

Original/Research Paper

Psycho-social needs of family members of patients hospitalized in the burn intensive care unit: A cross-sectional study

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Abstract

This study aimed to determine the psycho-social needs of the families of patients hospitalized in the burn intensive care unit (ICU). This cross-sectional study recruited 152 family members of patients hospitalized in the burn ICU, using the convenience sampling method. Data were collected from May to August 2018. The data collection instrument included the socio-demographic information questionnaire for first-degree relatives (FDRs), and the critical care family needs inventory (CCFNI). The data were analyzed using Spearman's correlation coefficient test. The average of the needs of family members of patients hospitalized in the burn ICU in the fields of support, information, proximity, comfort, and assurance were 27.69 (SD=2.45), 62.98 (SD=7.1), 73.79 (SD=3.2), 18.82 (SD=3.35), and 25.26 (SD=2.14), respectively. The most and lowest the needs of family members of patients hospitalized in the burn ICU were in the areas of proximity and comfort, respectively. There was a significant positive relationship between needs and assurance ($\rho=0.162$, $P<0.05$), information ($\rho=0.264$, $P<0.05$), support ($\rho=0.698$, $P<0.05$), proximity ($\rho=0.618$, $P<0.05$), and comfort subscales ($\rho=0.692$, $P<0.05$). Providing adequate and appropriate support for the burn's patients and their families, especially by nurses, and noticing their primary needs reduces their anxiety, strengthens their trust in the medical team, enhances the quality of services to the patients and their families, and increases their satisfaction. Therefore, appropriate planning and increasing the workforce in these wards are essential.

Keywords: Burns, Burn Units, Intensive Care Units, Family, Needs Assessment.

1 | Introduction

Illnesses and accidents leading to hospitalization in intensive care unit (ICU) are usually life-threatening events, leading to anxiety and concern in the family members due to the possible loss of the loved one [1]. The high stress and anxiety in these families are due to factors such as the volatility of the patient's prognosis, unfamiliarity with the hospital environment and advanced equipment [2], fear of the patient's death, financial concerns, role changes, and changes in daily life [3]. Admission to the ICU

following a life-threatening illness occurs suddenly and without warning. Therefore, patients and their families do not have time to cope with the disease due to the patient's critical condition [4]. This results in the family members' concerns and lack of mental concentration, harming the personal and social relationships and decision-making in urgent situations concerning ICU patients [5]. Patients with unique psychological and physical conditions cause more severe problems for their family members [6]. Therefore, they may not be able to accurately detect their needs during the early stages of a crisis [1].

To provide comprehensive and quality medical care to the patients hospitalized in the ICU, the medical team must attend to the patients' and their families' psychological and social needs [7, 8]. Studies have shown that families can participate in patient care after discharge if their needs are met [9, 10]. However, the nurses and healthcare personnel do not often meet the psychosocial needs of the patients' families [1]. Immediate identification and being responsible for the needs of the families reduces the adverse effects of stress on them, decreases the stress effects on the treatment team and the patient, and directs the family's attention to patient care [11, 12]. The health and well-being of each family member depend on meeting their needs, which are influenced by the healthcare team [9, 10].

The needs of families of patients hospitalized in the ICU include five categories: information [13], assurance [14], support [15], comfort [16], and proximity [17]. Searching for information leads to the creation of information needs in such a way that the information must be a personal matter that people need information about [18]. The need for assurance is related to ensuring the health status of family members by healthcare workers [19]. Another important need of the family in ICU patients is support needs that help them manage the stressful situation better and makes their expectations about the prognosis of ICU patients more reasonable [20]. Another demand of the family members of patients admitted to the ICU is comfort. Comfort is a feeling of well-being that those receiving treatments experience and that actively, passively, or jointly satisfies a fundamental human need that everyone recognizes and seeks [21]. Additionally, the requirement for proximity demonstrates the family's desire to interact and sustain ties [14]. Their priority and importance vary in different cultures and societies. For example, proximity to the patient and the right to visit the patient daily is an essential need in some communities, whereas proper communication with the medical staff is the priority in other societies. Fulfilling the need for assurance promotes their hope and security and eradicates their uncertainty. The purpose of receiving information is to understand the patient's condition, and its fulfillment raises some principles for decision-making and preparing the patient, reduces the family's anxiety, and improves their sense of control [1, 11]. The need for proximity is the desire to communicate and maintain family relationships, and its fulfillment provides emotional support for the family and the patient. The need for comfort reduces the chaos. When people feel comfortable, their energy is saved, and their anxiety is reduced [2]. Finally, the need for support is seeking help from experts and professionals, and its fulfillment helps them to cope with the stress [1, 7].

