ISSN: 2457-0400

WORLD JOURNAL OF ADVANCE HEALTHCARE RESEARCH

www.wjahr.com

Impact Factor: 7.675

Volume: 10, Issue: 4

Page N. 221-225

Year: 2026

Original Article

Coden USA: WJAMA3

# PERCEPTION OF FAMILY MEMBERS REGARDING NEEDS OF PATIENT'S FAMILY MEMBERS IN CRITICAL CARE UNITS

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**Article Received:** 05 March 2026 **Article Revised:** 25 April 2026 **Article Published:** 04 April 2026

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**DOI:** https://doi.org/10.5281/zenodo.19435965

**How to cite this Article:** Asia Nazir*[1], Zafar Iqbal Channa[2], Muhammad Ishatiaque[3], Waqas Latif[4] (2026). Perception of Family Members Regarding Needs of Patient's Family Members in Critical Care Units. World Journal of Advance Healthcare Research, 10(4), 221–225.

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**ABSTRACTS**

**Introduction:** Admission of an important member of family in intensive care unit (ICU) is highly important for medical professionals. During staying in hospital, family members have perceived panic experience of anxiety and stress. The purpose of the study was to assess family perception regarding needs of patient's family members in intensive care units (ICUs). **Methods:** A quantitative non-experimental, descriptive cross sectional research design was used to achieve research objectives. Data of 116 family members were collected by using adopted and modified Urdu Version of Critical Care Family Needs Inventory (CCFNI) questionnaire. **Findings:** Findings showed that family members have felt higher needs regarding their patients' needs while admitted in ICUs. Needs for assurance was found as the highest need for family members with mean score of 4.66±0.37. Information need was considered as higher needs with mean score of 4.61±0.43 and needs for comfort was constituted as high need with mean score of 4.56±0.56 as compare to need for support with mean score of 4.36±0.50 and need for proximity with mean score of 4.25±0.71 and statistically significant difference was measured at $p$-value < 0.001. **Conclusion:** Findings support the evidence in literature from previous studies. Family assurance and information were highly be prioritized by all medical professionals once their patients admitted in ICUs. Family members then timely decide treatment option about patients whether prognosis is good or worst. **Recommendations:** Hospital and nursing administration collaboratively work to emphasize policy on visitation and include family member in ward rounds. Appropriate provision of information flow towards family member regarding patient's condition must be enhanced to assure family regarding satisfaction of needs.

**KEYWORDS:** Family member, Family needs, Family perception, Intensive care unit.

## 1. INTRODUCTION

### Background Information

Admission of an important member of family in intensive care unit (ICU) is highly important for medical professionals. During staying in hospital, family members have perceived panic experience of anxiety and stress. These feelings remain at peak due to their loved one has been admitted in ICU and they are not sure about prognosis and recovery or some sought of disability even die (Brysiewicz, 2014).

Society of critical care medicine, (2013) reported that, more than 5million patients annually admitted to the intensive care units (ICU) in the United States. These admissions not only affect the patients, but the family member as well, especially those family members who dealt with the crisis of death of their patient in the ICU (Gentry. S et al, 2014). Hospitalization of one of members can make anxiety and mental problems in other members of the family. Especially when the patient is hospitalized in some stressful wards such as critically

care unit or emergency unit and anxiety becomes double (Mahdieh Sarhadi, 2014).

Internationally majority of the critically ill patients are serious in ICUs and their family members are under traumatic situation to take decision about the treatment and care of their patient in theses intensive care unit (Sarhadi M. et al, 2014). It has also been proven from studies that more than 60% of family member of patient admitted in ICU were presented with the symptoms of anxiety and depression regardless of the patients overall condition in ICU. (Maria Kourti, 2014).

Studies have suggested that recognition of family needs of intensive care unit of admitted patients has prime important for nurses. It denotes family centered care of critically ill patients and helps to understand the concept of family satisfaction with care as nurses provide. Nurses are key stakeholders to ensure care to critically ill patients and therefore nurses need to develop supportive relationship with patient's family member by providing proper information, helping family member to cope with their stress and ask question about their patient in ICU (ElieAzoulay, et.al, 2001). Another important aspect of care is the evaluation of family needs of critically ill patient for understanding of patient condition and proper decision making. (Azoulay E, et.al, 2001).

