Research Article

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Describing Nurse's, Doctor's and Family Members' Perceptions on Family Needs In Critical Care Units at King Khalid Hospital-Jeddah, Saudi Arabia

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ABSTRACT

Background: *Admissions of critically ill patients in critical care units are considered a stressful and traumatic situation for FMs causing negative effects for them. This results in poor coping or failing to cope with this stressful event, leading to family dysfunction, negatively affecting the patient's progress.*

Aim and Methods: *The aim of the study was to describe the received family needs of family members. Quantitative descriptive design using the Critical Care Family Needs Inventory Tool was used. 67 Family members, 184 critical care nurses and 77 doctors were included in the study using a convenience sampling method.*

Results: *Both pediatric intensive care (mean 3.71) and emergency room respondents (mean 3.61) ranked "to be assured that the best possible care is being given to the patient" at the most important need. This need was ranked the second most important need by respondents in intensive care (mean 3.65).*

Keywords

Family needs during critical illness, Family stress during critical illness, Patient-family centered care during critical illness.

Background

Families are integrated units where an event affecting one member affects the whole unit. This is apparent during hospitalization, when one family member (FM) becomes critically ill, all family members (FMs) are negatively affected by the hospitalization. Admissions of critically ill patients in critical care units (CCUs) are considered a stressful and traumatic situation for FMs causing negative effects for them [1,2]. Negative effects include emotional distress, psychological disturbances and altered family roles. This leads to disruption of family functioning and integrity. Poor family functioning during the illness experience can in turn negatively affect patient outcomes [3] resulting in poor coping or failing to cope with this stressful event, leading to dysfunction, negatively affecting the patient's progress. Further to this, FMs experience fear of the unknown [4], hence, they are unable to support the patient and may transfer their anxiety to the patient [5].

In addition, patients in CCUs are often physiologically and psychologically compromised and incapable of making decisions [6,7] due to their critically ill sate [8] with the result that the FMs serve as spokespersons for them. Even though FMs are in a state of disequilibrium, they are expected to make decisions regarding the care of the patient which further adds to the stress experienced [6,7]. Further to this, FMs are left out of the care planning process until they are requested to make decisions for their loved one. FMs are emotionally burdened by the overwhelming nature of the critical illness and if they have inadequate coping resources, their supportive roles can be inhibited, thus preventing them from acting in the best interests of the patient with their decision making [9].

The stress expereinced by FMs of critically ill adult patients is similar to the stress expereinced by FMs who are parents of the critically ill patients such as infants and children. The combination of the child's condition and the intial shock of seeing their child seriously ill can cause a great deal of stress for FMs who are parents [10]. Major stressors for parents are alteration in parental roles, uncertainty of the infant's outcome, alteration in attachment,

ineffective communication with healthcare providers which can lead to barriers in parent-infant interaction [11]. These stressors can lead to feelings of shock and uncertainty [11], guilt, fear, anger, loss, and hesitation [12].

Under circumstances of extreme family stress as a result of the critical illness of a loved one, FMs are unable to recognize their own needs [13]. Hence assessing and understanding the needs of FMs from nurses, doctors and the FMs' perspective is important to achieve the holistic care approach and quality of care. Since the seminal work of Molter [14], family needs has been well researched within the western world [9,15-17], however only a few studies have been completed with the middle eastern context [5,18].

Fortunatti [19], completed a literature review using the Critical Care Family Needs Inventory (CCFNI) using 15 studies mostly conducted in the western world, reported that a total of 86.7% articles documented the most important needs of FMs as assurance needs which "are having responses delivered sincerely" and "knowing the prognosis of the patient." Further to this, the least important needs were reported to be the needs relating to support [being notified of religious leaders and being visited by a pastor] and comfort needs [having good food in the hospital and having comfortable furniture in the waiting area] [19].

Incorporating FM needs as part of patient care in CCUs has resulted in a shift of care from the biomedical approach to a patient family centered care (PFCC) approach. Even though the PFCC approach originated in the pediatric context, this approach has now been adopted to adult patients where the goal of care is aimed at planning, delivery and evaluation of healthcare, which is based on mutually beneficial partnerships among patients, FMs and healthcare professionals [20]. In addition, PFCC is a philosophy of care that acknowledges that the family has the greatest influence over health and well-being of the patient [21]. In applying PFCC, FMs should be treated with dignity and respect; individualized, flexible, and responsive practices; information sharing so that families can make informed decisions and able to care for and rear their children in ways that produce optimal child, parent, and family outcomes [22].

