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## RESEARCH ARTICLE

### The Nurses-family Members' Relationship at the Intensive Care Units in Jordan: A Phenomenological Study

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#### Abstract:

#### Background:

Communication with patients' families facilitates and creates a trustful relationship between nurses and patients' families and helps nurses to identify and understand patients' and families' needs.

#### Aims:

This study aimed to explore Jordanian ICU nurses' communication experience with patients' families.

#### Methods:

A phenomenological approach was utilized to explore the nurses' communication experience with family members of patients in the ICU. Participants were recruited from three ICU units in Amman, the capital of Jordan.

#### Results:

Eighteen critical care nurses were interviewed. Two major themes of nurses' communication experiences were identified: Precarious relationships and disruptive communication patterns.

#### Conclusion:

To achieve high-quality care, participants recognized the importance of appropriate communication with family members. Results showed the importance of continuous improvement of communication skills with patients and their family members.

**Keywords:** Communication, Family members, Intensive care units, Nurses, Jordan, Health conditions, Fatigue.

#### Article History

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## 1. BACKGROUND

Family members assume significant roles in the patients' treatment plans. Such roles may vary depending on family members' willingness and capabilities of the assumed roles. Previous reports showed that family members are suffering due to responsibilities and demands of their patients [1]. However, for those who have patients in the intensive care units (ICUs),

several factors may influence their involvement that also affect their mental and psychological wellbeing. For example, Alfheim and colleagues [2] reported that family members of patients in ICU suffer post-traumatic stress symptoms especially among young ones and those with fragile personality. Similarly, Chang *et al.* [3] found that family members of patients in ICU had fatigue and difficulty sleeping and expressed high need for social support. Such biopsychosocial disturbances could be explained in various ways, such as feeling powerless, inability to maintain their wellbeing, fears due to patients' health conditions, and uncertainty about themselves and their patients' health conditions [4].

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Nevertheless, the nurse-family member relationship might act as buffering factor that might enable positive experience of family members of patients in ICU. It has been found that effective communication between nurses in the ICU with family members and patients is vital to optimize outcomes for both patients and family members [5]. This could evoke attention towards the significant contribution of quality of relationship between nurses and family members of patients in ICU on patients' healthcare outcomes [6, 7]. The question remains how nurses perceive the importance and influence of nurses-family members' communication on the quality of their nursing care and patients' healthcare outcomes.

Nurses in the ICU are assuming different roles while caring for their patients [6, 8]. Advancement in healthcare services and theorem of care have expanded nurses' roles to include family members in their plans [9]. No doubt that communication is an essential part of the nurse-patient relationship. Therefore, nurses might resort to family members to enhance such relationships especially when patients are suffering critical physiological situations that prevent them from effectively communicate with nurses [10].

Nurses may also serve as educators, supporters, enablers, and comforters for family members of patients in ICU [10, 11]. On the other hand, nurses might also get benefit from family members as a mean of recovery for their patients during and after discharge from ICU [12]. The positive experience of family members of patients in ICU have also been found to suffer less psychological and social disturbances [13]. Such positive impact of nurse-family member communication would speculate that ICU nurses are able to use family members as an effective mean to attain healthcare outcomes, and simultaneously, enable positive experience of family members that would positively reflect on family members and their patients' health and wellbeing.

Although the nurse-family members' relationship has been lately attracting healthcare researchers, most of the studies are addressing such a phenomenon from a quantitative perspective. Also, those utilizing the qualitative approaches have emphasized on the lived experience of family members rather than the meaning of the relationship with nurses in ICU or how such a relationship has been defined and used as a mean to adapt to unpleasant experience in ICU.

Furthermore, the Arabic culture, which identifies and signifies the family connectedness, has never been addressed in such format and, to authors' knowledge, this phenomenon has never been addressed. Arabs while signifying the family connectedness are also socially disgracing those who fail to commit to their responsibilities toward their family members in particular during sickness period. Religion and traditions are in harmony to socially blame their dereliction of their family obligations. This would propose the need for a qualitative study utilizing the phenomenological approach to explore communication styles and format between nurses and family members of patients in ICU from nurses' perspectives that will enable better understanding for the phenomenon. Therefore, this study aimed to explore Jordanian ICU nurses' communication experience with family members of patients in ICU and barriers related to communication.