Families of admitted patients play a pivotal role in end of-life decisions, and about treatment modalities for life-sustaining situation of admitted patient (P Brysiewicz, 2010). Individual coming to an ICU feel confronted by the massive range of sensory impetuses, especially patient's family members because they are in condition of distress and fear for caring of critically ill patient. Therefore, proper assessment of family needs is first step in providing proper care to ICU patients and their families by the nurses (Mehta, 2009).

Recent studies showed that critical care units are equipped with advanced technologies and accessories. Therefore, ventilator associated events and complications have been reported. Such events lead to increase rate of morbidity and mortality in ICU admitted patients. Likewise, family members have encountered increased level of stress, uncertainty towards prognosis and anxiety that could intensify either patient can survive or not (Munyiginya P & Brysiewicz P, 2014). Therefore, family perception regarding family needs was very important to study in Pakistan and to assess their needs while their patients have been admitted in ICU. To the best of studies and knowledge, in Pakistan, no such studies were found and dire need was felt to study on this topic.

## LITERATURE REVIEW

### General literature

Intensive care medicine was developed as a special care field after epidemic of poliomyelitis. It was found in early fifties with the development of mechanical ventilation. After this development, new technologies have been emerged for the treatment and care of critically ill patient. Thus the concept of ICU got prime importance in tertiary care hospital. It is evident that the environment of ICU effect on psychological health of patient and their family members (Pittard, 2009).

Individual coming to an ICU feel confronted by massive range of sensory impetuses, especially patient's family members because they are in a state of distress and fear. Therefore, proper assessment of family needs is the first step for nurses in providing ICU patient care and their families (Mehta, 2009). Many studies have shown that the environment of the ICU can be unaccustomed and threatening. When their loved ones are admitted in the ICU the family members are not sure about the outcome of the patient. They feel that might be the loved one will survive with some sought of disability or die.

Studies have suggested that ICUs are mechanized and highly technical settings and also come to be the reasons of tension and anxiety among family members of admitted patient. Families of these patients become vulnerable for failure to cope with the care in ICUs. Because healthcare providers are unable to understand the family needs (R. Gundo et al, 2014). Recognition of family needs of ICUs admitted patients are prime important for nurses. It strengthens family centered care of critically ill patients and helps to understand the concept of family care satisfaction. Another important aspect of care is the evaluation of family needs of critically ill patient for understanding of patient condition and proper decision making for their patients (Azoulay E, et.al, 2001).

In a cross-sectional Malaysian study has vindicated that nurses working in intensive care setting are focusing only on monitoring of patients and they just neglect the family needs. Whereas nurses account priority on patient rather family needs and this leads to family dissatisfaction and mistrust (Dharmalingam. K.T, 2016). American College of Critical Care Medicine (ACCCM) work on family centered care and issued guidelines to support family members. These guidelines are not only focusing on the provision of care but encourage family members' participation two main aspects. Firstly, open visitation policy in adult intensive care units and secondly, collaborative decision making about care of critically ill patient (Janice L. Hinkle,2009).

In a study with title of "What families want – an assessment of family expectations in ICU" was recently conducted in Pakistan. In this study, researcher has worked to develop a communication tool as a guideline for healthcare providers to boost communication between nurses and family members rather to assess family needs of ICU admitted patients. Author has also indicated that environment of ICU can influence condition of patients family. Thus family members need to take more time and skills to understand the condition of patient admitted in ICU (Siddiqui et al, 2011).

**Specific literature review**

Concept of family needs from the perspective of family members are widely accepted by medical professionals including nurses and allied health professional. From primitive study of Molter family needs were identified 1970s. In this study, nurses role were enhanced to address the family needs of critical ill patient because nurses in the ICU play an essential part in handling these needs. For this reason, nurse is an immediate person in ICU whom families contact first to acquire information about their loved one and present all times to their duty (P Brysiewicz, 2010). Results of Nancy Molter (1979) study also suggested that family members want honest, intelligible, and timely information; liberal visiting policies; and assurance that their loved one is being cared by competent and compassionate people. Providing better information was associated with better results in terms of meeting the needs and increasing the level of satisfaction of family members.

