

Factors Affecting the Nurse-Patients' Family Communication in Intensive Care Unit of Kerman: a Qualitative Study

Laleh Loghmani¹, Fariba Borhani^{2*}, Abbas Abbaszadeh³

¹Departemant of Nursing, Faculty of Nursing and Midwifery, Kerman paradise University of Medical Sciences, Kerman, Iran

²Medical Ethics and Law Research Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran

³Departemant of Nursing, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

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ABSTRACT

Introduction: The communication between nurses and patients' families impacts patient well-being as well as the quality and outcome of nursing care, this study aimed to demonstrated the facilitators and barriers which influence the role of communication among Iranian nurses and families member in ICU.

Methods: This study is a qualitative study with content analysis. Participants were eight registered nurses and ten of patients' families. Patients were admitted to the ICU of two large university hospitals in Kerman, Iran. We used non-structured interviews for data collection. All interviews were transcribed verbatim with a simultaneous, constant comparative analysis of the audio tapes.

Results: According to data analysis, facilitative factors between nurses and families' communication consisted of spiritual care, emotional support, Participation, notification and consultation and barriers that were misunderstandings regarding treatment, job and patient difficulties.

Conclusion: The findings led into the recognition of the important barriers and facilitators in communication between ICU team and the family of the patients. By identification of the barriers and facilitators of communication, establishing new rules and using creative methods in education and establishing the communication of ICU team especially using patient-based approach we can have effective communication.

Introduction

High quality family communication is the backbone of the art and science of nursing.¹ it has a significant impact on patient well-being as well as the quality and outcome of nursing care², and is related to patients' family overall satisfaction with their care.³ The maintenance of high nurse- patient's family communication also depends on the nurse and patients' family. The quality of care in an ICU has been shown to be influenced by several factors including: inadequate nursing staff, too much nursing documentation, too long waiting time, and lack of specialized nurses.⁴

There are challenges in nurse- patients' family communication evidence from four

sources. These are personal observation, narratives from client and their families, media reports, and official health reports. There is public outcry about the behavior of nurses during communication with their patients' family in ICU.⁵ The issue of nurse-patients' family communication remains a problem in Kerman, despite concern expressed by the public, Iran ministry of health, Iran health service, and the nurses and midwives council for Kerman.⁶ It is important to know that doctors do their wards rounds once per day and are available to see seriously ill patients only on call basis and so some of these poor nurse- patients' family communication may happen during their absence.⁷ It is wondered whether those

* **Corresponding Author:** Fariba Borhani (PhD), E- mail: fborhani@msn.com.

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training activities and programs are yielding the expected results, especially in the area of nurse-patients' family interactions. Identifying factors believed to facilitate positive interactions between nurses and their patients' family or patients' family as well as barriers to these positive interactions will do much to promote the well-being of those seeking health care.⁸ The increased insight about nurse-patients' family experiences in this study should help nurses and other health care workers establish positive and appropriate therapeutic relationships with patients' family. Study findings can also be used to inform decision makers in health and nursing about what needs to be done to improve communications patterns between health providers and patients' family. Areas for future research in nurse-patient's family communication were also identified. It would also be of help to other educational institutions especially those involved in health education, health research and health training programs.

Since the relationship of a nurse and patients' family is the essential and effective prerequisite on the successful care results; therefore, this issue was not yet evaluated and the elements of relation in its interactive, psychic, intellectual and dynamic components were ignored.⁹ By considering the lack of standard pattern for patients' family -nurse relationship and its different communicating methods, study about the interactions of patients' family -nurse can increase the knowledge of nurses toward how to communicate with the patients, especial during an interaction with them, and how to understand the patients via a communication between patient family and nurse¹⁰ in Iranian context.

