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FAMILY GRATIFICATION IN CRITICAL CARE UNIT; MANIFESTING REALITY

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Abstract: Objective: Assessing and improving quality in health care by making patients and family members satisfied with the provided care. **Methodology:** we surveyed the family members of critical care patients who got admitted in multidisciplinary critical care unit for more than 72 hours between the time period of May and September 2016. Developed a standard questionnaire and validated using a pilot study. The survey consists of 12 items which classifies care of patient, care of family, professional care, intensive care unit environment and overall satisfaction, responded in 4 point Likert scale. **Results:** A total of 247 patients relatives participated in the survey experienced highest level of satisfaction in patient care with the mean item score and SD of 3.74±0.53 and the least satisfied with waiting area and visiting policies with the mean item score and SD of 3.56±0.74 respectively. **Conclusion:** Family members of critical care patients were highly satisfied with the provided patient care irrespective of their relationship towards the patient and expect open visitation policies.

Keywords: Family gratification/satisfaction, Critical care, Intensivist, Communication

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INTRODUCTION

In recent times, health care quality is considered as a major phenomenon in evaluating and monitoring improvements in health care[1]. Impression of the client and their members of the immediate and extended family are expected as essential aspect in measuring health care excellence [2, 3]. On the other side, gratification of the family member is the major controversy to be solved out while providing intensive care[4]. The critical care unit is an atmosphere that is featured by recurring expected ambiguity, inconclusiveness, and sudden death of patients. The patients in the critical care unit were deliric and most of the family members are responsible for their decisions in patient care[5]. Hence, the family satisfaction is one of the key factors in assessment of quality care[6]. The extensive duty of the Intensivist is to provide clear, detailed, benevolent information to the family members in making appropriate decision for their patients, who can't decide for himself[7]. Critical care unit health care team members should come forward to develop a collaborative and a participating relationship with the patients relatives in order to exchange information related with patient care and thus to alleviate doubts of the family members, and hence aid in coping the distress. Delivering prompt, comprehensive and clear information to patients family members resulting in increased family gratification[7] and helps to meet the needs of patients resulting in good patient outcome[8].

Background:

Collaborative communication from the health care team to the family members helps them to understand the patient condition, treatment plan and their prognosis. So that, family members can participate actively in making decisions in care and speak for the client [9-11]. Family gratification will be more when the patient/nurse ratio will be appropriate and they receive no conflicting information by each caregiver. Most of the critical care patient family members are lonesome, anxious, frightened and panic; acquire limited consideration from the healthcare team[12, 13]. Most of the critical care unit has inadequate staff nurses and hence the workload is more enough to give attention to the patients. And henceforth excluding the family members while providing care [14-16]. In critical care units, the provision of care is acute and dexterous and invasive. The sequence of events is completely dissimilar to both the patient and the family member.

It is essential that the caregiver should act as a collaborator between the patient and the family member and thus, aid in adapting the situation [17-20]. Both verbal and non verbal communication plays a vital role in the critical care unit in providing and getting clear, concise, comprehensive, compassionate information. Henceforth, reducing the queries and the stress, anxiety of the family members [21-23]. Family members always feel apprehensive about the patient diagnosis, prognosis, treatment plan, and the team in critical care. They struggle in coping the current

situation as of patient. If we don't want to mask the things happen, there is a need to facilitate visiting hours of patients to the family members [24-28]. Family visits enhance the communication between the health care team and also helps in alleviating their doubts regarding patient care and thus reducing anxieties [29]. Moreover, it aids in family satisfaction in the way how the health care team communicates with the family member [30-32].

Critical care unit is a place where discussions about end of life care or comfort care, death and discussions are more common. It is a difficult times for the family members to accept the patients poor prognosis and its exacerbations. Thus, counselling by the health care team comprises of primary physician, Intensivist, staff nurses, social workers, is essential in making the family members to understand and cope up with the situation. Two third of critical care patients relative experienced anxiety and depression post critical care unit experience [33]. One third of critical care patient's relative experience post traumatic stress disorder or either the symptoms after 90 days of discharge or death from critical care unit. The family members who experience post traumatic stress symptoms felt that there was a communication gap between the critical care team with them and also the information provided from the team is inadequate[34].

The main aim of this study is to assess the level of satisfaction with the provided critical care: to assess the key factor which is responsible for family satisfaction, by developing a standard questionnaire to evaluate family satisfaction across India.