Burn complications are one of the leading causes of death globally [22-25]. Burn injuries produce some of the most painful patient experiences and may result in unpleasant physical and psychological outcomes among patients [26]. Despite major improvements in the treatment of burn survivors, it had different physical and psychological effects such as pain, pruritus, scars, stress, and shame about scars [27-30]. According to the findings of a scoping review on family needs in ICU, unfulfilled informational needs have an impact on family happiness and the mental health of the family members. Additionally, structured written and verbal information can improve satisfaction and lessen psychological strain to some extent [13]. The search in the available databases revealed that this is the first study investigating the needs of families of burn ICU patients. Thus, this study aimed to determine the psycho-social needs of the families of patients hospitalized in the burn ICU.

2 | Methods

2.1 | Study design and subjects

This cross-sectional study recruited 152 family members of patients hospitalized in the burn ICU, using the convenience sampling method. The sampling of this study was done at Zare burn specialist hospital in Sari, Iran. This hospital is under the supervision of the Mazandaran University of Medical Sciences. The departments of this hospital include the burn department, burn ICU, reconstructive surgery, and emergency department. This hospital has 216 beds, of which 14 are in the ICU.

2.2 | Ethics consideration

The research was approved by the ethics committee of Mazandaran University of Medical Sciences, Sari, Iran (IR.MA-ZUMS.REC.1396.10397). After obtaining permission from the hospital administration, the researchers visited the hospital. Verbal informed consent was obtained from participants.

2.3 | Sample size

The researchers calculated the sample size required to assess the psycho-social needs of family members of patients hospitalized in the burn ICU 158 based on the following formula with $d=6\%$, $1-\alpha=0.95$, and a potential 25% attrition rate.

$$N = \frac{(z_{1-\alpha/2})^2 p(1-p)}{d^2} = \frac{(1.96)^2 (0.73)(1-0.73)}{0/0036} = 126$$

$$126 \times 1.25 = 158$$

2.4 | Inclusion and exclusion criteria

The study inclusion criteria included first-degree relatives (FDRs) of the patient (father, mother, siblings, spouse, and children) who visited the patient in the first 24–48 hours after being admitted to the hospital, aged ≥ 18 , were literate, and were willing to participate in the study. Participants who did not want to participate in this study were excluded.

2.5 | Data collection

The researchers assured the participants about the confidentiality of the data and their withdrawal from the study whenever they wished. Furthermore, they ensured the families that not participating in the study or withdrawing from it would not harm the treatment process and care for their patients. Data were collected from May to August 2018. The data collection instrument included the socio-demographic information questionnaire for FDRs, and the critical care family needs inventory (CCFNI). The researchers provided the FDRs with information about the purpose of the study verbally and through a leaflet containing information of the research project. If they were willing to participate in the study, the researchers obtained informed written consent from them. After that, the questionnaire was given to the FDRs to complete it.

2.6 | Questionnaires

The first questionnaire gathered information about the age, gender, marital status, education, income status, occupation, family relationship with the patient, being a housemate with the patient, history of the family members' hospitalization in ICU, caring for another patient in the family, and the time of the first visit with the patient. The latter encompasses the needs of patients' FDRs, including 45 questions with five subscales. The CCFNI subscales are the needs of FDRs of patients hospitalized in ICU, including the need for support (15 items), information (8 items), proximity (9 items), comfort (6 items), and assurance (7 items) based on four points; 1 for not important, 2 for slightly important, 3 for important, and 4 for very important [12]. CCFNI is a family needs assessment instrument in ICU, widely used in research, and its reliability and validity have been confirmed in different countries [8, 31, 12]. The validity and reliability of this tool have been done in Iran. In agreement with the original instrument, in the exploratory factor analysis, five distinct components were extracted from the CCFNI, which accounted for more than 52% of the total variance. In the convergent validity, the correlation between the total score of the tool and the criterion of the state-trait anxiety questionnaire was positive and significant. Cronbach's alpha coefficient was 0.89 for the whole tool and more than 0.70 for all

dimensions [32]. The present study showed that the reliability of this instrument is 0.7 using the test-retest reliability.

2.7 | Statistical analysis

The data were analyzed using SPSS software version 21 with a significance level < 0.05 . Descriptive statistics were used to present the frequency tables, and the two-dimensional tables were employed to describe the data related to socio-demographic characteristics reporting the frequency, percentage, mean, and standard deviation. The Kolmogorov-Smirnov test evaluated the normality of the data. Then, the data were analyzed using Spearman's correlation coefficient test.