Although progress has been made to include not just the patient in the care but also FMs, it is more challenging in a critical care context where complexity of care are prioritized over relational approaches. This is further complicated in a multicultural environment [23], where the critical care context in itself has its own distinctive patterns and subcultures [24].

Significance of the Study

The specialty of critical care focuses on patients with life threatening illness, resulting in critical care being a very frightening environment for both the patient and FMs [25]. Furthermore, within the period of critical illness, the patients FMs experience unique needs related namely to their perception of assurance, closeness, information, comfort and support. Understanding and satisfying these needs, enables FMs to interact and support the patient, promoting trust and assurance in the nurse patient relationship [19] which is a necessary step in providing appropriate patient care [25].

A literature review by Al Mutair, Plummer, O' Brien et al. [26] concluded that more emphasis should be placed on identifying FMs needs in relation to the influence of cultural values and religion held by the FMs and the organizational climate and culture of the working area in CCUs. It seems that there is a gap in the literature available regarding FMs needs and support in Saudi Arabia. In addition to the context of Saudi Arabia which is the homeland of Islam, FMs are characterized by strong ties and is seen as a family unit where members are connected socially and emotionally in all aspects of life. During a critical illness, all FMs are expected to partake in the care of the patient [26]. Hence the impetus of this study was to describe the perceived needs of FMs, within the Muslim cultural context in Saudi Arabia.

Aim of the Study

The aim of the study was to describe nurses', doctors' and FMs' perceptions on family needs in CCUs at King Khalid Hospital in Jeddah.

Objectives of the study

- To describe nurses', doctors' and FMs' perceptions on family needs in CCUs at King Khalid Hospital, Jeddah.
- To compare doctors', nurses' and FMs' perceptions of family needs in CCUs at King Khalid Hospital, Jeddah.

Operational definition of FMs within the study

For the purpose of the study, FMs included parents, partners (husband/wife), daughter, son, or any person who played a significant role in the patient's life. For all pediatric patients, FMs included only parents (father and/or mother).

Research Design

This study used a quantitative descriptive research design. This approach was chosen because it assisted to describe what already existed about the phenomenon under study.

Study setting

The study was conducted in CCUs at King Khalid Hospital, Jeddah. King Khalid Hospital is 531-bed military hospital located in the Western Region of Saudi Arabia which consists of ten CCUs.

Sample and sampling

The study included 184 critical care nurses (CCNs), 77 doctors, and 67 FMs from all the adult CCUs, pediatric CCUs and the emergency departments. A non-probability convenience sampling technique was used to include all available FMs, doctors and CCNs in the CCUs at the time of data collection.

Inclusion criteria

- All doctors and CCNs with more than 6 months of experience working within a CCU.

- Parents of paediatric patients who have been admitted for more than 12 hours.

Exclusion criteria

- All doctors or CCNs with less than 6 months of experience working within a CCU. This exclusion was made so as to include the most experienced staff within the CCUs.
- Parents of pediatric patients who have a patient admitted to the pediatric CCU for less than 12 hours. This exclusion is made as FMs might be in severe emotional turmoil within the first 12 hours after admission.

Data collection technique and process

Data was collected by the means of a questionnaire. The questionnaire consists of 2 sections:

Section A: Demographic details of respondents
Section B: Needs inventory of family needs.

Section B of the questionnaire consisted of forty five (45) items to elicit respondents' perceptions about family needs. The items are related to family needs derived from the Critical Care Family Needs Inventory (CCFNI) a tool revised by Jane Leske[27]. The 45 items of family needs were divided into five categories: support (items 1 to 14), information (items 15 to 23), proximity or closeness (items 24 to 32), assurance (items 33 to 39) and comfort (items 40 to 45). The responses are noted on a 4-point Likert scale, and the scoring is coded as not important (1), slightly important (2), important (3) and very important (4). The same tool was used for all categories of respondents. The English version of the tool was used for doctors and nurses while an Arabic version was used for FMs. The original English version was translated into Arabic by qualified English to Arabic translator. This tool was then given to two Arabic speaking faculty staff members to verify that the Arabic content of the tool did not deviate from the original English content.