Methods:

Study setting:

It is a prospective survey centered study, conducted in a 25 bedded, multidisciplinary critical care unit of a tertiary care medical college and hospital comprises of medical, surgical and respiratory ICUs. Our ICU bed occupancy rate ranges from 82% to 90% with an average nurse patient ratio of 1:2. Approval to conduct this study in tertiary care medical college and hospital was obtained prior to data collection from the responsible authorities.

Subject:

The study subjects were identified as a primary relationship with the patient or the next of kin or the decision maker of the patient who was admitted in a multidisciplinary critical care unit for more than 3 days between the time period of May 2016 and September 2016. We made sure that the subject has stayed with the patient and aware about the ICU policies & Procedures and environment. The inclusive criteria were 1) Relatives who were stayed with the patients for more than 72 hours; 2) 18 years of age and above; 3) Willing to participate in the

study and the exclusive criteria were 1) Relatives who were stayed with the patients for less than 72 hours; 2) Below 18 years of age; 3) Not willing to participate in the study.

Tool:

The standard questionnaire was developed suitable for our ICU settings, validated using a pilot study. It is a simplified tool, which took about 5-10 minutes to complete the questionnaire. In brief, the questionnaire consists of two sections: the first section assess the family characteristics of the patient such as age, sex, education, relationship with the patient, Is he/she lives with the patient, length of stay with the patient. The second section comprises of 12 items which classifies the care of patient, care of family, professional care, ICU environment and overall satisfaction. Each item to be responded in 4 point-Likert scale arranged from very satisfied (4) to very dissatisfied (1). We have added a special column of comments or suggestions in addition to 12 items to know the patients family members expectations from critical care team.

Data Collection:

The questionnaires were given to the patient relatives at the time of counselling, with the utmost care taken to maintain their privacy. Verbal concern was obtained from all the subjects who are willing to partake in research activity, after explaining the purposes and objectives of the study. Freedom has given to the subject for with drawl at any point of time during the study. Clear explanations were given to the subjects regarding the participation that taking part in the research activity is absolutely confidential and their participation or denial will never reflect in the treatment of patient. The questionnaire was given and entered answers were checked for any blanked out field and collected for computerized entry. The completed questionnaires were scored.

Data Analysis:

Demographic variable including age, sex, education, relationship with the patient, is he/she lives with the patient, length of stay with the patient were entered as numbers and percentages were obtained. Frequencies for all variables were found out. Chi square analysis was performed to analyze the relationships among the variables and care of patient, care of family, professional care, ICU environment and overall satisfaction. The gathered details were entered in the statistical package of social sciences (SPSS), version 19. Data were conferred using inferential and descriptive statistics in the pattern of numbers, percentages, frequencies, chi square tests, cross tabs; t-test is used to find out the means and standard deviation.

Results:

An aggregate of 716 patients got admitted in multidisciplinary critical care unit between the time period of May 2016 and September 2016. In which, 247 patients met our inclusive criteria for participation in this study. Amid 247 patients, 133(53.8%) were male and 114(46.2%) were female. Children and children in laws took a major role in taking care of patient in this study i.e. of 78(31.6%). The second largest participation in caring of patient was spouses i.e. of 55(22.3%). The others in primary relative took part in patient care were siblings, parents and others. It is depicted in table 1. The relationship to the patient in providing care in category of others was paternal and maternal relatives and friends (table 2).

Table 1: Demographic characteristics of participants

Characteristic	n	%
Mean age (SD)	37.7 5 (12.03)	
Gender		
Male	133	53.8
Female	114	46.2
Relationship to patient		
Parent	28	11.3
spouses	55	22.3
Siblings	51	20.6
Children & in law	78	31.6
Others	35	14.2
Lives with patient		
Yes	130	52.6
No	117	47.6
Level of Education		
Non-literate	45	18.2
High School	55	22.3
Higher Secondary	39	15.8
Diploma	5	2
UG	81	32.8
PG	22	8.9

Table 2: Relationship to patient in category of others

Aunty	2
Brother in law	4
Cousin	1
Friend	11
Grand son	3
Grand father	1
Mother in law	1
Sister in law	6
Uncle	6

Patient's relatives were highly satisfied in patient care with the mean item score and SD of 3.74±0.53 respectively. The second largest satisfaction obtained from the relatives was the professional care with the mean item score and SD of 3.71±0.54 respectively. Overall satisfaction from the patient relatives and care of family members scores with the mean item score and SD of 3.66±0.62 and3.58±0.70 respectively. The patient's relatives were least satisfied with the ICU environment with the mean item score and SD of 3.56±0.74 respectively. Relatives were expecting improvements in the waiting area (table 4) with the mean item score and SD of 3.44±0.85 respectively.

