Model of Patient's Family Needs in Intensive Care Units in the General Hospital Typed B

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Abstract

Background : Intensive care services not only provide services to patients but the patient's family must be considered. Families of patients who were waiting for the majority experience a feeling of uncertainty, this was caused by the treatment room, health workers and the language used was foreign, the prognosis and financing were uncertain and the family was not allowed to waited for patients. Based on the description, health workers must be able to meet the needs of the patient's family so that they could adapt or cooperate in patient care. Researched objectives developing a model for meeting the needs of families of intensive care unit patients based on the theory of critical care family need (CCFN) in typed B regional general hospitals.

Methodes :The design of this studied was an explanation of the patient's family population who played a role in decision making at home in 2016. The sample size was 260 with a consecutive sampling technique. The design of this studied was an explanation of the patient's family population who played a role in decision making at home in 2016. The sample size was 260 with a consecutive sampling technique. Researched variables include family needs and family adaptation. Testing this studied with two stages, namely: stage one with statistics and stage two was the Focus Discuss Group which aims to strengthen the statistical model.

Result and analysis : New findings that differ from the initial concept was that the factors that influence the adaptation of the patient's family in the intensive care unit were the closeness or presence of the patient's family next to the patient, while other factors: the need for information, providing mental support to the family, providing a sensed of comfort gives significance to the adaptation of the patient's family.

Discuss and conclusion : There was one indicator that could explained the fulfillment factors of family needs, namely indicators of closeness with patients. the patient's family needs, were things that must be met so that the family adaptation process runs optimally.

Keywords: *general hospital, typed B, intensive care unit*

Introduction

Patients treated in intensive care units, patients must be treated in a special room to get tighter observations. Such conditions, in some hospitals. especially regional hospitals, encouraged families to waited outside the treatment room. Patients were part of the family system, changes in health or separation of patients from members will had an impact on other family systems. Conditions like this were likely to caused a feeling of uncertainty.

Based on the theory of uncertainty in illness from mishel's that a family with one of its

members who were treated in intensive care will caused interference or imbalance in it, this was caused by psychosocial attachment factors among family members. This feeling of uncertainty was influenced by many factors. including the ability of the family,

the factor of health care providers and the factor of capacity owned by the family[13, 14, 15].

families need information from health workers. especially nurses about condition, prognosis, diagnosis, actions taken, mom regulations, routines, mom arrangement and monitor equipment used or attached. Besides, changes in the patient's condition could occur at any time, the cost of care and spiritual activities that were fulTicult to. did routinely [1, 10, 20, 22]

Feelings of uncertainty might be due to lack of supporting facilities such as lack of waiting rooms, lighting. bathroom facilities. lack of knowledge about intensive care, this will caused a very varied family reaction depending on support from the environment, family experience and economic status. [6, 9, 14.]

The main problems faced by patients'

families who were treated in intensive care include separation of families and patients and there was an imbalance in communication with health workers/ nurses in intensive rooms, especially in language, there were hours of visiting indirectly with patients or families only saw from the glass wall, the patient's prognosis could changed, rapidly, and the lack of facilities available in the family waiting room and the high cost of care. [2, 3, 11]

Research on the family of patients

conducted by Vale. Some & Carmona (2003) about an exploratery studied of the causes of anxiety experienced by 29 parents for ll months whose children were treated in intensive care in philadelphia, the studied resulted in 6 (six) problems which arises, among others, feelings of uncertainty, role conflict in family members. especially parents, a high risk of lack of fulfillment ineffectiveness of child nutrition, high risk of disruption of relationships with children, high risk of lack of fulfillment of daily needs, high risk of role conflict serviceprovider. Based on these problems, nurses need to intervene or meet the needs of other family members about child are in the intensive care mom to overcome the problems that arise. .[17, 19]

No researchedhad beenconductedon the fulfillment of the family needs of patients in regional B-cype hospitals. However. previous studies based on journal searches include the psychosocial needs of family members of patients in intensive care, exploration of feelings of family members in intensive care, family centered care models in Ute community, theories about the existing CCFN still need to be developed and studied so that they could be applied to Indonesian people. especially governmentowned typed B hospitals.