Author Nancy Molter (1979) developed list of 45 need statements through extensive literature review and applying vast clinical experience. Survey design approach was used on 23 proficient graduate student's nurses from the field of critical care area. Developed tool of listed needs was used in a follow-up study on needs of relatives of critically ill patients that was consistent with Molter's work. Results were congruence that the need "to feel there is hope" was also graded high. However, there were differences on how the other needs were rated and one open ended option added in the tool to provide a chance to a family and nurses to add any need if they feel so on (Leske, 1986).

Later on, Molter (1979) exhibited that consequent studies using critical care family needs, critical care family needs inventory (CCFNI) was developed and needs were categorized into five groups including 1) need for support, 2) need for comfort, 3) need for information, 4) need for proximity and 5) need for assurance (Lee & Lau, 2003; Maxwell, et al., 2007).

**Need for Assurance**

According to a Malaysian study, need for assurance defined as "the necessity for the hope in desired result" and it was ranked as most important need of family members. In relation with the level of education of the family members, huge difference was found. Indeed, highly qualified family members want more assurance as compare to lower level of education (Dharmalingam T.K et.al, 2016). Literature from Rwanda study indicated that families of critically ill patient expressed that the need to have questions answered honestly which was very important and they ranked need for assurance as most important on likert 4X scale (P Munyiginya, 2014).

**Need for Comfort**

According to Dharmalingam T.K et.al, (2016), need of comfort define as "the personal and comfort needed by the family members" and constituted as least important. But in a study of P. Munyiginya (2014), need for comfort was very important as the majority of participants ranked it as important because, family members need to have the waiting area room near to ICU and having comfortable furniture in waiting room area.

**Need for Information**

Dimension of information was referred as "the necessity for the family members to obtain real information regarding the status and progress of their family member during treatment". Need for information was ranked as the most important need as compared to other need items (Dharmalingam T.K et.al, 2016).

A majority of the family members perceived that the need to know exactly what was being done for the patient as being a very important need. Family members ranked the need of knowing how the patient was being treated medically as a very important. The need to know why things were being done for the patient was ranked as very important. Results of this study also showed that the participants perceived the need to know the expected outcome as being indicated that this was a very important need (P Munyiginya, 2014).

Perceived need of information was labeled as most important as in the acute phase of ICU admission the family feels more stressed and need accurate and adequate amount of information. Because the family members perceived that proper information can reduce uncertainty and increase families' hope (Al-Mutair A et. al, 2013).

**Need for Proximity**

Need for proximity in literature was defined as "the necessity for the family members to contact and remain close with their patient throughout the ICU treatment (Dharmalingam T.K et.al, 2016). Participants perceived that it was very important to have flexible visiting hours and it was labeled as important that they could visit at any time to their loved one in the ICU to ensure their proximity.

Literature has suggested that Pakistani family members have strong bounding and caring relationship which are reflected in mutual commitment among family as compare to Saudi family system. Consequence of this mutual binding, family members have opportunities to visiting ill as and when needed. This practice of visiting ill is highly encouraged in the Islamic teachings. Visiting sick person provides emotional, psychological and financial support to patient and to their family. Families with high educational level regarded proximity as a least important because they wanted ICU staff to focus on health condition of their patient and provide better care to their loved one as admitted in ICU (Al-Mutair A et. al, 2013).

**Need for Support**

Need for support was referred as "the resources and support systems that the family members are getting during the ICU treatment of their family members" (Dharmalingam T.K et.al, 2016). Already cited study also indicated that it was important to have ICU environment clarified to family members before shifting their patient in the ICU. Another aspect of family need was also labeled as important to have someone to help with financial problems along with the provision of religious help (P Munyiginya, 2014). Families and nurses do not consider the needs of support and proximity unimportant but they ranked them lower than the assurance, information and cultural and spiritual needs (Al-Mutair A et. al, 2013).

In general studies, one of study was carried out in Kigali, Rawanda in 2014 regarding needs of patient family member in ICUs. Results were analyzed as per importance of needs. Results showed that assurance as a first and comfort was second and support was ranked as a least important on the tool of Critical Care Family Need Inventory (CCFNI). Along with that the importance of nurses awarness with needs of family members were also recognized. Nurses are key healthcare providers who are ultimetly responsible for satisfaction of patient's family and able to provide family centred care. But currently the family members are not included in the treatment plan and even nursing professional were not trained properly to support and communicate with family members (P Munyiginya, 2014).

**Purpose of the study**

Purpose of this study was to assess family perceptions regarding needs of family members of ICU admitted patients.

