

## **CHALLENGES ENCOUNTERED BY INTENSIVE CARE NURSES IN MEETING PATIENTS' FAMILIES' NEEDS IN MALAWI**

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### **ABSTRACT**

Critically ill patients may be incapable of making decisions, thus forcing their family members to make decisions on their behalf. Intensive care units (ICUs) are a new additions to hospitals in developing countries. The nurses' roles, in caring for ICU patients and supporting their families, have not been researched extensively in Malawi. The purpose of this study was to explore the challenges ICU nurses face in providing family support while delivering complex care to patients. The results provide insight, from a developing country, related to intensive care nursing of patients and their families. It also provides a nursing perspective to hospitals striving to improve their ICUs.

A descriptive, exploratory, qualitative study was conducted at two hospitals in Blantyre, Malawi, during March and April 2008. Data collection involved interviewing ten ICU nurses. The following themes emerged from the data: lack of adequate ICU training; lack of written policies to manage ICU patients' families; and lack of preparedness to provide continued and persistent information to families; manage the continued presence of families; promote families' abilities to rest; and to deal with specific religious practices and competing demands for patient and family care.

Recommendations include: creating an ICU information booklet; introducing the provision of family support care in ICUs; creating respectful, trusting, empathetic and collaborative relationships with families; providing waiting areas for ICU patients' families; educating hospital

management regarding the stressful working situation of ICU nurses; and instituting a post registration programme in intensive care nursing in Blantyre.

**KEYWORDS:** family support, intensive care nursing, Malawi, nursing challenges

## **INTRODUCTION AND BACKGROUND INFORMATION**

An intensive care unit (ICU) is a specialised care area where facilities for critically ill patients are concentrated and the level of care is complex, intense and frequently life sustaining (Size, Borgstein & Haisma, 2005:12). Typically, units require one nurse per patient to provide highly specialised care (Whiteley, Bodenham & Bellamy, 2004:2).

In Malawi, the first ICU was established at Kamuzu Central Hospital, Lilongwe in 1990. Subsequently, Queen Elizabeth Central hospital in Blantyre established its ICU in 1992 and Mzuzu Central Hospital in 2000. Each ICU has four functional beds. Mwaiwathu, a private hospital in Blantyre, opened its 4-bedded ICU in 1998. This means that a total of 16 ICU beds exist for the 13 million people in Malawi. In Malawi, ICUs function as multidisciplinary units for critically ill neonatal, paediatric and adult patients admitted for surgical, medical, cardiac and neurological reasons.

Critical illness or injury may result in an emergency admission to ICU. This may be physically and emotionally stressful to families who usually accompany their sick relatives during hospitalisation (Williams, 2005:6). The admission happens without any opportunity for preparation, both emotionally and physically, for family members of critically ill patients. This causes fear of death, uncertain outcomes, emotional turmoil, financial concerns, role changes, disruption of routines, and unfamiliar hospital environments (Medina, 2005:99). Critically ill patients are often incapable of making decisions regarding their own care. This forces family members to make decisions on behalf of these patients, compounding the family members' stressful experiences (Wasser, Pasquale, Matchett & Bryan, 2001:192). Patients admitted to ICUs require technical support for multiple organ failure, airway problems, and/or drug infusions to treat their severe conditions (Size, Borgstein & Haisma, 2005:12). In addition to technical support provided to patients, nurses must address the psychosocial challenges and ethical conflicts associated with caring for critically ill patients and their families. Medina (2005:99) identified the following as needs of families of ICU patient: receiving assurance; remaining near the patient; receiving information; being comfortable; and getting support. The traditional healthcare professional-patient relationship should include a professional-family relationship dimension as well (Coyle, 2000:45).

## STATEMENT OF THE RESEARCH PROBLEM

Supporting families of critically ill ICU patients is an essential responsibility of ICU nurses (Hardicare, 2003:34). Although ICU nurses help both the critically ill patients and their families, patients are the primary focus of the nurses' attention, due to the complexity of care required for their survival, and hopefully for their recovery (Chien, Chiu, Lam & Ip, 2006:40). Being an ICU nurse is a job with high demands, including the provision of family support and care. The unique demands and pressures of this role, specific to developing countries, has been inadequately researched.