Based on the view of mohammadzadeh *et al.*, it is necessary to extract the experiences of patients via the relationship of patients' family -nurse and also determine the most valuable issue based on the view of patients during an interaction with nurses.¹¹ Such information leads into the increase of

knowledge about communication, it helps the nurses in order to change the communication skills focused on the individual.¹² By considering the significance of professional relation (communication) in the care major and its vital role, studying this issue in the field of care in our context, in depth, is essential and required. Since most of developed countries in patients' family -nurse relationship process utilize the defined standards, but there are not clear standards in appropriate to the conditions of the caring relations in our context.¹³ Therefore, the studies which were done in our country about the patients' family and nurse relation indicate a problem in this field. For example, Abedi *et al.*, in their studies came to this conclusion that the process of patient-nurse relation is beginning to decline and it is possible to promote it (help to promote it) by presenting the educational plans and programs for the nurses.⁶ Aein *et al.*, points to the interrelationships between nurse and patients' family.⁵ The view of Mohammad Zadeh *et al.*, is based on the presence of a supporting environment and sufficient sources in order to promote the relationship between patient-nurse.¹¹ The barriers and facilitators of patients' family -nurse relation based on the care-background of our country were not more addressed. In this regard, since it is not possible to summarize the human events in a form of mathematical equations, therefore, it is necessary to use the most appropriate guidelines in order to obtain the depth realities of humans and in this case, the qualitative studies play an important or effective role in clarifying the ambiguous pints.¹⁴ Consequently, by considering that there are limited studies about the relationship of patient family -nurse and also there are various relationship styles in each society based on their social and cultural background, In general, it can be said that lack of a relationship between families - treatment teams results into stress, temper, lack of confidence, violence, dissatisfaction among the families of patients, a

contrast and conflict between members of a family and treatment team, implementing the treatment plans (in a long time) with less success and bad decision making and as a result, the person who faces more damages and losses is the patient. In a qualitative study, Morrison described nurses' perceptions of the concept of caring as central to nursing practice. It involves meeting needs of patients in nurse client interactions. In all 7 categories emerged from the analysis that provided a detailed description of caring. These included interpersonal approach, clinical work style, concern for others, time management, attitudes, personal qualities and level of motivation.¹⁰ Other descriptions by the nurses related to the physical aspects of care. Positive interpersonal relationships between the nurse and family were considered to be caring and caring for family was optimum when nurses were motivated in the form of rewards by managers. Caring also depended on the skill and the competence of the nurses. Competent and skilled nurses delivered high quality nursing care to clients at the right time. Caring practices of these nurses were also demonstrated by positive facial expressions and closeness to clients.¹⁵

The caring nurses were truly present with clients and families. It was noticed that they were thoughtful, considerate, empathic, and decisive and practiced holistically. They did not view the clients as being isolated from their families, and in turn, viewed the families as part of the community.

Nursing researchers generally agree that patient dignity is highly valued by family. They also agree that a lack of dignity may lead to poorer health outcomes.¹⁵ In another study nurses were asked to describe experiences where client dignity had been maintained and where it had been compromised. The interviews were unstructured and experiential in nature. In all four nurses were interviewed, it was noted that nurses need to respect clients and accord them privacy. It was also reported

that clients should not be seen as an object or body alone. Patients' family needed to be seen to possess an innate right to be treated with dignity and respect in all situations and at all times whether the client was conscious or unconscious, alive or dead. Respect would appear to these nurses to mean treating a person with respect to their personhood, that is, the nature of the person, their feelings, their individuality and their wishes. The body and its treatment was a central theme in nurses' accounts. Quality care was also acknowledged when nurses showed an interest in clients as people. Nursing practices, which gave clients this impression, included nurses listening to and talking with them. Knowing the client was not seen as a single process; patients appreciated nurses who shared personal details about themselves and their family.⁹ Nurses who got to know clients as people were seen to encourage more social contact between clients and their relatives.¹⁶ McAdam¹⁷ reported that clients and relatives were comfortable with nurses who were available, accessible, and approachable and these were demonstrated through nurses who had time for clients and relatives.

Based on the importance of professional relation in nursing and its important role, this issue should be more dealt. While in most of the developed countries in nurse and patients' family relation, defined standards are applied. However, obvious standards consistent with the conditions in Iran are not defined while the studies conducted in Iran are about the relation of nurse and patients' family and showed problem in this regard. For example, Abedi et al., found that the relation of the nurse and patients' family is not favorable and by presenting educational plans for the patients, it can be improved.⁶ Aein et al., discussed about the weak interpersonal relation between the nurse and patient family.⁵ In another study, the presence of a supporting environment and adequate resources to improve the relation between the nurse and patients' family is

emphasized.⁹ Based on the position of the relation of nurse and patients' family in the quality of nursing care, the main question in the mind of the researcher is the facilitators and barriers of the relation between the nurse and patients' family based on the background of nursing in Iran? As the human being relations cannot be summarized in a research, it is required to use suitable study solutions to achieve the deep reality of human being and quality researches can have important role in clarification of ambiguous fields.