Data collection commenced immediately after ethical approval was obtained. Appointments were made with the unit managers of each CCU, to request permission to distribute questionnaires to both doctors and CCNs. Questionnaires were distributed to the doctors and CCNs during their lunch times. Questionnaires were distributed to FMs whilst they waited in the waiting areas of the CCUs. All questionnaires were distributed by the researchers and research assistants who were Arabic speaking especially during data collection involving FMs.

Reliability

The CCFNI has documented reliability and validity from numerous studies in which it has been used. According to Bijttebier [28], the internal consistency of the subscales ranged from 0.80 to 0.62 and all factors were significantly related to each other. In addition, Chien, et al. [29] examined the psychometric properties of a Chinese version of the CCFNI. The results of the study by Chien et al. also demonstrated a satisfactory internal consistency ranging from .80 to .92. Gundo et al. [1] found an overall reliability of 0.97.

Validity

Apart from the expert review of the tool by Arabic faculty staff members, a pilot test was conducted with two doctors and four CCNs using the English version of the tool and three FMs using the Arabic version of the tool. The pilot test established whether both versions of the tool are understandable. Any comments received from respondents resulted in amendments of the tool without substantial variation from the original version.

Ethical considerations

Ethical approval was first obtained from the Nursing Director at the hospital. Thereafter ethical approval was obtained from King Abdullah International Medical Research Center (KAMRC) and the Institutional Review Board (IRB) was obtained. The questionnaires were distributed to the respondents with an attached letter explaining the purpose of the study, permission obtained from management approving the study at the respective hospital, and information to ensure that the completed questionnaires were confidential and anonymous.

Data analysis

Data was analyzed using IBM SPSS software package version 20.0. Data was described using range (minimum and maximum), mean, and standard deviation. Significance of the obtained results was judged at the 5% level. Further to this, Chi-square tests for categorical variables were completed , to compare perceptions of family needs between different groups, Fisher's Exact or Monte Carlo correction for Correction for chi-square when more than 20% of the cells have expected count less than 5 and F-test (ANOVA) for normally quantitative variables, to compare between more than two groups.

Results

Sociodemographic details of participants

The sample realization of the study consisted of 184 CCNs nurses 77 doctors and 67 FMs from three CCUs within the hospital namely PICU, adult ICU and ER.

Table 1 illustrates the demographic characteristics of doctors and CCNs. Most CCNs were females (81.5%) while all doctors (66%) were male. The CCNs' ages ranged from 21 to 61 years with mean age of 34.58 ± 8.31 while the doctors' age ranged from 22 to 56 years with the mean age of 34.39 ± 8.16. The majority of CCNs were non-Saudi (83.7%) while 67.5% doctors were Saudi. In terms of experience within the critical care context, 40.2% of CCNs and 58.4% of doctors had less than 6 years of experience. Table 2 highlights the sociodemographic details of FMs. Female FMs were more than male family FMs 52.2% and 47.8% respectively. FM's ages ranged from 22 to 60 years with the mean age of 46.72 years and 65.7% of FMs were above 50 years of age with and the majority of them being Saudi (98.5%).

Family needs

Table 3 highlights the top seven needs of family between the three units. Both PICU (mean 3.71. and ER (mean 3.61) ranked "to be

assured that the best possible care is being given to the patient" as the most important need. This need was ranked the second most important need by respondents in ICU (mean 3.65). The second most important need for both PICU (mean 3.68 and ER (3.61) and the most important need of ICU (Mean 3.55) was "to be assured that the best care possible is being given to the patient", to know the expected outcome, to have questions answered honestly, to know why things were done for the patient, to know how the patient is being treated medically, to know exactly what is being done for the patient and to know specific facts concerning the patient's progress were the family needs that reported mean score above 3.5 from all responses. No statistical significance was noted among the three units.

Table 4 below highlights the comparisons between the total mean scores of family needs perception between the three units It was found that the score for PICU ranged from 88.0 to 176.0 (max) with the mean score of 140.35 ± 18.32. The family needs perception score for ICU ranged from 80.0 to 175.0 with the mean score of 137.57 ± 19.85 while for ER scores ranged from 88.0 to 199.0 with the mean score of 136.10 ± 19.19. No statistical significance was noted among the three units.