3 | Results

3.1 | Participants' characteristics

Of the 158 patients' FDRs, 152 participants were willing to participate. Six participants did not participate due to a lack of willing to participate in the present study. Finally, we conducted the final analysis on 152 patients' FDRs (response rate=96.20%) (Figure 1). The mean age of participants was 34.00 (SD=11.00) years. Of the participants, 54.61% were male, 64.47% were married, 38.82% had a diploma, 36.18% had medium income status, 21.71% were the father of patients, and 29.61% were employees. The individual characteristics of the participants are presented in Table 1.

3.2 | The needs of family members of patients hospitalized in the burn ICU

As shown in Table 2, the average of the needs of family members of patients hospitalized in the burn ICU in the fields of support, information, proximity, comfort, and assurance were 27.69 (SD=2.45), 62.98 (SD=7.1), 73.79 (SD=3.2), 18.82 (SD=3.35), and 25.26 (SD=2.14), respectively. The most and lowest the needs of family members of patients hospitalized in the burn ICU were in the areas of proximity and comfort, respectively.

3.3 | The relationship between FDRs' needs of the patients hospitalized in ICU

As shown in Table 3, Spearman's correlation coefficient results reveal that there was a significant positive relationship between needs and assurance ($\rho=0.162$, $P<0.05$), information ($\rho=0.264$, $P<0.05$), support ($\rho=0.698$, $P<0.05$), proximity ($\rho=0.618$, $P<0.05$), and comfort subscales ($\rho=0.692$, $P<0.05$). There was a significant positive relationship between the assurance subscale and information subscale ($\rho=0.358$, $P<0.05$). There was a significant positive relationship between the information subscale and

support ($\rho=0.188$, $P<0.05$), proximity ($\rho=0.269$, $P<0.05$), and comfort subscales ($\rho=0.268$, $P<0.05$). There was a significant positive relationship between the support subscale and proximity

($\rho=0.656$, $P<0.05$) and comfort subscales ($\rho=0.678$, $P<0.05$). Also, there was a significant positive relationship between the proximity subscale and comfort subscale ($\rho=0.498$, $P<0.05$).

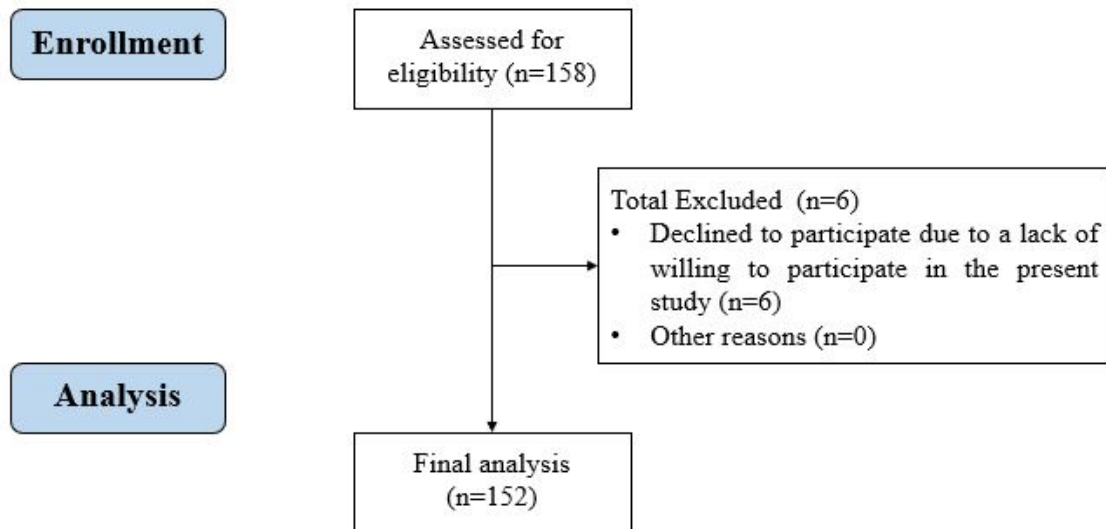


Figure 1. Flowchart of the study.

Table 1. Socio-demographic characteristics of patients' family members (N=152).