The researchers showed that we don't know the relation of nurse-patient's family well and the previous studies didn't provide the required knowledge in this regard.⁵⁻⁷ As there is no comprehensive study regarding the relation process of the patient family and the nurse and as it is the interpersonal and cultural relation, any society based on cultural-social ground can have different communicative styles. The researcher attempted to do the qualitative study to acquire more information. The aim of the present study is determining the facilitators and barriers of the relation between the nurse and patient family in ICU in teaching hospitals of Kerman (Iran).

Materials and methods

The study was conducted at intensive care units in Kerman hospital. The hospitals have 6 ICUs with a bed capacity of 60 and the total number of nurses was 45. Eight Nurses and of 10 patient's families participated in this study. Purposeful sampling was used for the initial interviews and, according to the emerging codes and categories data was collected by means of theoretical sampling. The purpose of the study was briefly explained to each participant. It was explained that the interviews would be recorded and that they were free to being out of the study if they did not want to continue. Consent form was then offered. If the potential participant read the information

letter and signed the consent form, the one was considered for the study. Upon accepting to participate in the research, and after signing the informed consent sheet, nurses and family member were given an appointment for the interview.

Interviews were carried out at the time the participants felt their workload was lower or had enough time to be interviewed. Individual non-structured interviews were conducted in a private room at the hospital. The interview guide consisted of core open ended questions to allow the respondents to explain their own viewpoints and experiences as completely as possible. The interview prompts were:

- 1) What factors are facilitated nurse- family's communications?
- 2) What factors are as barrier to nurse-family's communication?

Participants where then asked to explain their own experiences and perceptions of "communication", as well as "facilitators and barriers" that affected taking on the communication. Depending on participants' tolerance and their interest in explaining their own experiences, the interviews continued with the topic questions and probes in order to capture a deeper understanding of the phenomenon under study. All interviews were carried out by the same interviewer. Interviews were recorded by a digital sound recorder, transcribed verbatim and analyzed consecutively. Interview transcriptions were repeatedly reviewed until meaningful themes emerged. The duration of interview sessions ranged from 20 to 90 minutes, with an average of one hour, and interviews were continued until data saturation was achieved.

Data were collected by interviewing participants. Data collection and analysis proceeded simultaneously. After each interview, the tape was transcribed manually by the researcher. The accuracy of the transcripts was checked by listening to the audiotape and reading the transcripts simultaneously. The analysis of the interview transcripts was guided by content analysis,

which has been identified as appropriate for analysis of interviews.¹⁸ Themes as the expression of the latent content of the text were identified. The data was coded by hand using different colors. Condensed meaning units were abstracted and labeled with codes. The codes were then sorted into both categories and subcategories based on comparisons between similarities and differences. A print out of these files was also made and categories were formed from them. Finally, higher-level categorization was constructed from the initial categories. That is, categories which fit into common files were also brought together to form final and major categories. Data acceptability criteria were applied using the following methods: prolonged engagement, assigning enough time, appropriate relation to understanding real data, peer and member check, and negative case analysis and objectivity (one of the data characteristics of research).

Results

Nurses who were employed for a minimum of four years at the hospital and expressed willingness to discuss their experiences were eligible for inclusion in this study. Those employed for four years had ample opportunity to observe and participate in nurse-family communication in the hospital setting. Additionally, all participants were full-time registered nurses from two hospitals in Kerman, Iran. Nurses' age ranged from 24 to 45 years. There was one male and seven female nurses. All had worked in the ICU from 4 to 20 years. All family members consisted of patients' parents, children and spouses, whose ages ranged from 20 to 55 years. Facilitative factors and barriers to nurse, patient and family communication were included in table 1 and explanations are in continue.

A. Facilitative Factors in Nurse- Patients' Family Communication.

A. 1. Spiritual considerations

Spiritual considerations are one of the content items of communication between the families and ICU team. As the patients in this department are in critical condition, premonition of the diseases is not satisfactory and all people consider the spiritual issues more than any time and ask God to get the patient better and they consider their religious actions including worship, praying or fasting and by praying to Allah get help for their patient. It is observed that the nurses asked the families to say prayer for their patients and ask for help.