**Objectives of the study**

- To assess needs of ICU patient's family members.
- To assess perception of families regarding needs of family members of ICU admitted patient.

**Research question**

- What are family perceptions about the needs of patient's family members of ICU admitted patient.

**Operational definition**

**Family need:** A need which is a requirement of family members regarding their patient, admitted in ICU. If their needs do not meet, they produce anxiety and stress.

**Perception:** The ability to see, hear, or become aware of something through senses.

**Family member:** Is a partner or spouse, parent, grandparent, adult child, adult grandchild (older than 18 years), or identified adult significant other who visits the patient in the ICU

**The patient:** This is a patient admitted to ICU because of critical illness or potentially life threatening physiological change

**Intensive care unit:** The specialized care unit in which critically ill patient receive care under close observation, i.e. medical intensive care units, surgical intensive care units, cardiac intensive care unit etc.

**METHODOLOGY**

Study was carried out on partial fulfilment of Master of Science in Nursing (MSN) at Shifa Tameer-e-Millat University, Islamabad. The data collected from predetermined setting hospitals of federal government and Punjab government in Pakistan after formal approval of IRB (Institutional Review Board) of the university. Data was collected from three medical intensive care and three surgical intensive care units of four tertiary care public sector hospitals. Two hospitals from federal Government named as Pakistan Institute of Medical Sciences, (PIMS) and Federal Government Services Hospital Islamabad. Two hospitals from Punjab Government named as Benazir Bhutto Hospital (BBH) and Holy Family Hospital (HFH) Rawalpindi.

Through descriptive cross sectional study, population of one hundred sixteen (n=116) family members of ICU admitted patients of all age groups. Sample size was calculated for family members of ICU admitted patient with formula: SS= $Z^2$ *P (1-P) / $d^2$. After putting formula, sample size for family member was 384 but census of admitted patient during one month was approximately 150 patients. Therefore, calculated sample size was re-adjusted to finite population and calculated sample with following formula was SS = N/1+ (N-1/N). Calculated sample size was 116 with 10% increase in sample to adjust dropout and refusal to participate in study. Selection of participant was made on the basis of inclusion and exclusion criteria. This design was appropriate because study was conducted in a natural setting where no experimental treatment or interventions administered on study population (Polit& Beck, 2008).

By using convenience sampling technique, Critical Care Family Needs Inventory (CCFNI)" was used as research tool which was developed by Molter and Leske (1979). A permission to use and modify CCFNI tool from original author (Molter and Leske, 1979) was obtained. Tool was translated in Urdu Language, keeping in mind the context of Pakistani Urdu language terms and words. CCFNI divided into three sections. Section-A, contained demographic data of patient's family members. Participant name was kept confidential (refer to Appendix F and G). Section-B consisted of 46 item statements on 5xLikert scale (Not Important, Slightly Important, Important and Very Important and Mordantly Important as neutral point. Statements related to family needs derived from the Critical Care Family Needs Inventory (CCFNI).

A pilot study was conducted prior beginning of main study from 22nd June to 27th June, 2017 to check tool's internal validity and reliability by using Cronbach's alpha (Findings revealed Cronbach's 0.861 which was

good. check and result of pilot study was Cronbach's α of 0.82 of translated tool. Each participant took an average of 10 to 15 minutes to complete the questionnaire. Contents and language used in Urdu questionnaire were understandable to the participants. Therefore, no further changes or remarks left on questionnaire and repeatedly used to other participants. Results then measured and found significance with no further changes.

Study was conducted in three medical intensive care and three surgical intensive care units of four tertiary care public sector hospitals. Two hospitals from federal Government named as Pakistan Institute of Medical Sciences, (PIMS) and Federal Government Services Hospital Islamabad. Two hospitals from Punjab Government named as Benazir Bhutto Hospital (BBH) and Holy Family Hospital (HFH) Rawalpindi.

## RESULTS

### 4.1. Results Description

The data were analyzed in both descriptive and inferential statistics by using International Business Machines Statistical Package for Social Sciences (IBM SPSS) version 21.0. Results of study were discussed in two parts as: 1) demographic data of family members and 2) perception and needs of family members of ICU admitted patient.