Table 3: mean item score and SD, SE of items

Items	Very satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Item score	Item sd
CARE OF FAMILY	173(70.04)	50.4(20.40)	19.2(7.77)	4.4(1.78)	3.58	0.70
CARE OF PATIENT	194(78.54)	45(18.21)	6(2.42)	2(0.80)	3.74	0.53
PROFESSIONAL CARE	188.3(76.24)	48(19.43)	10(4.04)	0.66(0.26)	3.71	0.54
ICU ENVIRONMENT	173.5(70.24)	42.5(17.20)	26(10.52)	5(2.02)	3.56	0.74
OVERALL SATISFACTION	183.25(74.19)	46.75(18.92)	13.75(5.56)	3.25(1.31)	3.66	0.62
INFORMATION NEEDS	173.75(70.3)	50.5(20.44)	17.75(7.1)	5(2.02)	3.59	0.70

The values are Mean ± S.D, S.E of items with (P<0.001)

Table 4: mean item score and SD, SE of each item

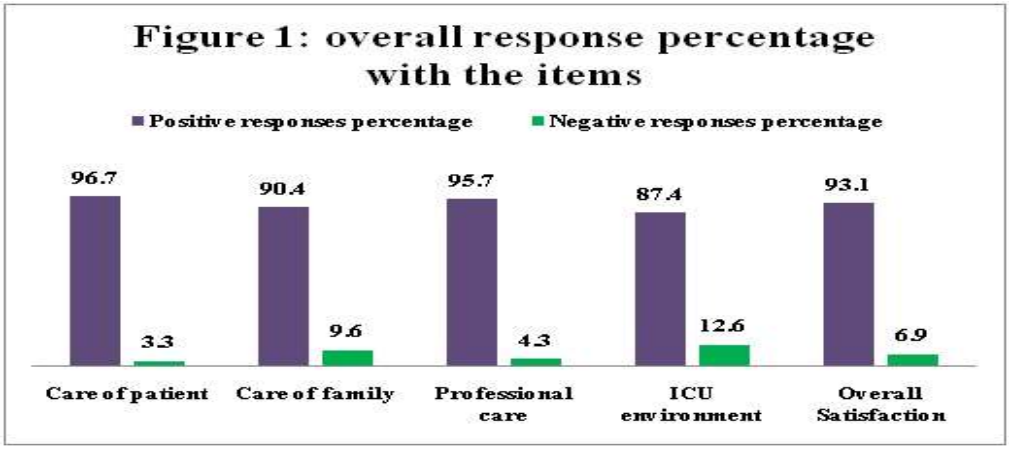
Questions	Minimum	Maximum	Mean	SD	SE
CONCERN AND CARING FOR PATIENT	1	4	3.80	0.47	0.03
NURSING SKILL AND COMPETENCE	2	4	3.72	0.52	0.03
NURSING COMMUNICATION	1	4	3.70	0.58	0.03
PHYSICIAN COMMUNICATION	2	4	3.72	0.54	0.03
ICU ATMOSPHERE	1	4	3.68	0.64	0.04
WAITING AREA ATMOSPHERE	1	4	3.44	0.85	0.05
COORDINATION OF CARE	1	4	3.65	0.61	0.03
CONSIDERATION OF FAMILY NEEDS	1	4	3.61	0.65	0.04
EASE OF GETTING INFORMATION	1	4	3.53	0.78	0.05
COMPLETENESS OF INFORMATION	1	4	3.52	0.80	0.05
SATISFACTION WITH THE AMOUNT OF CARE	1	4	3.69	0.59	0.03
COURTESY,RESPECT AND COMPARISON OF FAMILY MEMBERS WAS GIVEN	1	4	3.63	0.64	0.04

The values are Mean ± S.D, S.E of items with (P<0.001)

Overall responses from the patient's relatives were assessed and the findings were expressed in table 5. Patient care scores the highest positive response percentage of about 96.7 and ICU environment scores the least positive response percentage of about 87.4 and the highest negative response percentage of about 12.6 respectively (table 5 & figure 1). The special column of comments or suggestions was included additional to the questionnaire to know their expectations. Majority of the patients relatives suggest for open visiting hours policy and need for improvement in waiting area.