A. 1. 1. Giving hope

If there is no hope for getting better, again the families of the patients try to be given hope from the ICU team. Even they feel they are telling lie. One of the nurses said: "giving unreal hope is not good but making the families hopeless not good... the realities should be said as the families don't suffer from trauma and it can be said that you should trust in God and in all your sentences, there should be God...but when it is said what God asks, the families get comfort, he is Not given hope and they are not being hopeless.

A.1.2.Considering God

The nurses guide the families to God and saying prayer when they thinking that there is no hope to relieve them and they can tolerate the sad moments. It can be said that they establish spiritual relation with the family. One of them said, "This department is very important and the patient is close to death and it is the last location, we should trust in God and say prayer". One of the nurses said: "we give information as possible, for example, we say, the patient is better now, your patient is good now but we don't know what happens later, say prayer.

A. 1. 3. Resorting to religious actions

Religious beliefs are more important at disease time than other periods in life and it is caused that a person accepts the disease.

Table 1: Facilitative factors and barriers to nurse-patients' family communication.

Factors	Category	Subcategory
Facilitators		
	Spiritual care	1- Giving hope 2-Considering God 3- Resorting to religious actions
	Emotional support	1- Mental support 2-Empathy 3- Mutual understanding 4- Comfort 5-Trust
	Participation	1- Participation in decision making 2- Physical care
	Notification	1-Identification of the information need of the family 2- Responding the need of the patient family 3- Training the patients' family
	Consultation	1-Consultation in selecting the therapy 2-Selecting the best type of care
Barriers		
	Misunderstandings about treatments needs	1-Differences in health beliefs between nurses and patients' family 2-Perceptions of unfair treatment 3-Conflicts with patients' family members 4-Miscommunications 5-Coercion 6-Forced dependence 7-Human resource problems
	Job problems	1-Professional nursing problems 2-Nurse problems 3-Ignoring professional ethics 4-Work environment
	Difficulties with patients	1-Payment requirements and processes 2-Patient problems

Thus, religious actions and providing required facilities for religious actions and meeting the religious demands of the patients when the patient is hospitalized in the hospital are of great importance. In all the observations conducted by the researcher, resorting to religious actions was observed. As some of the families were saying prayer, some others were sending peace upon the Prophet and reading the Holy Quran. One of the nurses said, go and say prayer for the health of your patient (observation 1, dated 2012/7/5).

A. 2. Emotional support

A. 2. 1.mental support

Anxiety is one of the major mental problems in a family. The major concern of the patients to treatment costs, dismiss and outcome of the disease were the major cause of anxiety. One of the ICU nurses said:" Here, the families of the patients are anxious, both for money and their life and the life of their patient is more important. They say, our patient will get better, are all the treatments for our patients good and effective?"

A.2. 2. Empathy

Empathy with the families and giving them comfort is one of the important issues being mentioned by the families. They wanted the ICU team to empathy with them. One of the participants said: ".....They understood me mentally, when they talked, I was mentally getting better". Another family as the brother of the patient said " some of the nurses were good both with the patient and their family members and they understood the patient and the disease and they were talking to give comfort to the patient.

A. 2. 3. Mutual understanding

The families preferred the nurses and physicians understand them and in this way most of communication problems are resolved. The sister of one of the patients said: " If the nurses and physicians understand them, they can establish strong understanding". The father of one of the patients said: " The nurses are good and they understand us and they know we are in a bad condition and they try to do their best".

A. 2. 4. Comfort

Giving comfort to the family of the patient is one of the communication behaviors of the nurse in facing with the critical needs of the patient and family. The nurse by some behaviors as being friendly and respecting the patient and empathy with the needs of the patient said that not to feel themselves as a stranger and it was a comfort for him. One of the families said: "The nurses are very good and kind, they try hard, they are not ill-tempered and they don't yell at us. We shout at them, but they don't yell at us. They talk calmly". Giving comfort to the patient is one of the actions. One of the nurses in ICU said: "The families of the patients are distressed and we try to give the patient comfort until the doctor comes".

Most of the families said that giving comfort by the ICU team reduced the stress and anxiety.

A sister of a patient said: " ICU is very stressful and I didn't know what happens to

my patient, two of the nurses were good and they were telling us not to be worried, we had many patients like this one and all of them got better. I trusted them and I relieved. The families in ICU need empathy".