The results of this study could provide insight, from a developing country's perspective, related to ICU nursing and the provision of family support. Additionally it could provide a nursing perspective to hospitals striving to improve their existing ICUs.

## PURPOSE OF THE STUDY

The purpose of this study was to explore the challenges nurses face in providing family support while delivering complex care to ICU patients.

## DEFINITIONS OF KEY TERMS

**Family support and care** is a method of care delivery that recognises and respects the role of families by assuming direct care giving roles and increased family members' involvement during patients' hospitalisation (Wright, 2007:15).

**Intensive care** is the specialised care of patients whose conditions are life threatening and require constant monitoring (Medterms, 2010).

**Malawi** is a landlocked country in southeast Africa and is among the world's least developed and most densely populated countries with a largely rural population (Wikipedia, 2011).

**Nursing challenges** are emotional, intellectual and technical difficulties that ICU nurses face when caring for critically ill patients and their families since the ICU environment is different from hospitals' general wards (Farnell & Dawson, 2006:321).

## RESEARCH METHODOLOGY

A descriptive, exploratory, qualitative study was conducted. Data collection began by interviewing three nurses from each participating hospital. However, sampling continued until five nurses from both participating hospitals had been interviewed and data saturation was achieved.

## **Research setting**

The study was conducted in the ICUs of two hospitals in Blantyre, Malawi. Both ICUs had the necessary basic equipment including ECG machines, pulse oximeters, cardiac monitors, blood pressure measurement instruments, and ventilators.

## **Sample**

Purposive sampling of ten nurses who met the inclusion criteria working in the two participating ICUs were selected for inclusion. Participants were nurses who had been working in the two participating ICUs for a minimum of six months and consented to participate in the study by being interviewed.

## **Data collection**

The data were collected during March and April 2008. Private, tape recorded interviews, by appointment were conducted following an interview guide. Each interview lasted for 25–40 minutes, until data saturation occurred. Hospital documents related to family support care were also reviewed at the completion of the interviews at each centre. The documents included minutes of family meetings, protocols, guidelines and information posters.

Trustworthiness of the study was ensured through addressing transferability, credibility, dependability and conformability of the results. Transferability was ensured through thick description of the participants' characteristics, the research setting and processes of the inquiry. Credibility was ensured through asking participants to provide their opinions about providing care to ICU patients' family members. To ensure dependability, the researcher documented all the raw data. Additionally the researcher identified and bracketed personal biases.

## **Ethical considerations**

The study was approved by the Ethics and Research Committees of the University of KwaZulu-Natal, South Africa and the University of Malawi, College of Medicine. Permission was obtained from the two participating hospitals' and units' managers, as well as from each individual participant. Anonymity and confidentiality were guaranteed to the respondents. No names were used and no one could trace raw data to any specific person, except the interviewer. The information was kept locked up securely. Only the researchers had access to the raw data. Subsequent to the acceptance of the research report, the data would be destroyed. The research report would not mention any names. Every person participated voluntarily, without any coercion whatsoever, and could

withdraw from the interview at any stage. No one was coerced to answer any specific question.

## ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

Data collection and data analysis were done concurrently. Transcription of the data commenced immediately after each interview. Data analysis was done manually. Transcripts were coded, word for word, to give an initial coding scheme, which was examined to identify any repetitions. Each description was read many times in order to gain a sense of the whole. After initial coding and identification of themes, an external researcher verified the themes. Information from reviewed documents which included protocols, guidelines and information posters were incorporated into the thematic coding process.

### Demographic data

Participants' demographic information is summarised in table 1. Participants' ages ranged from 26–46 years and their years of experience in the ICUs ranged from 9 months to 11 years. All participants were females and Christians. Eight participants were nurse and midwife technicians, one was a nurse technician and one a registered nurse and midwife. All received on the job training for intensive care nursing. None had undergone formal intensive care nursing training to become registered as an intensive care nurse.