## 2. METHODS

### 2.1. Design

A phenomenological approach was utilized to explore the nurses' communication experience with family members of patients in ICU. The philosophy of phenomenology is important to explore and understand everyday experience without assuming knowledge of those experiences [14]. It offers a unique opportunity for capturing the lived experience of nurses, and allows for understanding the phenomena from the perspective of how people interpret and attribute meaning to their existence [15].

### 2.2. Setting and Sampling

Data were collected using purposive sampling technique. A total of 18 ICU nurses were recruited from three ICU units in Amman, the capital of Jordan. To be included, participants had to be a fulltime registered nurse who provide direct patient care in the ICU, with an experience of at least one year in the ICU. The one year of experience criterion was to ensure having enough experience to share. Prospective participants were interviewed to explain the purpose and procedure of the study, and to answer their questions. Those who agreed to participate were asked to sign a consent form. Finally, the sample size was determined based on data saturation.

### 2.3. The Study's Rigor

In order to increase the credibility of the study results, the authors used both the prolonged engagement with the topic and the extended time with participants. The aim was to improve data sensitivity through lessening the disagreement between the assumed meanings by the researcher and those understood by the participants.

### 2.4. Data Collection

This phenomenological study was based on an in-depth interviews with participants using semi-structured interview protocol to understand participants' experience of communication with patient's family members in ICU. Tape-recording and transcript verbatim were done. Thematic analysis was utilized to generate data from the transcribed interviews, where themes within data were identified, analyzed and reported to identify common meanings and shared practices.

Interviews were conducted by the primary researcher using Arabic language and recorded using an audiotape recorder with permission as stated in the signed consent form. The interviewer started the interviews by asking nurses to complete demographic data and then initiated a short conversation on a general topic. Then, open-ended questions were asked to prompt the nurses to tell their narratives. The starting question used was: "Could you please explain your experiences of communication with the patient's family?" The interviewer also asked for clarification and frequently prompted interviewees during the interviews, until they had no more to tell. After obtaining their permission, the interviews were conducted in the charge nurses' offices. Each interview took between 30-60 minutes.

**2.5. Data Analysis**

Identifying common meanings and shared practices is the aim of data analysis process in qualitative research [16]. The primary researcher conducted the transcribed verbatim for each tape-recorded interview, which was later analyzed using thematic analysis that is defined as “a method for identifying, analyzing, and reporting patterns (themes) within data” [17]. To ensure that accurate information was transcribed, audio recordings and transcripts were frequently reviewed. All transcribed data involved coding the data, categorizing, and assigning the data into specific themes. All authors were involved in data analysis.

**2.6. Ethical Approval**

Permission to conduct the study was obtained from the involved hospitals prior to commencing data collection. Verbal and written information about the study was given to each

potential participant. Participation was voluntary and based on written informed consent. Participants were informed that they could withdraw at any time and that all data would be confidentially treated. All study transcripts and demographic data were identified by code numbers. All electronic documents were saved on the researcher’s password-protected computer, and hard copies stored in a locked drawer with access restricted to the primary researcher. However, the entire interview tapes will be permanently destroyed, and the transcripts will be shredded after three years.

**3. RESULTS**

Eighteen critical care nurses participated in the study. The mean age of the participants was 28.3 years (Range= 25–38 years). They had worked as ICU nurses between 2 and 16 years (M= 5.6 years). The participants’ characteristics are provided in Table 1.

**Table 1. The participant characteristics (N= 18).**

Participant Characteristic	n
<b>Age (years)</b>	
20-25	4
26-30	9
31-35	4
36-40	1
<b>Gender</b>	
Male	10
Female	8
<b>ICU Experience/year</b>	
1-5	7
6-10	10
11-15	0
16-20	1

**Table 2. Examples of the content analysis.**

Raw Data Extracted from Transcript	Heading	Category	Theme
Some patients and family members prefer to contact physician rather than nurses. Providing family with information related to their patient's condition is a family right. When family members asked me a question, then re-ask it to someone else, I feel that there is no trust in nurse’s competency.	Nurses are hurt by distrustful patient members	1.1 Doubtfulness	1. Precarious relationship
I am very careful in my communication styles when deal with family members, I communicate with them just in topics related to my job descriptions as outlined by hospital and professional rules. When information is critical, I do not tell them, I refer them to the physician.	Nurses are not sure how to effectively communication with family members	1.2 Role ambiguity	-
In one day, my colleague asked me to help her in positioning her patient. As per health policies, and infection control wise, I wear gloves, patients' daughter shout on me, why you wear gloves, are you disgusted from touch my mother, go out	Normal communication is impossible due to members’ aggressive attitude	1.3 Victimization	-
Answering questions for each visitor came to visit the same patient.	Communication is the most difficult task with visitors	2.1 Being overwhelmed	2. Disruptive communication pattern
Some family members may be dissatisfied with something in hospital overall, so they may communicate in inappropriate way.	Nurses’ afraid to interact with family members	2.2 Disrespectful manner	-

(Table 2) contd....