A comparison in perception of family needs between the doctors, CCNs and FMs is illustrated in table 5 below which indicated the highest ranked needs. All family needs as perceived by FMs were ranked with means scores of greater than 3.70. To know how the patient is being treated medically (information) needs was ranked the highest for FMs; to be assured that the best care possible is being given to the patient (Assurance); to know specific facts concerning the patient's progress (assurance); to talk to the doctor every day (assurance); to know exactly what is being done for the patient (information); and to feel that the hospital personnel care about the patient (assurance) were scored and achieved mean scores greater than 3.8 by FMs.

FMs perceived these needs as priority needs as opposed to CCNs and doctors and the differences were statistically significant between all the needs listed in the table below. In addition as reflected in table 5, "to be called at home about changes in the patient's condition" (assurance) and to see the patient frequently" (proximity)" showed a statistical significance between doctors, CCNs and FMs' perception about family needs. Further to this, the top 15 needs of FMs were mostly assurance needs (60%).

With regards to the CCFNI dimensions as reported in table 6, it was noted that they were significant differences between the perception of family needs from FMs and CCNs and doctors. In relation to the information dimension, the mean score for FMs was significantly higher than CCNs and doctors 31.70 ± 3.05, 29.25 ± 4.32 and 29.19 ± 4.12 respectively; Proximity dimension 30.76 ± 3.77, 25.57 ± 4.69 and 27.05 ± 4.61 respectively; Assurance dimension 26.36 ± 2.41, 23.77 ± 2.96 and 24.25 ± 2.86; comfort dimension 20.12 ± 2.84, 17.71 ± 3.73 and 18.52 ± 3.13. For the support dimension all respondents perceived that support was an important need 42.55 ± 5.46, 40.68 ± 7.47 and 42.08 ± 7.77.

		Nurses (n= 184)		Doctors	(n= 77)
		No.	%	No.	%
Gender	Male	34	18.5	51	66.2
	Female	150	81.5		
Age (years)	20 – 29	56	30.4	25	32.5
	30 – 39	78	42.4	30	39.0
	40 – 49	14	7.6	3	3.9
	≥ 50	36	19.6	19	24.7
Min. – Max.		21.0 – 61.0		22.0 – 56.0	
Mean ± SD.		34.58 ± 8.31		34.39 ± 8.16	
Median		32.0		30.0	
Nationality	Saudi	30	16.3	52	67.5
	Non-Saudi	154	83.7%	25	32.5
Years of experience in critical care unit	0 – 5 years	74	40.2	45	58.4
	6 – 10 years	54	29.3	30	16.9
	11 – 15 years	33	17.9	12	15.6
	16 – 19 years	11	6.0	2	2.6
	≥ 20 years	12	6.5	5	6.5
Unit	PICU	54	29.3	29	37.7
	ICU	63	34.2	25	32.5
	ER	67	36.4	23	29.9

Table 1: Percent distribution of demographic data of nurses and doctors.

	Family members	No.	%
Gender	Male	32	47.8
	Female	35	52.2
Age (years)	20 – 29	6	9.0
	30 – 39	8	11.9
	40 – 49	1	1.5
	≥ 50	52	77.6
Min. – Max.		22.0 – 60.0	
Mean ± SD.		34.28 ± 11.25	
Median		34.0	
The relationship with the admitted patient	Mother	19	28.4
	Father	17	25.4
	Son	4	6.0
	Daughter	10	14.9
	Others, specify	17	25.4
First time to have family member in ICU	Yes	49	73.1
	No	18	26.9
Nationality	Saudi	66	98.5
	Syrian	1	1.5
Unit	PICU	18	26.9
	ICU	38	56.7
	ER	11	16.4

Table 2: Percent distribution of demographic data of Family members (n= 67).

	PICU (n = 101)	ICU (n = 126)	ER (n = 101)	F	p
To be assured that the best care possible is being given to the patient	3.71 ± 0.48	3.61 ± 0.59	3.56 ± 0.56	1.955	0.143

To know the expected outcome	3.68 ± 0.51	3.65 ± 0.60	3.51 ± 0.56	2.618	0.74
To have questions answered honestly	3.69 ± 0.56	3.61 ± 0.64	3.55 ± 0.57	1.372	0.255
To know why things were done for the patient	3.61 ± 0.62	3.58 ± 0.64	3.47 ± 0.61	1.598	0.204
To know how the patient is being treated medically	3.63 ± 0.56	3.54 ± 0.68	3.44 ± 0.62	2.525	0.082
To know exactly what is being done for the patient	3.57 ± 0.62	3.56 ± 0.61	3.47 ± 0.63	0.908	0.404
To know specific facts concerning the patient's progress	3.50 ± 0.63	3.40 ± 0.68	3.40 ± 0.60	0.758	0.469

Table 3: Comparison between the three units according to family needs perceptions (n= 328).

