mode, mean, SD, and the Pearson's coefficient of correlation (parametric) were performed. Data with a p-value less than 0.05 was considered statistical significance.

Critical Care Family Needs Inventory (CCFNI)

Molter (1979) developed the Critical Care Family Needs Inventory (CCFNI) which utilized 45 needs-based question and focus on determining how family members felt about emotional and physical issues and the type of information they required to help them understand the care needs of their relative.

Results

Socio-demographic Characteristics of respondents

Table 1 show the socio-demographic characteristics of respondents, there was 111 respondent who participated in this study. Most of the respondents' ages between 30-40 were 51(45.9%). The majority of the respondents were female 68(61.3%). The majority of the respondents have a family income range between RM 2000-3000 41 (42.3%). Most admissions caused because of disease were 46(41.4%). The majority of respondents' length of stay in ICU ward (1- 7 days) was 82 (73.9%).

Table 1
Socio-demographic Characteristics of the respondent(n=111)

Socio-demographic characteristics	Frequency	%
Age of participants (years)		
<20	6	5.4
20- 30	29	26.1
30- 40	51	45.9
>40	25	22.5
Gender		
Male	43	38.7

Female	68	61.3
Race		
Malay	102	91.9
China	8	7.2
India	0	0
Others	0.9	0.9
Religion		
Islam	102	91.8
Kristian	1	0.9
Buddha	8	7.2
Hindu	-	-
Others	-	-
Occupation		
Employed	52	48.8
Unemployed	39	35.1
Others	20	18.0
Education Level		
Primary school	8	7.2
Secondary school	46	41.4
Collage	41	36.9
University	16	14.4
Income		
<RM 1000	14	12.6
RM1000 -2000	28	25.2
RM 2000- 3000	41	42.3
RM >3000	22	19.8
Relationship to patient		
Mother	20	18
Father	16	14.4
Sister	23	20.7
Brother	27	24.3
Others	25	22.5
Admission causes		
Diseases	46	41.4
MVA	41	36.9
Operation	15	13.5
Others	9	8.1
Length of ICU Stay(days)		
1	8	7.2
1- 7	82	73.9
7- 21	13	11.7
>21	8	7.2

Correlation between family satisfaction and family needs.

The correlation analysis revealed a significant positive correlation between family satisfaction and family need. There is significant correlation between family satisfaction and family need the p-value is .001. Therefore, there is a positive correlation between family satisfaction and family needs. The correlation between family satisfaction and family needs is presented in Table 2.

Table 2

Correlation between family satisfaction and family needs (n= 111).

	Family need
Family satisfaction	.347**[a] .001[b]

[a] Pearson correlation [b] p-value sig (2–tailed)

Item score Family satisfaction with concern and caring by ICU Staff

Table 3 shows family satisfaction with concern and caring by ICU staff, the scoring scale was most important (5) Excellent (4) Very good (3) Good (2) Fair (1) Poor. Most of the family satisfaction with concern and caring by ICU staff was 48(43.2%) very good and 33(29.7%) were excellent and only 1(0.9%) respondent scored fair.

Table 3

Family satisfaction with concern and caring by ICU Staff (n=111)

Items	Excellent %	Very good %	Good %	Fair %	Poor %
The courtesy, respect and compassion your family member was given	33 (29.7)	48 (43.2)	29 (26.1)	1 (0.9)	-

Item scoring Family satisfaction with symptom management.

Table 4 shows family satisfaction with symptom management. Most of the family satisfaction with symptom management pain was very good 50(45%) were top list. The next list was family satisfaction with symptom management agitation very good 47(43.2%) and the bottom list breathlessness was 44(39.6%). However, only 2% (fair) were satisfied with symptom management breathlessness.