Raw Data Extracted from Transcript	Heading	Category	Theme
Nurses actually need more training on communication skills, and have to treat family, as they love other nurses treat their family, considering patient as your relative. I feel that nurses' communication is not satisfied and nurse need to improve their communication skills with family members.	Nurses reflect that they are not learned properly about communication skills	2.3 Self-incompetence	-

The primary researcher personally transcribed all interview data as this would enable him to live with the data, and being familiarized and fully immersed within it. Transcriptions of the interviews were immediately undertaken after each interview. The transcriber repeatedly listened to the audio recorded interviews and attempted to ensure that the transcript contained everything I heard. Immersion in the data occurred through listening to the interviews and re-reading transcripts. Reading the transcripts several times also meant that a sense of the whole of the text was developed. The analysis of the narrative revealed two major themes with six subthemes. Table 2 showed examples of the content analysis from text to categories.

**3.1. Theme 1: Precarious Relationship**

According to Sergeant (2016), precarious relationship is defined as the relationship that is deviated from the standard relationship and characterized by job instability and lack of benefit. In this study doubtfulness, role ambiguity, and victimization were emerged from the analysis.

**3.1.1. Doubtfulness**

Doubtfulness was the feeling mentioned by most of the nurses. It refers to uncertainty of the members related to nurses' knowledge and skills of nurses. Although family members were asking nurses about their patients' health status, they seem to trust more what the physicians told them. One nurse stated that,

*Some of them (families) were in doubt with the nurses if they say we do not know and reply that the ICU nurses do not know enough information related to their patients (Participant 5).*

Nurses felt that the family members need to trust nurses and show confidence in nurses' responses to their inquiries, which is assumed to enhance the nurses-family members' interaction. Nurses are aware of the importance of a trustful nurse-family members relationship in which quality of nursing care, their contribution to patients' care, and being supportive to family members are clearly affected depending on how efficient and trustful is the nurse-family member relationship. Another nurse commented that:

*Some of the family members prefer to contact physicians rather than nurses, while others ask what they need, and then they ask the physician again to confirm what we said. They almost trust doctors (Participant 13).*

It was noted that family members were doubting the nurse's knowledge. This could explain why they refer to physicians to give answers to the same questions. While it is possible that family members refer to physicians to confirm the nurses' answers for their inquiries, this seems not applicable here as family members were not showing respect and trust to

nurses' responses, indicating a skeptic manner rather than seeking confirmation. Nevertheless, nurses are required to show their confidence and knowledge while responding to family members' inquiries and concerns that will contribute to enhancing confidence in nurses and minimizing the doubtful manner of family members.

**3.1.2. Role Ambiguity**

Role ambiguity was a negative experience with family members, which was due to a lack of clarity or uncertainty related to the nurse's position or role. The fact that a family member was unsure of the nurse's responsibilities may cause dissatisfaction, stress and tension, and that is why they trust physicians. One nurse stated that:

*One simple thing that is, sometimes, a family member asks for care that is not related to our roles, when I did not do it. Therefore, they may view me as inhuman (Participant 3).*

Another nurse explains his experience with a family member who asked a question that should be asked to the physician. He stated that:

*One day, a family member found a teaching leaflet in the hospital about her mother's disease process and related medication. She said (to the nurse) why nobody told me that. I would like to know more about my mother's condition (Participant 11).*

An important aspect of nurse-family communication was the trusting relationship. Some nurses believed that such responses to the family member's inquiry were incorrectly understood, which would be stressful and upsetting to family members.