	Frequency (%) (N=152)
Age	
≤30	54 (35.53)
31-49	86 (56.59)
≥50	12 (7.88)
Gender	
Male	83 (54.61)
Female	69 (45.39)
Marital status	
Single	54 (35.53)
Married	98 (64.47)
Education	
High school dropout	39 (25.65)
Diploma	59 (38.82)
University	54 (35.53)
Income status	
High (>150 Million Rials)	14 (9.22)
Good (100 to 150 Million Rials)	36 (23.68)
Medium (50 to 100 Million Rials)	55 (36.18)
Low (< 50 Million Rials)	47 (30.92)
Relationship with patients	
Father	33 (21.71)
Mother	18 (11.84)
Sister	29 (19.08)
Brother	24 (15.79)
Spouse	28 (18.42)
Child	20 (13.16)
Occupation	
Unemployed	3 (1.98)
Worker	27 (17.76)
Employee	45 (29.61)
University student	15 (9.87)
Farmer	13 (8.55)
Housewife	36 (23.68)
Other	13 (8.55)

Values are given as a number (percentage) for categorical variables.

Table 2. The needs of family members of patients hospitalized in the burn ICU.

Needs	Mean±SD
Support	27.69 (SD=2.45)
Information	62.98 (SD=7.1)
Proximity	73.79 (SD=3.2)
Comfort	18.82 (SD=3.35)
Assurance	25.26 (SD=2.14)

Table 3. Correlation coefficients between different subscales of family needs of patients hospitalized in the ICU (N=152).

	Needs	Assurance	Information	Support	Proximity	Comfort
Needs	1.000					
Assurance	0.162*	1.000				
Information	0.264*	0.358*	1.000			
Support	0.698*	N/A	0.188*	1.000		
Proximity	0.618*	N/A	0.269*	0.656*	1.000	
Comfort	0.692*	N/A	0.269*	0.678*	0.498*	1.000

P-value was obtained with the Spearman correlation coefficient test.

*P<0.05.

4 | Discussion

The study findings showed a significant and direct relationship between support and other psychosocial needs of the burn patient's FDRs. Burns is one of the most common soft tissue injuries that can have side effects such as extensive and deep wounds and eventually death. Burns can also have severe psychological effects on patients [33, 34]. Supporting the patient's family and helping them encourages them to continue caring for the patient [35]. In holistic nursing, psychological support is considered a prerequisite for treatment [36]. Supporting the patients and their family means comprehensive care of their medical condition and meeting the psychosocial needs of their family members, who are under severe stress and anxiety.

The previous study results are in line with the present study and show that supporting the family members encourages them and fulfills their needs. It shows the influential role of support in reducing their psychological and social problems. Most studies have shown that support is the most significant psychosocial need of the patient's family members [37-39]. It may be because supporting the family members of burn patients is important from two aspects. In addition to the psychological aspect of the issue, financial support and solving the problems of burn patients is significant too. Statistics show that burns are directly related to income and cultural poverty in Iran; the poor are more prone to burns than the rich [40]. This is because people with good financial ability use standard devices. Since most of the participants in this study are middle-class (35.9%) and poor (30.7%), the treatment costs of burn patients are high [40], health insurance system services in Iran have low coverage, and the Iranian families highly depend on each other, it can be inferred that the need for

emotional and financial support in the participants is more significant than other subscales.

This study revealed a significant and direct relationship between comfort and other psychosocial needs of the patient's FDRs. It means that family members can better meet their psychosocial needs if they enjoy higher comfort and prosperity. This result is consistent with other studies that have displayed that providing comfort for patients and their family members by nurses and medical staff declines their stress and problems [36]. Since many patients hospitalized in Zare Burn Hospital are from other cities, the family members have to stay in the hospital courtyard or the nearby park for over a month. Therefore, comfort is one of the priorities for the family members of these patients. On the other hand, most studies have demonstrated that comfort is the least significant need of families [5, 41]. In the early days of the patient's admission to the ICU, when the families confront more emotional stress and seek information about their patient's condition, comfort and the related needs are less significant. Thus, this study was conducted on the 4th day of the patient's hospitalization.

These research findings also showed a significant and direct relationship between the proximity and other psychosocial needs of the patient's family members. When high proximity exists between the FDRs with the nurses and the patient, their psychosocial needs will be fulfilled, and they will have more peace. Other studies confirm that more visiting opportunities for FDRs will help eradicate their psychosocial needs and reduce their psychological reactions in the ICU [6]. Peplau believes that interpersonal communication and visits are efficient factors in increasing the understanding and recognition of the patient's needs, problems, and expectations from the disease control process. She also believes that motivating and involving the patients to accept

responsibility and help improve their conditions will maintain and improve their health, ultimately leading to the satisfaction of the family and the hospitalized patients [4, 42]. Although there are many obstacles to visiting ICU patients, including the nurses' uncertainties, ward regulations, inadequate personnel, and lack of time, studies have shown that families are interested in visiting and caring for the patient and consider it important [5]. They stated that their anxiety and worry declined during visiting the patient [43]. It can be inferred that the need for proximity to the patient is essential because there are limitations for the family and relatives of patients hospitalized in the ICU, especially in the burn department, to visit their patients.