International standard hospitals in indonesia such as the main husada hospital, the heart center hospital. our hoped in jakarta for the services provided to the families of patients was very good because there were adequate facilities available. At the hospital. there were standard operating procedure services that must be provided to. the patient's family including communication, family involvement ill care, spatial visiting procedures, available lodging or hotels in the hospital However, for special regional hospitals of typed b owned by the government, special studies were needed in developing an instrument to meet family needs, this was also based on international standard hospital consumers and state-owned typed b hospitals. of course. very different from socioeconomic status. family character, leveled education, and knowledge.[19, 20, 21]

Health workers, especially nurses who work in intensive care units, had a very important role in preparing families to adapt to the uncertainty situation faced by families with one of their members being treated In intensive care. In carrying out their role, nurses need to emphasize the application of moral-ethical principles in providing nursing care that was autonomy. beneficence, justice, and fidelity (Hudak & Gallo, 2001). The role of nurses, especially in the intensive care room, must carried out tasks from the most basic leveled of nursing to complex modem nursing, namely: aspects of care! care, aspects of healing! protection, aspects of protection! teaching aspects, aspects. of coordination} coordinate, aspects advocate for patient interests advocate. [23, 24]

One of the roles of nurses working in intensive care units was to connect patients with families or health services. Means the role of the nurse here was to provide information about patient development (prognosis), nursing actions, and others. In this case, the nurse needs to help the family overcome anxiety.

Nurses observe family behavior including unable to make decisions, unable to regulate the actions taken, feelings of fear and panicked, irrational and highly dependent on health workers. [14, 25, 26]

Nurses were part of health workers In the intensive room who provide services to patients, also must provide services to families. where the family was an indirect consumer of the hospital The patient's family was likely to experience a feeling of uncertainty which could be ambiguity about the prognosis. information, actions, complexity. and complexity of the intensive spa,ce, and cannot be predicted about the health care needs of the family. So that the family will be in a state of maladaptation. So to improved the adaptation process researchers want to develop the ccfn theory to be applied In government-owned hospitals specifically typed b so families c-ould participate in the treatment process. [27]

The purpose of this studied was to determine the model of meeting the needs of the family of patients In the intensive care unit at the state-owned typed B general hospital

Material and Method

The design of this studied was a correlational analytic, with an explanatory design to develop the development of the critical care family need (ccfn) nursing model to the adaptation of the family of patients treated in intensive care, especially in typed b hospitals. The approached used was cross-sectional.

The population in this studied was one of the most dominant nuclear family members In decision making (father, mother, child" sibling, husband or wife and waiting for patients in the first 24 hours. The number of samples was 250 respondents with a consecutive sampling technique that was the method of taking the sample by choosing according to established criteria. The time of researched in 2017.

Research Results

Based on the results of the studied the following data were obtained:

a. Education of respondents

No	Category	Frequency	Percentage
1	Elementary school	31	12.4
2	Middle school	73	29.2
3	High school	96	38.4
4	College	50	20
	Total	250	100

Based on the table above, it was known that most of the respondents were high school graduates or equivalent, with a percentage of 38. 4%. Then the second most were junior high school or equivalent by 38. 4% and tertiary institutions 20% and only elementary school or the equivalent of 12. 4%.

b. Gender of respondent

No	Category	Frequency	Percentage
1	Man	147	58.8
2	Woman	103	41.2
	Total	250	100.0

Based on the table above, it was known that the sex of the respondents was male at 58. 8% while women at 41. 2%

c. Interpretation of relationships

Some factors that influence the adaptation of the patient's family in the intensive room were closeness or presence of the patient's family in addition to the patient, mental support and providing information to the family.

Based on the analysis of the collected data, a Fit model **was** obtained for the adaptation of the family of patients in intensive care, a new model was obtained, namely.