The brother of one of the patients said: " Our communication was good and they had good emotional communication with us. They were giving us information. They said, our patient is getting better and it was understandable. We were convinced. Some of the nurses were good and they understood us, when they were talking, I felt good".

A. 2. 5. Trust

Communication with the families causes that they trust you. The families of the patients feel a kind of trust to the ICU team and they feel that they do their best in ICU. Even if they don't do anything for the patient, they don't find fault with them. The sister of one of the patients said: " we had a good relationship and we were communicating emotionally. If the nurses take time and give them comfort, they will be impressed and they trust the nurses more than their families and the effect of their words is more than the words of the family".

A. 3. Participation

Other content of communication in the present study is participation. Based on the two features of audience as participation and participation content. The audience of the participation in this study is family and participation content is "care recommendations", "helping for decision making and "giving information about the conditions of the patient by the nurse".

A. 3. 1. Participation in decision making

In ICU, due to the critical condition of the patients and immediate decision making for them is asked less than the families. In most cases, they are informed and the consent is obtained. If the necessary measurement is taken for the patient, the families are asked to take decision about their patient, for example, transferring other hospital and so on. A family said: " As we don't know anything of

what they do for the patients and we trust the doctors and the hospital, any decision taken by them is accepted”.

A. 3. 2. Participation in physical care

Rarely, it is happened that the families are asked for help in ICU. ICU is an isolated location and frequent visits make this place infectious but in post-ICU, the families are asked for physical care.

One of the nurses said:” If we have time we asked the family member to do bandage, because he learns and he can be an aid”.

“...If a patient is hospitalized for a long time, his family is allowed to come and talk with the patient and rub his hands and feet and this is effective on his health, namely in nutrition that is effective for health”.

Another nurse said:” As ICU is a special department and families cannot participate in nursing actions and if necessary, the family can visit his patient to give him comfort and training measurements are done in this department”.

A. 4. Notification

A. 4. 1. The identification of the information need of the families

Another type of communication content is giving information to the families and obtaining information about the patient from the families. The major content of communication is done via exchanging information. Obtaining information about the patient is one of the important needs of the families and the families are more anxious about their disease and premonition and they need to have the complete information and if the needs are not met, they feel anxious.

Based on the conditions in the study field, the nurses had time to focus only on critical issues related to patient health and the content of their communication was responding the needs. Indeed, based on the increase of work load, they didn't have time to deal with the long-term needs of the patients and the patients found that they should talk only about their immediate and critical issues with the nurse. One of the

nurses said:” Most of the families asked us about the disease and its trend. What are we doing in this process and sometimes the families want to know completely about the disease. What is the name of the disease, who is the doctor and what we have done for them and we were explaining them, as possible”.

One of the nurses said:” As the patients in ICU are mostly suffering from brain trauma, most of the families want to know if their patient is getting better or not?”.

A. 4. 2. Responding the information need of the patient families

Responding the family need to the health of their disease was due to the concepts leading into the needs of the families. This concept showed the role of patient family in this group. Most of the families tried to obtain information about the disease, diagnosis, treatment and their disease. For example, a nurse said:”I want known about prognosis of disease and they give me information”.

A. 4. 3. Training the patients' family

Training and increasing the information of the patient family is another type of communication content of the relation between ICU team and the patients' family and it is a communication bridge.

Increasing the information of the patient or his/her family is another communicative behavior of the nurses facing with the patient needs that was done as “information training” by the nurse beside other duties or during the implementation of nursing techniques. Increasing the information of the patient or his family is in the form of explanation with the disease process, patient preparation to implement care techniques and care recommendations to the patient or the family.

One of the nurses said:” We train the family of the patients, some of the patients have special diet and we tell them to have special diet for the patient and sometimes the kitchen cannot provide some of the items for

the patient and we train the family of the patients to know what is useful for the patient and if they can provide for them”.

A. 5. Consultation

A. 5. 1. Consultation in selecting the therapy

One of the groups of communication content is consultation of therapy team to the family to select the best therapy. The families require ICU team consultation for better choice. In most cases, the families are guided by the therapy team to have the best therapy services for their patients. The sister of one of the patients said:” we want to know we can take our patient to another hospital and choose a skilled doctor, is there any effective drug for our patient. We do our best that our patient feels better. They should tell us what we can do”.