Moreover, this study demonstrated a significant and direct relationship between the information subscale and other psychosocial needs of the patient's FDRs. When the FDRs have more information about the patient's illness and treatment conditions, they feel more relaxed psychologically. The results of other studies confirm that giving information to patients' families positively affects their psychosocial needs [16, 37, 44]. Studies show that the proper and informed provision of information by nurses is one of the most effective means of communication and the basis for successful interventions in facing critical conditions for the families of patients hospitalized in the ICU [39]. Increasing the information level of family members about the patient's condition, changes, and treatment stages decline their stress and increases their trust in the nurse's efforts and empathy.

Finally, the findings showed a significant and direct relationship between assurance and other psychosocial needs of the patient's FDRs. A study confirms this finding and demonstrate that families' problems and needs decrease, and their stress is eradicated if they trust more and have higher mental security from the services provided by nurses [45]. Nurses, as influential members of the treatment team, play different roles considering the patient's physical, psychological, and social needs. To perform their roles, they must establish good relationships with their patients [45]. The patients' and their FDRs' assurance to the nurse can resolve most of the problems because the negative mental aspects between them will disappear, and they will respect each other and their rights.

4.1 | Strength and weaknesses

This study had some strengths. Due to the nurses' focus and attention on the care of the burn patient hospitalized in the ICU, the feelings and needs of the family are inadvertently ignored. On the other hand, considering the special conditions of burn patients hospitalized in the ICU, very limited studies have evaluated the

needs of the families of these patients in Iran. In addition, timely identification and response to the needs of the family reduces the negative effects of stress on the family and its negative effects on the treatment team and ultimately the patient. This study also had weaknesses. The small sample size was one of the weaknesses of this study. Also, another weakness of the study was the use of a self-report questionnaire, which can cause response bias.

4.2 | Limitations

This study had limitations. A cross-sectional and analytical study may not have been able to identify the needs of burn patients' FDRs. Also, conducting the study in a treatment center can reduce generalizability. Another limitation of the present study was the small sample size. Due to the specific conditions of burn patients' FDRs, the sample size of this study was considered small. Therefore, the present study was not fully powered and the results should be considered preliminary. Future work is needed in larger samples to further validate these findings. Also, the study assessed the psycho-social needs of family members of patients hospitalized in the burn ICU using a self-report questionnaire that may lead to a response bias. All responses were from one department at one single hospital, which may have a negative impact on external validity.

4.3 | Recommendations for future research

According to the results of this study, it is suggested that future studies, they should examine the factors affecting the improvement of communication between nurses and FDRs of burn patients and subsequently provide more support to them. It is also recommended that other researchers assess the needs of family members of burn ICU patients in other burn hospitals and on different days to compare them.

5 | Conclusions

Providing adequate and appropriate support for them, especially by nurses, and noticing their primary needs reduces their anxiety, strengthens their trust in the medical team, enhances the quality of services to the patients and their families, and increases their satisfaction. Therefore, appropriate planning and increasing the workforce in these wards are essential. Moreover, the strict rules for visiting the patients should be modified because they can harm the patients, family members, and family dynamics. This study suggests that hospitals provide booklets and hold training classes to inform the family members of burn patients more about burns and their complications.

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Authors' contributions

Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work: MAHG, SAS, ME, RAMPT; Drafting the work or revising it critically for important intellectual content: MAHG, SAS, ME, RAMPT; Final approval of the version to be published: MAHG, SAS, ME, RAMPT; Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: MAHG, SAS, ME, RAMPT.

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Ethics approval and consent to participate

The research was approved by the ethics committee of Mazandaran University of Medical Sciences, Sari, Iran (IR.MA-ZUMS.REC.1396.10397). After obtaining permission from the hospital administration, the researchers visited the hospital. Verbal informed consent was obtained from participants.

Competing interests

We do not have potential conflicts of interest with respect to the research, authorship, and publication of this article.

Availability of data and materials

The datasets used during the current study are available from the corresponding author on request.

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