Table 5: overall response percentage with the items

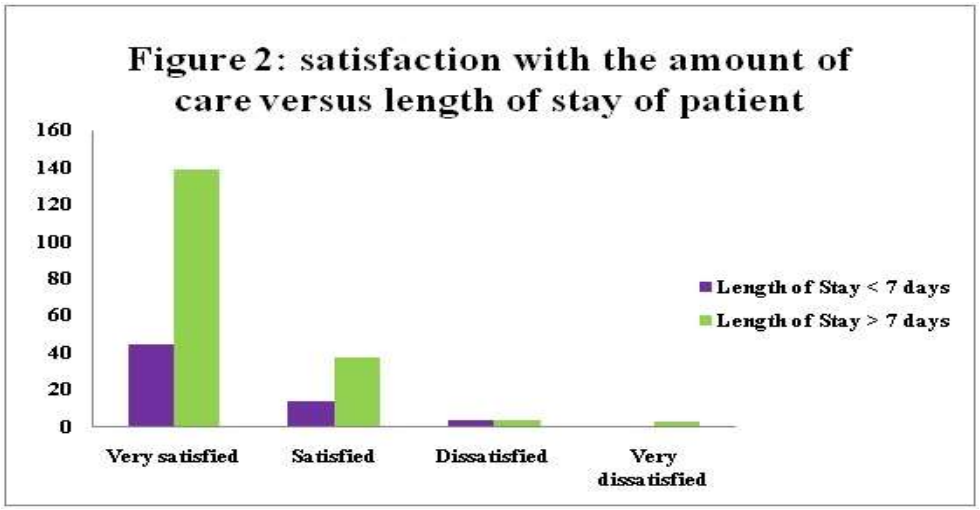
Items	Positive responses percentage (%)	Negative responses percentage (%)
Care of patient	96.7	3.3
Care of family	90.4	9.6
Professional care	95.7	4.3
ICU environment	87.4	12.6
Overall Satisfaction	93.1	6.9



It is observed that significant increase in level of satisfaction with the patients relatives who were stayed more than 7 days compared with the patients who stayed less than 7 days. There are no significant changes in the level of dissatisfaction with the patients relatives who were stayed more than 7 days compared with the patients who stayed less than 7 days as shown in table 6 and in figure 2.

Table 6: satisfaction with the amount of care versus length of stay of patient

Satisfaction With the amount of care	Length of Stay < 7 days	Length of Stay > 7 days
Very satisfied	45(18.2%)	139(56.3%)
Satisfied	14(5.7%)	38(15.4%)
Dissatisfied	4(1.6%)	4(1.6%)
Very dissatisfied	0(0%)	3(1.2%)



Discussion:

In this study, we have assessed family satisfaction of critical care patients in aspect of patient care, care of family, communication, ICU atmosphere, professional care etc. This study highlights the issues faced during Intensivist-relatives communication. As Intensivist took a major role in alleviating all issues related with clear understanding of patient prognosis, he can identify the need of certain psychological factors to be considered in providing care for the family [35]. In addition, he can improve his communication skills, and helps in avoiding contradictions in information provided by the caregivers [36]. He helps to resolve the conflicts among patient's relatives and assess for the need of flexibility in visitation hours [37]. Thus pave a way for family satisfaction in critical care patients. In conclusion, relatives will gain more time to discuss their queries with the Intensivist and get clarified, resulting in satisfaction with the provided care. Our study findings too depict that, physician communication, nursing communication, in considering the family needs resulting in overall satisfaction of family members.

Quality of patient care and satisfaction of family members are interrelated with each other. Especially critical care patients required more attention not only with the care of patient as well as the care of family members. Multiple studies suggest that quality of nursing care resulting in patient and family satisfaction [23, 38]. The other study conducted in emergency department state that, nursing care, professional care, visiting policies and length of stay attract the patient satisfaction [2]. Our study shows positive towards patient care, care of the family, professional care and the family expects open visiting hours. Patients stayed more than a week shown greater gratification compared with the patients who stayed less than a week. Our study shows least satisfaction in the areas such as ICU atmosphere like waiting area and visiting policies as our intensive care unit strictly adheres to the policies in reducing infection rates.