Regarding descriptive statistics, in Table 4.1 showed demographic data of family members in which out of one hundred and sixteen family members, 98.3% was the response rate of respondents and only two family members did not return questionnaire. Regarding gender, age and marital status, 64.7% (n=75) were males and 35.3% (n=41) were females. Age of participants ranged from 18-59 years with a mean of 32.46 ±9.34 years and marital status showed as 33.6% (n=39) were unmarried, 65.5% (n=76) were married and divorced was only 0.3% (n=1).

The monthly income showed that majority of family members group were having monthly income ranged from 10,000 to 20,000 was 38.8% (n= 45), 21000-3000 was 31.0% (n= 36), 31000-40000 was 22.4% (n=26) and only 7.8% (n=9) was taking more than 40000 of monthly salary.

Regarding receiving care, 67.2% (n=78) of patients receiving mechanical ventilator care and 32.8% (n=38) were without mechanical ventilator care. Regarding relationship, more than 33.6% (n=39) of patient relatives were their brothers and 19.0% (n=22) were sisters and only 2.6% **(n=3)** were husbands. Data also revealed that majority of family members were matriculate (37.1%) rather the intermediate (32.8%), graduates (18.1%) and masters (5.2%).

Regarding residence area belonging, previous ICU experience and mode of payment of treatment, 51.7% of patients belonged to local Rawalpindi area than the Islamabad (19.0%), AJK (11.2%), and 18.1% come to receive treatment from the cities of Punjab and Khyber Pakhtunkhuwa provinces. Data also showed that 25.9% of family members had previous ICU admitted patient experience and 87.9% (n=102) were receiving free treatment in government hospital than the self-payment (12.1%) to purchase medicine.

**Table 4.2 Demographic Data of Family Member.**

| S. No | Demographic | Freq. | %age |
|---|---|---|---|
| 1 | Gender<br>Female<br>Male | <br>41<br>75 | <br>35%<br>65% |
| 2. | Marital Status<br>Married<br>Unmarried<br>Divorced | <br>76<br>39<br>01 | <br>65.5%<br>33.6%<br>0.9% |
| 3. | Monthly Income<br>10,000-20,000<br>21,000-30,000<br>31,000-40,000<br>>40,000 | <br>45<br>36<br>26<br>9 | <br>38.8%<br>31.0%<br>22.4%<br>7.8% |
| 4. | Patient is receiving care on:<br>Mechanical ventilator<br>Not on mechanical ventilator | <br>78<br>38 | <br>67.2%<br>32.8% |
| 5. | Relationship with the patient:<br>Brother<br>Sister<br>Mother<br>Son<br>*Other | <br>39<br>22<br>13<br>12<br>30 | <br>33.6%<br>19.0%<br>11.2%<br>10.3%<br>25.9% |
| 6. | Qualification<br>Under matric | <br>8 | <br>6.9% |

| | | | |
|---|---|---|---|
| | Matric<br>Intermediate<br>Bachelor degree<br>Master | 43<br>38<br>21<br>6 | 37.1%<br>32.8%<br>18.1%<br>5.2% |
| 7. | Family member were resident of: Rawalpindi<br>Islamabad<br>Azad Jammu and Kashmir<br>Chakwal **Other | 60<br>22<br>13<br>6<br>15 | 51.7%<br>19.0%<br>11.2%<br>5.2%<br>12.9% |
| 8. | Previous ICU Experience<br>Yes<br>No | 30<br>86 | 25.9%<br>74.1% |
| 9. | Mode of Payment for care<br>By-self<br>Free by hospital | 14<br>102 | 12.1%<br>87.9% |

*Husband, Wife, father and Daughter.
**Sargodha, Gilgit, Gujrat, Jahlem, MianChannu, Peshawar, Bahawalpur and Mianwali.
In part two of questioner regarding family member item-statements, table 4.2 has discussed collective results in percentage. 92.3% of patient's family members have reported in need for information category, 85.0% need for proximity, 93.2% need for assurance, 87.3% need for support and 91.3% need for comfort category.