**3.1.3. Victimization**

Victimization in a workplace refers to the "emotional issues for nurses who are exposed to abusive behaviors and have negative influences on both their own physical and psychological health and the quality of service they provide" (Palaz, 2013, p. 24). Such an environment may affect nurse's motivation, decrease their concentration, and negatively affect nurse-family member communication. One nurse talked about a situation with a family member:

*One day, my colleague asked me to help her in positioning her patient. As per health policies and infection control, I put on gloves. The patient's daughter started shouting at me, why did you put on gloves? Are you disgusted by touching my mother? (Shout) go out (Participant 6).*

Another experience by a nurse:

*After caring for a patient post-Road Traffic Accident, he became stable. However, he was in need to be transferred to another specialized center. A family member said that because*

they (nurses) do not want to provide the care, they want to transfer him (Participant 15).

This drew attention to the fact that nurses must gain family members' trust and actively assess families or involve them in planning and discussions of nursing care. Therefore, nurses need to demonstrate their ability to provide emotional support while dealing with a patient's situation, especially in the presence of a family member.

### 3.2. Theme 2: Disruptive Communication Pattern

One of the scope of the nurse-family member relationship includes the opportunity to provide information regarding the patient's health status. Establishing effective communication with family members is an essential aspect of nursing care. Nurses experienced difficulties in communication with family members. These difficulties lead nurses to distance themselves from the family members. The communication difficulties they experienced were being overwhelmed, disrespectful expressions, and self-incompetence.

#### 3.2.1. Being Overwhelmed

One of the main difficulties in communication between nurses and family members was related to the presence of many visitors. In Jordan, there are very large families, and they keep coming to see their beloved sick ones. Therefore, nurses need enough time to provide information and give support. By the hospital policy, two visitors are allowed at the same time to see the patient. Each time, those visitors ask nurses the same questions related to the health condition of the patient. In addition, it might be that nurses were not well prepared to communicate with families who had ICU patients. According to the nurses, this might affect patients' care by disrupting the nurses' concentration.

*Family members were visiting daily and asking the same questions each time they came into the patient's bed. This reduces the amount of time to communicate with family members on what they want to know (Participant 11).*

Another experience by a nurse:

*There were too many relatives, and they all asked the same questions and sometimes irrelevant questions, and they repeated the same questions to other nurses or physicians (Participant 15).*

It was emphasized by the nurses that the presence of many visitors to the same patient and asking the same questions interfered with their satisfaction and work. This highlights the importance of communicating with one family member, agreed upon by the whole family to be the one who communicates with the nurses.

#### 3.2.2. Disrespectful Manner

Some of the nurses felt that family members did not communicate in an appropriate way. Despite the role of nurses in helping patients and their members, members' negative responses to nurses, such as blaming them and speaking and behaving aggressively, discouraged appropriate communication between them. One nurse stated that:

*Some patients and relatives ask for everything, and if you reply excuse me, I am busy, or if you do not reply to their inquiries, they may respond inappropriately as they believe that nurses hide something that they do not want to express (Participant 16).*

Another nurse said:

*Some family members say we pay money, so you must do that (Participant 11).*

Those nurses continued to describe how important it is for the family members to talk to them as individuals. However, this might be related to the fact that nurses judge the family members' behaviors without reflecting on the situation as a whole. Therefore, nurses must control the family members by assessing and intervening with them in a professional way.

#### 3.2.3. Self-incompetence

Some nurses felt that they were educationally underprepared to provide family members with information, especially those with poor prognosis. They felt that providing family members with bad news and poor health prognosis were the most difficult communication issues. This is due to the fact that nurses have not properly learned about communication in the clinical area. A nurse stated that:

*Educating and training staff about communication skills are very important for ICU nurses (Participant 2).*

Another nurse commented that:

*Communication needs a broad knowledge of nursing, so if a nurse's knowledge and skills are not enough, the nurse should avoid communication with patients and relatives to avoid any misunderstanding of medical information (Participant 18).*

Nurses realized that insufficient communication skills could result in underestimating and misunderstanding nursing care, which might lead to aggressive behaviors by family members, as mentioned above. This emphasized that nurses need to improve their communication skills and have specific training on how to communicate and support family members, which could be achieved through interactive workshops.

## 4. DISCUSSION

The present study examined nurses' communication experience with patients' families and examined the barriers that influence communication among Jordanian critical care nurses. Participants described how they played an important role in providing the family members with the information that illustrated their patient's health status. However, the findings of this study revealed that nurses are confronted with difficulties during their communication with family members that have directly influenced their relationship with families and the quality of care provided. The study revealed two major themes: precarious relationship and disruptive communication patterns. The sub-themes reflected the nurses' efforts that aimed at enhancing communication skills in spite of the negative feedback and perception of patients' families.