In other study, 20% of patients admitted in intensive care for less than 2 days, 44% for 3 to 6 days and rest 25% for more than a week [39]. In our study, 74.5% of the patients who stayed in intensive care unit for more than a week and the rest 25.5% of the patients were stayed in intensive care unit for less than a week. In our study most of the patient's family members were highly satisfied with patient care, physician and nurse's communication and completeness of information. Relatives were least satisfied with waiting area and visiting policies. It has to be taken into consideration to meet their unmet expectations with the possible resources. In our study, most of the patients were taken care by their children and children in law. Next to them were the spouses. As in other study, it is argued that, major role in caring of critical care patients were spouses [24]. In our study, there are no significant differences in the level of satisfaction with gender and age group.

In other study, spouses were considered as greatly involved in direct care of critical care patients [40]. And also, they were more likely to get satisfied with the patient care when compared with the other relatives who took care of critical care patients [41-43]. In our study, all type of relatives irrespective of their relationship to the patient were found to be satisfactory with the patient care, care of family and professional care. Furthermore, the visitation policies in numerous critical care units have been depicted as prohibitive/restrictive and open/liberal. Critical care units with restricted visitation are those that permit family visits amid specific times of the day with a confined number of relatives per period. Those with open visitation permit the family access 24 hours a day with or without any limitation on the quantity of visitors [44, 45]. Open policies on visitation are more common in pediatric critical care units; be that as it may, it is still uncommon in adult critical care units [46]. In the most recent decade, critical care has developed all around the globe; however there are still no particular tenets about the visitation policies. Even in most developed countries like USA[47] found to have strict restrictions on visiting policies.

In addition, there are other hindrances to the reception of open visitation strategies like absence of adequate space, communication issues between the health care workers and the family members, disputes, common clashes and workloads. Moreover, it builds worry for relatives, who may feel committed to remain in the critical care units [48]. Concern with the health care worker especially nurses feel that, the nearness of families disturbs their work; they trust that advantages are justified regardless of the inconvenience, particularly for the patients. In our study, we tried to assess the family gratification of patients who stayed in a tertiary care medical college hospital critical care unit. We found that family members were highly satisfied with patient care and evaluated the areas which need further improvement such as waiting area and visitation policies.

Conclusion:

To conclude, we were happy that, most of the patient's relatives experienced good level of satisfaction with the current care. The areas where unmet needs, have to be taken into account for improvement in future. Further research has to be initiated regarding improving experiences of relatives of critical care patients irrespective of their diagnosis, prognosis and the length of stay.

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CONFLICTS OF INTEREST:

Competing interest declared none

REFERENCES:

1. Latour JM, Hazelzet JA and van der Heijden AJ. Parent satisfaction in pediatric intensive care: a critical appraisal of the literature. Pediatric Critical Care Medicine,2005.6(5):p.578-584.
2. Soleimanpour H, Gholipouri C, Salarilak S, Raoufi P, Vahidi RG, Jafari Rouhi A, et al. Emergency department patient satisfaction survey in Imam Reza Hospital, Tabriz, Iran. International journal of emergency medicine,2011.4(1):p.1-7.
3. Soleimanpour H, Tabrizi JS, Farnam A, Nikakhtar M, Mokhtarpour M, Golzari SE, et al. Attitudes of emergency medicine physicians towards family presence during resuscitation. Resuscitation,2013.84(12):p.e149-e150.
4. Serra Neves FBC, Dantas MP, Bitencourt AGU, Sena Vieia P, Magalhaes LT, MeiratelesJM, et al. Analysis of family satisfaction in intensive care unit. Revista Brasileira de terapia intensiva,2009.21(1):p. 32-37.
5. Ely EW, Shintani A, Truman B, Speroff T, Gordon SM, Harrell FE, Inouye SK. Delirium as a predictor of mortality in mechanically ventilated patients in the intensive care unit. Jama,2004.291(14): p.1753-1762.
6. Clarke EB, Curtis JR, Luce JM, Levy M, Danis M, Nelson J, et al. Quality indicators for end-of-life care in the intensive care unit. Critical care medicine,2003.31(9):p.2255-2262.
7. Molter NC. Needs of relatives of critically ill patients: a descriptive study. Heart & lung: the journal of critical care,1978.8(2):p.332-339.
8. Johnson D, Wilson M, Cavanaugh B, Bryden C, Gudmundson D, Moodley O. Measuring the ability to meet family needs in an intensive care unit. Critical care medicine,1998.26(2):p.266-271.
9. Lynn-McHale DJ and Bellinger A. Need satisfaction levels of family members of critical care patients and accuracy of nurses' perceptions. Heart & lung: the journal of critical care,1988.17(4):p.447-453.
10. Harvey MA, Ninos NP, Adler DC, Goodnough-Hanneman SK, Kaye WE, Nikas DL. Results of the Consensus Conference on Fostering More Humane Critical Care: Creating a Healing Environment. AACN Advanced Critical Care,1993.4(3):p.484-507.
11. Hickey M. What are the needs of families of critically ill patients? A review of the literature since 1976. Heart & lung: the journal of critical care,1990.19(4):p.401-415.
12. Latour JM. and Haines C. Families in the ICU: Do we truly consider their needs, experiences and satisfaction?Nurs Crit Care.2007 Jul-Aug;12(4):173-174
13. Azoulay É and Sprung CL. Family-physician interactions in the intensive care unit. Critical care medicine,2004.32(11):p.2323-2328.
14. Fox S and Jeffrey J. The role of the nurse with families of patients in ICU: the nurses' perspective. Canadian journal of cardiovascular nursing= Journal canadien en soins infirmiers cardio-vasculaires,1996.8(1):p.17-23.