A.5.2.Consultation in selection the best type of care

The brother of one of the patients said:” We want to know what we can do when our patient was discharged from the hospital, how we can behave with him, where can we ask for help in emergency condition. We ask them to guide us”.

Another family said” As my patient didn't have good vein for injection, I asked the nurses to introduced another person who can do the injection”.

When the patients were dismissed and they needed nursing care at home, most of the families were searching for a center or a person for nursing his patient at home.

A family asked the nurses: “Can you introduce me a nurse at home for my mother”.

B. Barriers to nurse-patients' family communication

B. 1. Misunderstandings about treatment needs

B. 1. 1. Differences in health beliefs between nurses and patients

One source of conflict between nurses and patients' family was the difference in belief regarding Western and traditional medicine, which was a major factor reported by ICU nurses. In one instance a nurse stated:

“Whatever that you tell the patient, he will not listen because... he believes in traditional medicine, sometimes the relatives will come and tell you that they prefer a local healer, in spite of having explained to them the implications of their actions.”

B. 1. 2. Perceptions of unfair treatment

A conflict occurs when the patient has the perception of unfair treatment by the nurse. Perceptions of unfairness have featured prominently in this study. In some cases the nurses reported that they provided priority services to patients with more serious conditions and were upset by those who had less serious conditions and wanted prompt care. Using their professional judgment, the number of nurses reported that they thought critically ill clients were more in need of urgent attention. A nurse quoted her patient family as saying: “Oh we can't sit here and somebody will just come and take our place.”

B. 1. 3. Conflicts with patients' family members

Nurses' interactions with patients' family members featured prominently in the negative nurse-client interactions. Often nurses reported confrontations with patients' family members.

Non-observance of visiting hours by patients' relatives resulted in negative interactions between nurses and family members of patients. Nurses complained that visitation by family members outside the stipulated visiting hours disrupted their work, disturbed other patients and threatened their privacy. Failure by family members to observe visiting hours elicited negative responses from the nurses. A nurse stated: “We tried to send them out because they came earlier than the scheduled visitation hour. We told them to leave as we were in the process of ward rounds but they refused to leave the ward.”

B. 1. 4. Miscommunication

Negative interactions between nurses and patients family occurred when information given by nurses was not properly understood. Patients misunderstood what

the nurses said and this resulted in adverse health outcomes. For example, the nurses reported that a patient did not receive the right information from the nurse about his treatment needs. The patient took his medication at the wrong time which later resulted in poor interaction between the nurse and patients' family.

B. 1. 5. Coercion

In their interactions with patients' family nurses applied force to make patients' family comply with instructions. Nurses were perceived as powerful and patients as powerless. This unequal relationship was seen as a barrier to effective nurse-family interactions. Some nurses used their power in an unacceptable manner by demanding that patients' family comply with whatever instructions they issued. In this sort of relationship, the patients' family was powerless and had to "trust and obey" the nurse in all situations. In this study, nurses in their interactions with patients' family demonstrated a hierarchical relationship. For example, a nurse was observed shouting authoritatively at a patients' family: "Madam would you mind your speech?"

B. 1. 6. Forced dependence

Forced dependence is defined as the use of force by a nurse to condition the patient. In situations where nurses have perceived patients to be difficult, the nurses applied forced dependence measures to compel their clients to obey orders. A nurse whose 'orders' were disregarded by a lady in labor was quoted as saying: "But we told her it was very dangerous for her and for the fetus. She couldn't understand, so we told her, 'if you don't help us we are going to tie you up'".

B. 1. 7. Human resource problems

There were human resource factors which undermined effective nurse- patients' family interactions. Staffing shortages were such that nurses did not have adequate time for their patients. Few numbers of nurses coupled with high workloads led to

inadequate interactions with patients. Nurses attributed the nursing shortage to the migration of nurses to other countries such as the United Kingdom and the United States. Reflecting on the nursing shortage, one nurse participant stated: "We don't have enough nurses; I don't think it is good enough for two nurses to attend to twenty patients during a shift. I don't think it is proper. That is happening and during the night, a nurse will attend to about 30 children with one ward. You can well imagine the workload and the frustration that happens under such circumstances."