**Table 1:** Participants' demographic data

Participant no.	Age in years	ICU experience	Gender	Religion	Professional qualification	Orientation period in ICU	Type of orientation
1	26	9 months	F	Christian	NMT	1 week	OJT
2	39	4 years	F	Christian	NMT	1 week	OJT
3	26	1 year	F	Christian	NT	3 days	OJT
4	35	4 years	F	Christian	NMT	1 week	OJT
5	43	5 years	F	Christian	NMT	1 week	OJT
6	45	11 years	F	Christian	RNM	1 year	OJT
7	46	3 years	F	Christian	NMT	3 days	OJT
8	32	2 years	F	Christian	NMT	1 week	OJT
9	31	3 years	F	Christian	NMT	2 days	OJT
10	29	2 years	F	Christian	NMT	1 week	OJT

**Key:**

NMT = nurse and midwife technician

NT = nurse technician

F = Female

RNM = registered nurse and midwife

OJT = on the job training

## **Thematic analysis**

The following themes emerged from the data analysis: lack of adequate ICU training; lack of written policies to manage ICU patients' family members; inadequate preparation to provide sustained information to family members, to manage family members' presence in ICUs, enhance their abilities to rest and to deal with specific religious practices. The nurses encountered competing demands in caring for ICU patient and for these patients' family members.

### ***Lack of adequate ICU training***

All nurses identified a lack of adequate formal ICU training as one of their major challenges, as portrayed by one nurse who said: *"I had a bit of orientation at . . . (one of the participating hospitals) by visiting doctors and anaesthetists which lasted for three days"*. This orientation was mainly done whenever a new nurse was allocated to work in the ICU, and the nurses learned through experience, as explained: *"It was not really adequate but with time and experience we are coping up well although we have some problems"*.

These orientations contained specific content on providing support to ICU patients' family members: *"No, the orientation did not include support care for the families . . . you just imagine what would need to be done by you if you had a patient in the ICU from general knowledge . . ."*.

### ***Lack of written policies for managing ICU patients' family members***

At the ICUs information was available about the visiting hours, but no information about providing support to ICU patients' family members was available. There were also no pamphlets. Participants reported a lack of clear written policies on how to support families by stating: *"The time I came here, I was told that when you admit, you do this and that, so I assume it is the policy . . ."*.

### ***Inadequate preparation to provide information to family members***

Nurses indicated that they found it stressful when family members asked questions, which the nurses felt unprepared to answer: *". . . when they are around asking a lot of questions, sometimes you are not sure of what to tell them. We have problems because we ourselves too have stress . . ."*.

### ***Managing the continued presence of family members in the ICUs***

Reportedly some family members desired to be present in the ICUs at all times and did not adhere to the ICUs' specified visiting hours: "*They come in and they do not want to go out . . .*". If one ICU nurse made an exception, the patients' family members insisted on such exceptions at all times: "*. . . your friend allowed us to stay here, so why are you not allowing us to stay? You are bad*".

### ***Family members' inability to rest***

Both institutions lacked resting facilities for family members. They frequently waited outside the ICUs, in other hospital wards or elected to go home. Nurses encountered difficulties to find family members when the ICU patients' conditions deteriorated or when the family members' permission was required for specific procedures. The participants stated: "*. . . they are always in the ward where the patient is coming from. If it is a female, surgical case . . . the guardian is always in the female surgical ward and sleeps there. If it is a male surgical patient, the guardian is in male surgical ward, if it is paediatric patient, it is always in paediatric ward, if it is maternity mother, it is always in the . . . maternity unit*".

Family members who left the hospital premises also posed problems: "*. . . when they go home they do not even know what is happening. When the patient has started gasping we have to check for phone numbers, call them, sometimes the lines are busy . . . by the time we get through and they are coming here, patient is already gone. It then becomes difficult to explain to them what was happening. Sometimes it happens that when they were going home they left the patient in a stable condition . . .*".

### ***Dealing with specific religious practices***

The church provided spiritual support and encouragement to families during hospitalisation of their loved ones, but sometimes it was a source of frustration when providing patient care: "*We also do find problems with some churches; they say they do not have blood transfusion*". The dilemma was more profound with minors, who had not made informed decisions to join the church, and therefore parents or guardians had a major influence on these children's accessibility to blood transfusions: "*. . . we do have problems especially if it is a child, who has not chosen that religion*".

### ***Competing demands for providing care to ICU patients and their family members***

Nurses reported feeling overworked, understaffed and having inadequate time for coping with family members' demands: "*. . . sometimes you are found to be alone on duty,*

*you don't really have time to attend to the relatives because you are busy...*". This situation caused emotional stress among nurses and contributed to nurses behaving in unprofessional ways: "*... sometimes one loses one's temper just because of pressure of work ...*".