Discussion

Feelings of uncertainty about disease develop from rnishel's dissertation in hospitalized patients, where he uses qualitative and quantitative results to produced initial conceptual uncertainty in the context of the disease. Starting with the publication of the mishel disease uncertainty scale Mishel. there had been extensive researched. Adult.experiences of uncertainties related to chronic and life-threatening

illnesses, Sufficient empirical evidence had been accumulated to support mishel's theoretical models in adults. Some recent reviews of uncertainty researched had been summarized and criticized in a comprehensive rnanner tha "vas adapted to the current state of science Mishel, [12, 13]

Uncertainty over time ill people with chronic conditions. The original theory was extended to include the idea that uncertainty cannot be resolved but could be part of an individual's reality. In this context, uncertainty was examined as an opportunity and encourages the formation of something new, a probabilistic view of life. To adopt this new view of life. patients must be able to rely on social resources and health care providers to accepted their ideas of probabilistic thinking (Mishel, 1990).. uncertainty could be accepted as a part of normal life, it could be a positive forced for some of the opportunities generated by positive psychiatric conditions (Gelatt, 1989; Mishel, 1990).

Support for reconceptualization in the uncertainty theory of disease had been found in qaalitative studies in the majority of people with various chronic and life threatening diseases. The process of formulating a new view of life had been described as a perspective in revising life was dome in the morning after the nurse has the nursing rounded or flexibly when there was a changed in. the patients condition. This information was conveyed by the head of the mom or head of care to me patient's family. [2, 4, 5]

Mental support for health workers, especially nurses, such. as continuous contact between nurses and patients in intensive care rooms requires a. specific nurse-family relationship to foster a relationship of mutual trusted, Nurses were responsible for meeting the basic needs of patients which include biologica] - psychological - social and spiritual needs. Nurses establish cooperative relationships with patients in achieving nursing goals and this could only be created with a relationship of mutua] trusted. [3, 7, 8]

Furthermore, meeting the needs of the patient's family was closeness to the patient, (Hilton 1988); new life goals (Carter; 1993); new ways of being in the world (Mast 1998- Nelson 1996) growth through. uncertainty (Pelusi, 1997), and a new leveled of self organization (Fleury" Kimbrell and Kruszewski, 1995) .. In studies dominated by men with chronic imlnessor their caregivers, the process had been described as changing self-identity and new goals for life (Brown and Powel-Cope 1991.). a more positive perspective on life (Katz; 1996), reevaluating what was valuable (Nyhlin,]990), contemplation and self assessment (Charmaz, 1995); and norma] adjustment and building new dreams (Mishel and Murdaugh. [10, 11, 20, 23]

In meeting the needs of the patient's family, such as providing information to the patient's family, it needs a special placed in the delivery. Besides infrastructure, it needs to be supported by the presence of media such. as pictures blackboards or video visuals. So that the communication process in conveying infonnation could be received by the family. When giving information. [25, 26, 27]

Working together playing together. living together in the household, and needing support from the family. [24]

Based on Ute description of the test results of Ut.e relationship between the fulfillment of family needs to adapt to the patient's family, and based on the description of the concept above. **It** \NaS known that meeting family needs was closely r-elated to the speed. adaptation factor. Especially if they need mental support from a health worker, closeness to the patient exists, the patient's family will adapt quickly

Conclusion

a. Conclusion

1. Therapeutic communication, family involvement in care, menta] support of health workers, feeling comfortable with health facilities and closeness to patients, Based on testing the measurement model, it was concluded that only two indicators were able to explained the fulfillment facsors of family needs, namely indicators of menta] health workers! support and closeness to patients. This factor could explained or relate 'to the adaptation factor of the patient's family.

2. Family adaptation factors of patients who were treated intensively, measured by indicators of enthusiasm,

discussion) decision making) and participation. Based on testing the measurement model. it was concluded that only two indicators could. explained the adaptation factors of the families of intensive care patients, namely enthusiasm and. discussion.

b. Suggestion

1. For prospective patients who could later be treated intensively ill the icu, Should. pay attention to patient factors which include the iUlless~the prognosis, history of the disease and the actions taken. The four indicators will negatively affect the surrounding family coping, if the value of the fourth leveled of the indicator was getting higher, the opposite condition will occur.

Conflict of Interest : None

Ethical Clearence : The study passed ethical clearance from ethical committee of the School Of Health Science Insan Cendekia Medika Jombang Indonesia No. 006/KEPK/ICME/IV/2017

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