B. 2. Job problems

B. 2. 1. Professional nursing problems

Task orientation and organization made it difficult for nurses to give holistic care to their patients. All nurses mentioned that they had to combine tasks in order to complete them which dissatisfied their efforts to render holistic care to patients. The nurses were busy and unable to communicate effectively with their patients. Nurses have become so adapted to this situation that they forget to teach and communicate with patients even when they are less busy.

B. 2. 2. Nurse Problems

Nurses who stay in rented premises outside the hospital cannot effectively respond to emergency calls. Stress, tiredness, frustration and long working hours without a break affect nursing attitudes, which has serious negative implications for patients and their family members. The nurses noted that stress and overwork led to frustration and anger in the work place. Personal life issues of some nurses affected their interactions with patients' family. In some cases, nurses identified personal issues as justification for how they interacted with patients and their families. According to one nurse: "I must be very frank here, some nurses bring their personal problems to the work place and just a slight provocation always upset them".

B. 2. 3. Ignoring professional ethics

Although professional ethics is a part of professional nursing curricula, lapses according to nurse participants have led to negative nurse- patients' family interactions. These lapses represent a breach of patients' rights and constitute patient neglect. Negligence by nurses or failure to take proper care of patients by nurses has emerged strongly in this research which was acknowledged by all participants. As one nurse stated: "Half of the negative nurse-patients' family interactions are caused by negligence of duty". Other examples of lapses in professional ethics occurred when nurse study participants reported transporting their patients between the emergency room and the outpatient department to search for their physicians and "sacking" or expelling patients when they did not report to the clinic on time.

B. 2. 4. Work environment

Managerial influences to a large extent determined the type of interactions between nurses and patients' family. Lack of concern about staff by managers interfered with nurse-family member communication. Nurses reported that managers were unsupportive and unresponsive to nurses' needs. Many nurses who left the hospital sought employment elsewhere in Kerman. One nurse stated: "Yeah, if legitimate requests to the officials are treated with contempt, confusion will always reign."

B. 3. Difficulties with patients

B. 3. 1. Payment requirements and processes

Participants mentioned that the payment requirements and processes in the hospital interfered with nurse- patients' family interactions and relationships. In some instances patients refused to be admitted even when it was strongly advised. Such professional advice was resisted by the patients because of financial reasons. One nurse quoted her patient as saying: "My husband is not in town; if my child is admitted, who will help me pay for the bill?"

B. 3. 2. Patients' problems

At times, patients' family does not comply with nursing recommendations or requirements. Of nurses, mentioned that patients found fault with everything the nurses did for them. According to one nurse: "So I had this patient in my ward and I can really say that she was one of the most difficult patients I have ever treated in my nursing career because no matter what I did for this woman, she always found fault. If she rang the bell calling you and if you didn't appear within a minute or two it was hell

Discussion

The present study aimed at determining the facilitators and barriers communication between the nurse and patients' family. The facilitators of communication between nurse and the family of the patients in ICU" were including the spiritual care, emotional support, participation, notification and consultation and barriers to communication were misunderstandings about treatments needs, job problems and difficulties with patients.

In this study, spiritual care, emotional support to meet patients' family needs was considered a major factor that supported positive nurse- patients' family interactions and relationships. In a study by O'Malley et al.,¹⁹ nurses indicated that they were able to meet patients and their families' needs due to the availability of time. According to Irurita²⁰, an effective nurse- family relationship was considered to be central to quality nursing and emotional support. McNamara²¹ confirmed that patients' needs had to be met, whether they were conscious or unconscious. The nurses in mentioned study described the essential structure of caring as the establishment of a human care relationship and provision of patients' family needs. Piquette et al.,²² acknowledged the need for healthcare institutions to care for their nurses in addition to health professionals' private and professional needs in order to render quality care. Norman et al.,²³ acknowledged

that good facilities and adequate resources in terms of workforce, equipment, supplies, support services and time to perform an adequate job were identified as important for nurses to give comprehensive nursing care. Based on the results of the study, it can be said that the main responsibility is continuation of this communication with the patient as the responsibility of the nurse and the patient family had low power in this communication.

Spiritual care were one of the most important issues being emphasized by the families and nurses and the nurses considered this issue more despite all their problems and by giving hope to the families, referring them to prayer and asking for his help and doing the religious actions tried to approach the families and reduce their anxieties.

Allah remembrance gives us comfort and they will be calm in this way. But giving unreal hope to the families is not good and God will is observed in all their words. The families ask for the health of their patients from God and they try to get close to God by religious actions.