	PICU (n = 101)		ICU (n = 126)		ER (n = 101)		Test of sig.	p
Total score	No.	%	No.	%	No.	%		
Min. – Max.	88.0 – 176.0		80.0 – 175.0		88.0 – 199.0		F = 1.282	0.279
Mean ± SD.	140.35 ± 18.32		137.57 ± 19.85		136.10 ± 19.19			

Table 4: Comparison between the three units according to total mean score of family needs' perception (n= 328).

	Dimension	Doctors (n = 77)	Nurses (n = 184)	Family members (n = 67)	F	p
To know how the patient is being treated medically	Information	3.35 ± 0.70	3.50 ± 0.58	3.85 0.56	12.889*	<0.001*
To be assured that the best care possible is being given to the patient	Assurance	3.61 ± 0.54	3.55 ± 0.57	3.85 ± 0.44	7.492*	0.001*
To know specific facts concerning the patient's progress	Assurance	3.36 ± 0.69	3.30 ± 0.62	3.85 ± 0.44	20.578*	<0.001*
To talk to the doctor every day	Assurance	3.34 ± 0.70	3.44 ± 0.65	3.84 ± 0.45	13.024*	<0.001*
To know exactly what is being done for the patient	Information	3.40 ± 0.69	3.48 ± 0.59	3.82 ± 0.52	10.039*	<0.001*
To feel that the hospital personnel care about the patient	Assurance	3.40 ± 0.69	3.24 ± 0.73	3.82 ± 0.46	18.275*	<0.001*
To feel accepted by the hospital staff	Comfort	3.42 ± 0.57	3.22 ± 0.70	3.79 ± 0.51	20.185*	<0.001*
To have someone be concerned with patient's health	Support	3.04 ± 0.80	3.0 ± 0.80	3.78 ± 0.55	27.227*	<0.001*
To know the expected outcome	Assurance	3.64 ± 0.54	3.56 ± 0.58	3.76 ± 0.52	3.244*	0.040*
To have questions answered honestly	Assurance	3.61 ± 0.57	3.57 ± 0.59	3.76 ± 0.65	2.518	0.082
To have explanations given that are understandable	Assurance	3.36 ± 0.69	3.29 ± 0.79	3.75 ± 0.61	9.510*	<0.001*
To know why things were done for the patient	Information	3.48 ± 0.66	3.52 ± 0.60	3.73 ± 0.62	3.548	0.030
To see the patient frequently	Proximity	3.17 ± 0.78	2.96 ± 0.89	3.73 ± 0.57	22.431*	<0.001*
To be called at home about changes in the patient's condition	Assurance	3.17 ± 0.86	3.04 ± 0.93	3.73 ± 0.64	15.764*	<0.001*
To receive information about the patient at least once a day	Assurance	3.31 ± 0.63	3.10 ± 0.79	3.72 ± 0.57	18.494*	<0.001*

Table 5: Comparison between the three groups according to items of perception and dimensions (n= 328).
F: F value for ANOVA test
*: Statistically significant at $p \leq 0.05$

	Score	Doctors (n =77)	Nurses (n = 184)	Family members (n =67)	F	p
Support scale	Total score	42.08 ± 7.77	40.68 ± 7.47	42.55 ± 5.46	2.117	0.112
	Percent score	66.85 ± 18.50	63.54 ± 17.79	67.98 ± 13.0		
Comfort scale	Total score	18.52 ± 3.13	17.71 ± 3.73	20.12 ± 2.84	12.209*	<0.001*
	Percent score	69. 55 ± 17.40	65.04 ± 20.75	78.44 ± 15.76		
Information	Total score	29.19 ± 4.12	29.25 ± 4.32	31.70 ± 3.05	9.925*	<0.001*
	Percent score	74.80 ± 15.27	75.0 ± 16.0	84.08 ± 11.28		
Proximity	Total score	27.05 ± 4.61	25.57 ± 4.69	30.76 ± 3.77	32.736*	<0.001*
	Percent score	66.86 ± 17.09	61.35 ± 17.37	80.60 ± 13.98		
Assurance	Total score	24.25 ± 2.86	23.77 ± 2.96	26.36 ± 2.41	20.626*	<0.001*
	Percent score	82.13 ± 13.63	79.87 ± 14.10	92.18 ± 11.48		