The study found that nurses emphasized the family

members' concerns about nurses' competencies, especially issues related to insufficient knowledge and skills of nurses in the ICU. This could be explained in terms of the interruption of communication that has contributed to family members' misunderstanding or underestimation of nurses' competencies. In the ICU, families are present for a short period of time, and this might enable them to judge their competencies; however, their short interaction, numerous questions, and insistence on obtaining answers to all their concerns might have contributed to their perception. In other words, nurses might have briefly answered families for their questions that caused such misconceptions and underestimation of nurses' competencies. This has been described as a precarious relationship and disruptive communication pattern that has been expressively stated as doubtfulness, role ambiguity, and victimization. Our findings are consistent with Yoo *et al.* [18], who found that members' negative responses to nurses, such as blaming them and speaking and behaving aggressively, would ultimately discourage nurse-member interaction.

A study aimed at determining the bullying and harassment experiences of nursing students in various nursing schools in Turkey, Palaz [19] found that nursing students experienced bullying behavior during their education and clinical practice, leading to a lack of concentration and apathetic feelings and enhancing their intention to leave the profession as early as possible. Similar studies were reported in other countries [20, 21]. Such a situation might be expected for students due to their lack of self-confidence and competencies; however, among nurses, the inappropriate communication pattern motivated nurses to confront the situation and consider it as challenge to pay more effort to improve their quality of care and performance [22].

The findings also indicated that one of the major barriers is related to the high number of visitors. The Arabic culture is significantly mandating all first and second blood relatives to take their roles and support the sick person. Thus, visiting the sick person at a hospital or home is mandated by culture, and those who deny that are disgraced by the community. In the ICU, where the patients are in critical situations, more visitors are expected. Nurses did report that almost all visitors have questions about their patients, and most of these questions are either repeated or irrelevant. Nurses might answer such questions superficially. This might negatively affect their relationship and lead to aggressive behaviors by family members. Family members might have felt that nurses either lack the knowledge or are indifferent in relation to their patient's care. In other words, families had a perception that nurses were intentionally attempting not to answer their questions and hiding important information that they felt they should know. This finding was consistent with Omari [23], who found that ICU nurses in Jordan were rarely encouraging family members to call the unit and ask questions.

Furthermore, Loghmani *et al.* [20] found that families who came outside the visiting hours disrupted nurses' work and that affected communication patterns between families and nurses. Moreover, Bloomer *et al.* [24] stated that the high number of visitors and visiting outside visiting hours lead nurses to distance themselves from the family to avoid troubles and

challenges. Therefore, nurses might need to adopt strategies that enable and promote nurse-family relationships and show compassionate feelings toward patients' families who are suffering because of their patients' stay at the ICU. Nurses might also need to adapt their communication style according to the degree of relationship between patients and the family members and show extra care to close family members who might be delegated to communicate information about the patients to other family members.

## CONCLUSION

The study delineates critical care nurses' perception of communication with family members and the barriers that influence this relationship. The findings of this study revealed that critical care nurses' care experience precarious relationship with family members. These include doubtfulness, role ambiguity, and victimization, which might have negatively affected them and prevented the trusting relationship between them. Nurse-family member communication is influenced by many factors, in particular, the high number of visitors that interfere with nursing care. In addition, aggressive behaviors by family members were seen as a barrier that might lead to preventing the trust relationship. Finally, nurses felt that they needed to be more knowledgeable regarding communication skills to improve the trusting relationship with the family members. Nonetheless, this study improves our understanding of the importance of communication between critical care nurses and family members and highlights the barriers that affect this relationship.

## ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Our study sought ethical board approval from the involved hospitals prior to commencing data collection.

## HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committee and with the 1975 Declaration of Helsinki, as revised in 2013.

## CONSENT FOR PUBLICATION

Verbal and written information about the study was given to each potential participant. Participation was voluntary and based on written informed consent. Participants were informed that they could withdraw at any time and that all data would be confidentially treated.

## STANDARDS OF REPORTING

COREQ guidelines were followed.

## AVAILABILITY OF DATA AND MATERIALS

The data and supportive information are available within the article.

## FUNDING

None.

## CONFLICT OF INTEREST

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