**Table 4.2 Cumulative results in percentage.**

| Category | Group | Cumulative %age (n=116) |
|---|---|---|
| Information | Family Members | 92.3% |
| Proximity | Family Members | 85.0% |
| Assurance | Family Members | 93.2% |
| Support | Family Members | 87.3% |
| Comfort | Family Members | 91.3% |

Table 4.3 showed the mean score of five need categories were computed which indicated that family members have mean score of 4.61±0.43 in information category, 4.25±0.71 in proximity, 4.66±0.37 in assurance, 4.36±0.50 in support, and 4.56±0.56 in comfort. Results were generally concluded that need for assurance was found as the highest need for family members with mean score of 4.66±0.37, need for information was considered as higher need with mean score of 4.61±0.43 and need for comfort was constituted as high need with mean score of 4.56±0.56 as compare to need for support with mean score of 4.36±0.50 and need for proximity with mean score of 4.25±0.71 of family members of ICU admitted patients.

**Table 4.3: Mean score of Need Categories.**

| Category | Group | Mean± SD | Minimum | Maximum |
|---|---|---|---|---|
| Information | Family Members | 4.61±0.43** | 2.90 | 5.00 |
| Proximity | Family Members | 4.25±0.71 | 2.20 | 5.00 |
| Assurance | Family Members | 4.66±0.37*** | 3.10 | 5.00 |
| Support | Family Members | 4.36±0.50 | 2.70 | 5.00 |
| Comfort | Family Members | 4.56±0.56* | 2.00 | 5.00 |

***Highest Need, **Higher Need, *High Need.

**Inferential statistics**

One way ANOVA and *post hoc* Tukey test was applied to compare mean difference within and between need categories. As table 4.4 and 4.5 showed that there was statistically significant difference found between and within the need category at p value of $< 0.001$ in family members ICU admitted patients. Table 4.4 also highlighted that the mean score of information, assurance and comfort categories were significantly higher as compared to proximity and support. No significant difference observed among information, assurance and comfort. Similarly insignificant difference was also observed between need for proximity and need for support categories score.

**Table 4.3: Mean score of five categories.**

| Need Category | Information | Proximity | Assurance | Support | Comfort | *P* value |
|---|---|---|---|---|---|---|
| **Mean Score** | 4.61±0.43 | 4.25±0.71 | 4.66±0.37 | 4.36±0.50 | 4.56±0.56 | 0.000 |

**Table 4.4 Comparisons Between and Within Need categories.**

| Post hoc Tukey Test | | | | |
|---|---|---|---|---|
| **Name of Need Categories** | **Difference Between Need Categories** | **Mean Difference** | **Std. Error** | **Sig.** |
| Information | Proximity | .36466* | .07009 | .000 |
| | Assurance | -.04224 | .07009 | .975 |
| | Support | .25000* | .07009 | .004 |
| | Comfort | .05172 | .07009 | .948 |
| Proximity | Information | -.36466* | .07009 | .000 |
| | Assurance | -.40690* | .07009 | .000 |
| | Support | -.11466 | .07009 | .475 |
| | Comfort | -.31293* | .07009 | .000 |
| Assurance | Information | .04224 | .07009 | .975 |
| | Proximity | .40690* | .07009 | .000 |
| | Support | .29224* | .07009 | .000 |
| | Comfort | .09397 | .07009 | .666 |
| Support | Information | -.25000* | .07009 | .004 |
| | Proximity | .11466 | .07009 | .475 |
| | Assurance | -.29224* | .07009 | .000 |
| | Comfort | -.19828* | .07009 | .039 |
| Comfort | Information | -.05172 | .07009 | .948 |
| | Proximity | .31293* | .07009 | .000 |
| | Assurance | -.09397 | .07009 | .666 |
| | Support | .19828* | .07009 | .039 |
| *. The mean difference is significant at the 0.05 level. | | | | |

## DISCUSSION

As per adopted and translated into Urdu version questionnaire of Critical Care Family Needs Inventory (CCFNI) tool, findings revealed that family members have higher needs regarding their patients in ICUs, especially on ventilator. In family member's needs categories, results revealed that need for assurance was found as the highest need for family members with mean score of 4.66±0.37, need for information was considered as higher need with mean score of 4.61±0.43 and need for comfort was constituted as high need with mean score of 4.56±0.56 as compare to need for support with mean score of 4.36±0.50 and need for proximity with mean score of 4.25±0.71 of family members of ICU admitted patients. Study results were congruence with preliminary and concurrent studies regarding perception of family members' needs of their admitted patients in critical area especially in ICUs.