Table 4
Family satisfaction with symptom management (n=111)

Items	Excellent %	Very good %	Good %	Fair %	Poor %
Pain	34 (30.6)	50 (45)	27 (24.3)	-	-
Breathlessness	33 (29.7)	44 (39.6)	32 (28.8)	2 (1.8)	-
Agitation	35 (31.5)	47 (42.3)	29 (26.1)	-	-

Item scoring Family satisfaction with Staffs ICU treated to a family

Table 5 shows family satisfaction with Staff's ICU treatment to family. Most of the family satisfaction with the Staff's ICU treats to family was very good at were top of the list. The items the highest agreeing percentage is item "consideration of your needs" about 37 (33.33%) give excellent and 50(45.04 %) give very good. For the items, Emotion support, Concern, and caring by ICU and Skill and competence of ICU have similar 34 (30.63) respectively.

Table 5
Satisfaction with Staffs ICU treated to family (n=111)

Items	Excellent %	Very good %	Good %	Fair %	Poor %
Consideration of your needs	37 (33.33)	50 (45.04)	22 (19.81)	2 (1.80)	-
Emotion support coordination of care	34 (30.63)	53 (47.74)	22 (19.81)	2 (1.80)	-
Concern and caring by ICU	34 (30.63)	53 (47.74)	23 (20.72)	1 (0.9)	-
Skill and competence of ICU	34 (30.63)	55 (49.54)	21 (18.91)	1 (0.9)	-

Item score Family satisfaction with communication ICU HUSM

Most respondents were satisfied with overall communication. Table 6 presents data were scored excellent impressions. Excellent satisfaction was the consistency of information at 43.2%, next excellent satisfaction was the completeness of the information at 41.1%, and the lowest at 38%. Similarly, the result was excellent 34.2%. Family satisfaction with communication with how often doctors communicated to you about your family member's condition family between doctors and nurses.

Table 6
Family satisfaction with Communication (n=111)

Items	Excellent %	Very good (%)	Good %	Fair %	Poor %
How often have doctors communicated to you about your family member's condition	38 (34.2)	52 (34.2)	17 (15.3)	4 (3.6)	-
How often nurses communicated to you about your family member's condition	38 (34.2)	51 (45.9)	21 (18.9)	1 (0.9)	-
Understanding of information	43 (38.7)	50 (45.0)	18 (16.2)	-	-
Ease of getting information	43 (38.7)	47 (42.3)	21 (18.9)	-	-
Honesty of information	44 (39.6)	49 (44.1)	18 (16.2)	-	-
Completeness of information	46 (41.4)	46 (41.1)	18 (16.2)	1 (0.9)	-
Consistency of information	48 (43.2)	46 (41.1)	16 (14.4)	1 (0.9)	-

Item Score Family Satisfaction with the ICU Environment HUSM

Table 7 shows family satisfaction with the ICU environment. The majority with ICU environment satisfaction for toilets was 54 (48.6%). The next list was family satisfaction was café 51(45.9%). In addition, excellent for both items for the waiting room and surau is equal was to 48(43.2%) However, only 1(0.9%) they're satisfied in the waiting room and café.

Table 7
Satisfaction of the ICU environment HUSM (n=111)

Items	Excellent %	Very good (%)	Good %	Fair %	Poor %
The waiting room	48 (43.2)	38 (34.2)	21 (18.9)	3 (2.7)	1 (0.9)
Visiting hours	49 (44.1)	38 (34.2)	17 (15.3)	7 (6.3)	-
Surau	48 (43.2)	42 (37.8)	19 (17.1)	2 (1.8)	-
Café	51 (45.9)	36 (32.4)	21 (18.9)	2 (1.8)	1 (0.9)
Toilet	54 (48.6)	37 (33.3)	18 (16.2)	1 (0.9)	-

Discussion

This study found that families were a total score satisfied 85.41 with their experience in the ICU. The result was higher than Canada' total score satisfied 83.31 and Switzerland total score satisfied, 83.0. However, both related to the largest population compared to these studies. These studies highlight several important factors of satisfaction among families. There are five factors are communication, concern and caring by ICU staff, symptom management, staffs ICU treatment to family, and environment ICU. The presence of family members is critical to optimizing end-of-life and grief experiences for patients, families, and healthcare professionals in ICUs. In the ICUs, family members usually want to be with their relatives and help meet their every need together with the health personnel (Feder et al., 2021). It is important to note the result satisfaction rating. Sole et al (2009), the nurse can include results and recommendations for research into the plan of care for patient and family.