15. Hardicre J. Meeting the needs of families of patients in intensive care units. Nursing Times,2002.99(27):p.26-27.
16. Gay EB, Pronovost PJ, Bassett RD, Nelson JE. The intensive care unit family meeting: making it happen. Journal of critical care,2009.24(4):p.629.e1-629.e12.
17. Robichaux CM. and Clark AP. Practice of expert critical care nurses in situations of prognostic conflict at the end of life. American Journal of Critical Care,2006.15(5):p.480-491.
18. LeClaire MM, Oakes JM and Weinert CR. Communication of prognostic information for critically ill patients. Chest Journal,2005.128(3):p.1728-1735.
19. Fassier T, Darmon M, Laplace C, Chevret S, Schlemmer B, Pochard F, Azoulay E.One day quantitative cross- sectional study of family information time in 90 intensive care units in France. Critical care medicine,2007.35(1):p.177-183.
20. Stapleton RD, Engelberg RA, Wenrich MD, Goss CH, Curtis JR. Clinician statements and family satisfaction with family conferences in the intensive care unit. Critical care medicine,2006.34(6):p.1679-1685.
21. Alvarez GF and Kirby AS. The perspective of families of the critically ill patient: their needs. Current opinion in critical care,2006.12(6):p.614-618.
22. Paul F and Rattray J. Short-and long-term impact of critical illness on relatives: literature review. Journal of advanced nursing,2008.62(3):p.276-292.
23. Damghi N, Khoudri I, Oualili L, Abidi K, Madani N, Zeggwagh AA, et al. Measuring the satisfaction of intensive care unit patient families in Morocco: a regression tree analysis. Critical care medicine,2008.36(7):p.2084- 2091.
24. Stricker KH, Kimberger O, Schmidlin K, Zwahlen M, Mohr U, Rothen HU. Family satisfaction in the intensive care unit: what makes the difference? Intensive care medicine,2009.35(12):p.2051-2059.
25. McDonagh JR, Elliott TB, Engelberg RA, Treece PD, Shannon SE, Rubenfeld GD, et al. Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. Critical care medicine,2004.32(7):p.1484-1488.
26. Heyland DK, Rocker GM, Dodek PM, Kutsogiannis DJ, Konopad E, Cook DJ, et al. Family satisfaction with care in the intensive care unit: results of a multiple center study. Critical care medicine,2002.30(7):p.1413-1418.
27. Fumis RRL, Nishimoto IN and Deheinzelin D. Families' interactions with physicians in the intensive care unit: the impact on family's satisfaction. Journal of critical care,2008.23(3):p.281-286.
28. Davidson JE, Powers K, Hedayat KM, Tieszen M, Kon AA, Shepard E, et al: Clinical practice guidelines for support of the family in the patient-centered intensive care unit:American College of Critical Care Medicine Task Force 2004–2005.Critical care medicine,2007.35(2):p.605-622.