Literature supported the results of current study regrading needs and p**erception of family members. Similar results were found i**n a study of Dharmalingam, TK., Kamaluddin, MR., Hassan, SK, & ZainiRhendra, HM. (2016). Five needs categories identified by patient's family members and need for assurance and need for information were found as higher needs with mean score of 3.69±0.34 and 3.59±0.37. Need for proximity, comfort and support were consequently on third, fourth and fifth with mean score of 3.21±0.53, 3.16±0.49 and 3.01±0.58.

In another study of Al-Mutair, AS., Plummer, V., Clerehan, R., & O'Brien, AP. (2013), in Saudi Arabia, need for assurance and need for information were ranked as higher needs with means score 3.66±0.43 and 3.52±0.68. Need for proximity and support were counted as third and fourth needs with mean score of 3.23±0.86 and 3.19±0.92. Fifth component of comfort was replaced with cultural and spiritual category, applied in their context by family members. Similar studies of Rawanda and Saudi Arabia (Munyiginya, P., & Brysiewicz, P. 2014 and S. H. Al Ghabeesh et al. 2014), also confirmed the finding of current study as result showed that the assurance (3.17), comfort (3.11), information (3.08), proximity (3.00) and support lastly (2.64) in former study and in later study, assurance (92.38±7.79) and information (80.78±10.30) were ranked as high level need as compare to proximity (80.32±10.90), support (72.91±10.95) and comfort (75.62±11.85).

## CONCLUSION

The study was based on belief that the admission of loved one in Intensive Care Units affects the entire family and their coping with it. It can be managed better if needs of family members were properly identified by nurses and family itself. Therefore, purpose of this study was to assess family and nurses perceptions regarding needs of patient's family member in intensive care units (ICUs). The results showed similarities between nurses' and families' responses to family need statements. Need categories as information, proximity, assurance, support and comfort were ranked and found with little variations in both groups. Assurance and information need categories were ranked very important in both nurses and family members. Comparatively, family members' had higher score in all categories as compare to nurses but assurance was significantly higher than that of nurses.

Results were congruent with available literature on the perception of nurses and family members about the family needs. Mostly, literature was derived from the western countries in which cultural differences were obvious as compare to current study settings. The study could further be replicated to investigate nurses and family members' perception regarding family needs within and outside countries.

**Recommendations**

Needs of intensive care patient's family members are neglected by health care providers especially by the nurses as primary care giver. Many healthcare experts do not comprehend that identifying and meeting family needs in intensive care units can improve patients' outcome and facilitate family members to manage with the patient's hospitalization in ICUs meritoriously (DharmalingamT.K, et al, 2016).

**Recommendations for Hospital and Nursing Administration:** Providing quality nursing care is effectively managed by the collaboration of hospital and nursing administration. The following recommendations can facilitate nursing administration as well hospital administration to recognize the family member's needs and their state

- Hospital and nursing administration should take initiative for the development of policies and protocols on family centered care and need assessment.
- Hospital and nursing administration collaboratively work to develop policy on visitation and to include family member in ward rounds and provision of information flow towards family member regarding patient's condition for family satisfaction.
- Hospital administration in cooperation with nursing administration can develop a plan for family counselling session and involve nursing professional in it to increase family satisfaction about care and provision of information regarding patients' prognosis.
- The public sector hospital can develop a plan for taking initiatives to start in-service training and continuing nursing educational program activities for family and nurses working in ICU.

**ACKNOWLEDGEMENT**

I would like to express my sincere gratitude to all the family members who generously cooperated in filling out the questionnaires and shared their concerns and experiences regarding patients admitted to Intensive Care Units (ICUs). Their participation and openness were invaluable for the completion of this research.

I am deeply grateful to my respected supervisor, **Sir Ishtiaque Ahmed**, and the biostatistician, **Mr. Waqas Latif**, for their continuous support, insightful feedback, and guidance throughout the development of my thesis and research article.

I would also like to extend my heartfelt thanks to my beloved husband and my children, **Aroosh Fatimah** and **Muhammad Arshman**, for their persistent encouragement, patience, and understanding during the course of this work.

Finally, I pay my deepest tribute to my devoted mentor, **Madam Dr. Anwar Aziz (Late)**, the Principal of the College of Nursing, STMU. She was a remarkable source of inspiration and a true professional who tirelessly worked to advance the nursing profession in education, clinical services, and research. Her dedication and visionary leadership continue to inspire many. I respectfully dedicate this article to her memory and pray that Almighty Allah bless her soul with eternal peace.

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