Table 6: Comparison between the three groups according to different subscale (n= 328) in overall.
F: F value for ANOVA test
*: Statistically significant at $p \leq 0.05$

Discussion

From the findings of this study, it is noted that within the sociodemographic data, most FMs experienced a 'first time' critical illness of a loved one. It was difficult to access literature on the experiences of FMs who experienced the first time admission of a loved one; however literature searches revealed that seeing a FM critically ill in critical care for the first time is stressful. The critical care environment is perceived by FMs as an aggressive and threatening space because it evidences the risk of the patient dying. According to de Beer and Brysiewicz [30], the critical care environment is harsh with its machinery, monitors and constant beeping of alarms which leads to feelings of inadequacy amongst FMs. In addition, the critical care environment can trigger feelings of doubt, helplessness, mental disorganization and depression.

In addition, this study most CCNs and doctors had less than 6

years of experience within the critical care context. Kanervisto, Paavilainen & Heikkilä [4] confirm that inexperienced staff can overlook the needs of FMs. It leads to the lack of communication, interaction, support, and cooperation. Contradictory or limited information from inexperience can lead to depression, stress, and anxiety of the FMs and overall family dissatisfaction. According to by Brysiewicz and Bhengu [30], CCNs that lack of training to deal with FMs led to them using their own experiences in dealing with FMs.

Further to this, within this study, the majority of doctors and nurses were between the age groups 30-39 years. According to Maxwell [6]; Pryzby [8] young healthcare providers have to be trained adequately to meet psychological needs of patients and FMs. This will enable young healthcare professionals to understand the experiences of FMs during the critical illness of a loved one thereby applying an appropriate approach to the unique needs of FMs and establish effective communication and cooperation. CCNs are in their professional positions to apply skills, knowledge, abilities, and attitude to reduce the stress of FMs addressing their psychological needs [9]. Indicating, understanding, and satisfying the needs of family members of the patients contributes to the establishing of proper cooperation, effective interaction, and to the promotion of trust and confidence in the nurse patient relations.

The need for information was scored the highest amongst FMs as opposed to CCNs and doctors. Cypress [31] reported that providing information to FMs about the care of the patient lessens their anxiety as they are not familiar with the ICU environment. Plakas, Cant and Taket [32], reported that the lack of information affects emotions in negative ways, such as uncertainty and agony about the outcome of the patient, and that information can relieve such emotions. Nelson, Kinjo, Meier, Ahmad and Morrison [33] also reported on six domains of information sharing similar to this study which included: illness and nature of treatments; prognosis for outcomes and quality of life; impact of treatment on patient experience; potential complications of treatment, expected care needs after treatment; and alternatives to treatment. These authors reported that these domains of information are relevant and important for discussion and decision making in the context of critical care. This is especially important when the prognosis of the patient is poor.

Within this study 60% of needs were assurance needs. This findings in on par with other studies in which assurance needs were perceived as greater needs that any other need of FMs. According to Fortunatti [19], who completed a literature review on family needs, and found that the most important needs were assurance needs from a total of 15 studies. Further to this, assurance needs were most common in countries from geographical areas including Asia, and South America. The most important assurance need within this study was "To be assured that the best care possible is being given to the patient". According to Shorofi et al. [34], being assured that the best possible care was given to the patient was the most important need perceived by nurses within their study as opposed to FMs. This can be ascribed to the fact that the medical team focuses more on the patient's treatment and care when the patient is in a critical condition [35,36].

Limitations of the Study

This study was confined to one setting. Further to this the questionnaire was lengthy and could have been time consuming especially within the busy context of critical care.

Conclusion

This research indicated the most important needs of FMs of critically patients as perceived by FMs', nurse and doctors. Identification of these needs is needed to establish proper connection, effective communication, and beneficial cooperation and provide the best possible care to FMs.

Recommendation

A larger scale study using space triangulation is suggested. In addition qualitative studies within the Saudi context are advised. Lastly, family need assessments should be incorporated within policies and guidelines for FCC within the critical care context.

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