## **DISCUSSION OF FINDINGS**

Nurses experienced numerous challenges in meeting the perceived needs of ICU patients' family members. The overriding theme was a lack of preparedness. Sub-themes included a lack of adequate ICU training, and lack of policies to manage family members. Nurses also reported inadequate preparation for providing sustained information to family members; managing the continued presence of family members; promoting family members' abilities to rest; and for dealing with specific religious practices and competing demands for patient and family care.

Lack of experience, the absence of written policies and inadequate education and training of ICU nurses were identified as major barriers for providing support to family members. Farnell and Dawson (2006:321) indicated that less experienced and less well trained nurses need a period of socialisation in order to acquire knowledge and skills to care for patients, before the nurses can provide support to patients' family members. Through experience, nurses learn to know their patients and these patients' family members (Pryzby, 2005:18). In the current study, some nurses indicated that their ICU orientation was inadequate. However, over time they had gained experience and coped with the situation. The nurses' knowledge of dealing with families in crisis affected their attitudes toward family members of critically ill patients. Working in an ICU is emotionally and intellectually challenging as the environment is different from that of the general hospital wards (Farnell & Dawson, 2006:321). In the study, none of the nurses had formal ICU training.

Proper family support requires adequate staffing. Nurses were reportedly usually in short supply in the ICUs and could not adequately meet family members' needs in addition to caring for critically ill patients. Engström (2006:27) reported that ICU nurses wished that one nurse could take care of family members, while another one cared for the critically ill patient, especially when they had just arrived in the ICU. In this study, having one nurse look after the patient and another one take care of family members was unfeasible due to the shortage of nurses.

The continuous presence of family members in the ICUs was stressful to the ICU nurses, interfering with the care rendered to the ICU patients. This "perceived interference" might be due to different cultural, educational and religious backgrounds and dynamics, which could affect family members' behaviour in ICU. Engström (2006:26) reported that families from different cultures were problematic due to diverse views of appropri-

ate behaviour when patients are critically ill. In Malawi, one or two family members are expected to stay near their loved ones, but this is impractical, as there is nowhere for them to stay. Waters (1999 as cited in Pryzby, 2005:23) compared cultural differences in families' expectations, regarding expected professional nursing support during critical illness among Whites, Hispanics and African Americans. It was reported that nurses needed to be culturally sensitive to family members' needs and should integrate preferred cultural routines into patients' nursing care plans.

## **CONCLUSION**

Nurses working in the two participating ICUs experienced challenges when caring for ICU patients and their family members. The challenges included a lack of adequate ICU training and the absence of policies to manage family members. Nurses were reportedly unprepared to provide sustained information to family members; manage the continued presence of family members; promote family members' abilities to rest; and to deal with specific religious practices. Nurses also experienced competing demands between caring for the ICU patients and providing support for these patients' family members.

## **RECOMMENDATIONS**

The following recommendations are made for hospitals instituting ICUs with implications for nursing practice, hospital management, nursing education and nursing research.

### **Recommendations for nursing practice**

Create a specific ICU information booklet; introduce the provision of family support in ICUs; and create a respectful, trusting, empathetic and collaborative relationship with family members thereby increasing families' involvement in patient care. Where possible, assign one nurse to deal with patients' family members.

Educate family members about the necessity for adhering to visiting hours and for ensuring that the ICU nurses have their correct contact details at all times.

### **Recommendations for hospital management**

Provide a waiting area for ICU patients' family members; inform hospitals' nurse managers about ICU nurses' stress levels; and ensure adequate staffing of ICUs.

## Recommendations for nursing education

Provide ICU in-service education regarding family support care and institute a post registration programme in intensive care nursing. Send a few nurses to foreign countries to obtain their intensive care nursing qualifications and then to return to Malawi to train other nurses.

## Recommendations for future research

Investigate the challenges faced by ICU patients' family members in Malawi by conducting interviews with these family members.

## LIMITATIONS OF THE STUDY

The results cannot be generalised to all ICUs in Malawi because of the small sample size and data collection took place only at two ICUs. Only the nurses' views were obtained. The ICU patients' family members might have had different experiences.

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