29. Henrich NJ, Dodek P, Heyland D, Cook D, Rocker G, Kutsogiannis D, et al. Qualitative analysis of an intensive care unit family satisfaction survey. Critical Care Medicine,2011.39(5):p.1000-1005.
30. Siddiqui S, Sheikh F and Kamal R. What families want-an assessment of family expectations in the ICU. International archives of medicine,2011.4(1):p.1.
31. Nierman DM, Schechter CB, Cannon LM, Meier DE. Outcome prediction model for very elderly critically ill patients. Critical care medicine,2001.29(10):p.1853-1859.
32. Sibbald R, Downar J and Hawryluck L. Perceptions of "futile care" among caregivers in intensive care units. Canadian Medical Association Journal,2007.177(10):p.1201-1208.
33. Pochard F, Darmon M, Fassier T, Bollaert PE, Cheval C, Coloigner M, et al. Symptoms of anxiety and depression in family members of intensive care unit patients before discharge or death. A prospective multicenter study. Journal of critical care,2005.20(1):p.90-96.
34. Lautrette A, Darmon M, Megarbane B, Joly LM, Chevret S, Adrie C, et al. A communication strategy and brochure for relatives of patients dying in the ICU. New England Journal of Medicine,2007.356(5):p.469-478.
35. Azoulay E, Pochard F, KentishBarnes N, Chevret S, Aboab J, Adrie C, et al. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. American journal of respiratory and critical care medicine,2005.171(9):p.987-994.
36. Azoulay E, Pochard F, Chevret S, Lemaire F, Mokhtari M, Le Gall JR et al. Meeting the needs of intensive care unit patient families: a multicenter study. American Journal of Respiratory and Critical Care Medicine,2001.163(1):p.135-139.
37. Wall RJ, Engelberg RA, Gries CJ, Glavan B, Curtis JR. Spiritual care of families in the intensive care unit. Critical care medicine,2007.35(4):p.1084-1090.
38. Al-Mailam FF. The effect of nursing care on overall patient satisfaction and its predictive value on return-to-provider behavior: a survey study. Quality Management in Healthcare,2005.14(2):p.116-120.
39. Tervo-Heikkimen T, Kuist T, Partanen P, Vehvilainen-julkunen K, Aalto P. Patient satisfaction as a positive nursing outcome. Journal of Nursing Care Quality,2008.23(1):p.58-65.
40. Azoulay E, Chevret S, Leleu G, Pochard F, Barboteu M, Adrie C, et al. Half the families of intensive care unit patients experience inadequate communication with physicians. Critical care medicine,2000.28(8):p.3044- 3049.
41. Zazpe OM. Informing the families of patients admitted to an intensive care unit. Enfermeria intensiva/Sociedad Espanola de Enfermeria Intensiva y Unidades Coronarias,1995.7(4):p.147-151.
42. Breu C and Dracup K. Helping the spouses of critically ill patients. AJN The American Journal of Nursing,1978.78(1):p.50-53.

43. Hampe SO. Needs of the grieving spouse in a hospital setting. Nursing research,1975.24(2):p.113-119.
44. Berti D, Ferdinande P and Moons P. Beliefs and attitudes of intensive care nurses toward visits and open visiting policy. Intensive care medicine,2007.33(6):p.1060-1065.
45. Vandijck DM, Labeau SO, Geerinckx CE, De Puydt E, Bolders AC, Claes B, Blot SI; Executive Board of the Flemish Society for Critical Care Nurses, Ghent and Edegem, Belgium. An evaluation of family-centered care services and organization of visiting policies in Belgian intensive care units: a multicenter survey. Heart & Lung: The Journal of Acute and Critical Care,2010.39(2):p.137-146.
46. Slota M, Shearn D, Potersnak K, Haas L. Perspectives on family-centered, flexible visitation in the intensive care unit setting. Critical care medicine,2003.31(5):p.S362-366.
47. Lee MD, Friedenberg AS, Mukpo DH, Conray K, Palmisciano A, Levy MM. Visiting hours policies in New England intensive care units: strategies for improvement. Critical care medicine,2007.35(2):p.497-501.
48. Garrouste-Orgeas M, Philippart F, Timsit JF, Diaw F, Willems V, Tabah A, et al. Perceptions of a 24-hour visiting policy in the intensive care unit. Critical care medicine,2008.36(1):p.30-35.