For the first communications, total score means 29.41 and SD 4.81. Priority the desire for information exchange is a common theme among ICU family communication is possibly the most important factor driving family satisfaction in ICU. When good skill communication is present, family members conclude that the best possible outcome has been achieved. Communications are strongly associated with satisfaction, to improve the quality of care, family members emphasized the need for better communication, greater access to physicians and better pain management. These studies potentially present the quality of skills communication by staff ICU HUSM as an important to improve satisfaction among family patients. It is supported by Alvarez et al (2006) stated that the effective communication between medical professionals and families is crucial.

Second, the environment ICU total means score satisfaction was 21.04 and SD 4.05. The result shows HUSM has identified environmental factors improvement. Sole (2009), reported that

the built environment in ICU, or the physical layout of a critical care unit has a subtle but profound effect on patients, families, and the critical team. These environmental changes have all been designed to enhance comfort and communication, allowing to feel more comfortable during waiting in the patient ICU and during a period of stress. In addition, family members of intensive care patients need to have a place to be alone in the hospital. This research has demonstrated that there are significant assurance, proximity, and information needs among family members of patients who have been admitted to the intensive care unit. To provide the best care and support to ICU patients and their families, should direct the development of connection, effective communication, and beneficial collaboration (Alsharari, 2019).

Besides that, finding of this research was giving information on the waiting room, breakfast, and being concerned about their family's well-being and satisfaction. Third, for the staff ICU treats the family's satisfaction, the total mean score is 20.43 and SD is 3.54. Family members were satisfied with the courtesy, respect, and compassion staff ICU delivery to their critically ill relative. Increased visiting time was seen as a strategy to improve the coping skills of the family members of patients (Roland et al., 2006). Family members are thus an integral part of the delivery of healthcare and the supervision of the well-being of ICU patients. The immediate requirements of family members of ICU patients should be determined and provided for in order to reduce the level of anxiety and psychological crisis (Alsharari,2019).

Conclusion

The findings were significant in terms of family requirements and satisfaction in the ICU HUSM. During their hospitalization in the intensive care unit, patients depend on other individuals for the care of their require (ICU). So, it helps patients feel satisfied and provides supportive care related to their intimacy, the family plays a major role in the care of critically ill patients in the ICU. It is important to make every interaction with family members useful and help the family members identify sources of support. Besides that, family member satisfaction and their needs in ICU have been included and considered in holistic critical nursing care. High family satisfaction leads to improved quality of care provided. The experience of having a loved one in the ICU can be a highly stressful and emotionally charged time for family members. The family's needs and satisfaction are critical factors that can impact both the patient's recovery and the well-being of the family.

Therefore, nurses must have trusting relationships with family members and be proactive to contribute to satisfaction. Overall, the finding of the study found that there is a positive correlation between family needs and satisfaction. Factor concern and caring by ICU staff and symptom management were given priority in providing satisfaction to families in ICU HUSM. Recent studies of family satisfaction also found that courtesy, respect, and compassion in staff ICU were strongly associated with satisfaction. Nursing care with concern and compassion and caring for family members was the greatest satisfaction in ICU HUSM. Therefore, critical care nursing requires concern, compassion, and caring. Many of these talents come with professional maturity and specific educational opportunities as well as supervision from appropriate role models. Overall, ensuring that family members are informed, involved, and supported can improve their satisfaction and positively impact the patient's recovery. Healthcare providers should prioritize family-centered care in the ICU to promote the well-being of both patients and their loved ones.

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