Generally, religious principles are powerful source for the patients leading into the improved health of the patients. The anxiety of being separated from religious acts and neglect in this regard will have negative effect on disease improvement and increased the hospitalization period and increased costs. Some of the patients consider disease as divine try and they believe that if they are religious, they will be saved. Other people think that they are punished due to their immoral behaviors. They believe that prayer, repentance increase the toleration of people against the disease and problems.²³ According to Redfern and Norman, when human being is at loss, he asks for God help and returns to him. Here, religious acts as saying prayer, praying are common mechanisms increasing the hope and qualification feeling.²⁴

As a part of comprehensive care, the nurses are required to ask a clergy man to visit the

patient for religious acts. This part of care is one of nursing and midwifery standards because a patient can have religious needs.²⁵ Regarding meeting the spiritual needs of the patients, Psychology society of USA recommended that the physicians should ask about the spiritual and religious inclinations of the patients. The foundation of the recommendations is such that caring the patient is more important than patient treatment and it includes many needs. Most of the patients try to meet their spiritual and religious needs.²⁵

Another facilitator reported in this study is emotional support between nurse and the families as sub classifications of empathy, comfort and trust.

The nurses' empathy with the patients' family in ICU was one of the positive issues being considered by ICU team in the present study. This meaning is also considered in the study of McAdam *et al.*, and Norman *et al.* The patients' family who reported high satisfaction was affected by the nurse consideration and empathy.^{17,23} The family of the patients admitted in the hospital found that when they had a patient in ICU, due to the lack of adequate information about their disease and the unfamiliarity with the environment are in stressful condition and they require empathy of the staffs. The interviews and observations in the present study showed that the families feel comforted when the team communicate with them by communication skills and techniques and explain about the environment of ICU.²⁶ Cleary *et al.*, believed that the nurses can present the nursing care as private or they can have close relation with patients' family and create more empathy. The results of another study showed that the more the patient's family are understood by the staffs of ICU, they more the satisfaction.²⁷

Proving the participation of the patient and his family is another action being done by the nurses without any plan. To reduce work load, the nurses did some activities of the patient with the participation of the patient

families.²⁷ McDonald et al., found that when the nurses ask for the help of the patients' family, there will be considerable coordination and the nurses reported that participation of the family in care services take time but in long term is time consuming.²⁸

The nurses defined their position by separating the participative role of the patient or his family from the unsuitable intervention in care services and they set a boundary between their duties and the doctor duties and the lack of intervention in each other duties. In a study done by Allen regarding the professional borders between the physician and the nurse, the nurses emphasized on their legal duties and stated that nursing care is one of their main duties.²⁹ In nursing basics, one of the roles of nurses about the patients' family is providing information for them and improving their knowledge. In the study, the nurses couldn't present training as formal to the patients' family due to the lack of time and increase of work load and constraint issues in providing information to the patients. But in each visit or during the discharge, they presented care recommendations as informal.³⁰ Hanoch and Pachur believed that nurses are responsible to present important information to the patients' family.³¹ In a study done by Pytel et al., the results of the study showed that providing information regarding the diagnosis and therapy test are the most important needs of the patients and the family and the nurses did the same.³⁰ Davidson et al., in a study regarding the communication with the family of the patients admitted in ICU showed that as there is high mortality rate in this department, the condition of the patient is not predicted and the nurses are obliged to give exact information to the patients' family who are faced with death to help them to take the best decision for their patients or visit him.³²

Giving consultation to the family of the patients is another communication content

with the family. When the families cannot take good decision for their patients or due to the lack of information about the skilled people or centers doing the best care services for their patient, the nurses can guide them to help the patient and the family.

Giving consultation to the patients' family is one of the therapy accepted quality indicators. All the patients can receive good consultation regarding the improvement of health and prevention of the disease. Consultation here has many advantages as 1- reduction of health care costs, 2- increasing the care services quality, 3- helpign the patient to achieve more independency and self-efficiency.³³

About barriers, analysis of nurses' experiences emphasized the theme of "Work Environment". Respondents were enthusiastic about promoting horizontal relationships between nurses and managers with the intent to find solution to problems that affected the institution. The nurses were also concerned about the institutional education and accommodation policies. These study observations were supported by other investigators who acknowledged that a major predictor of job satisfaction for nurses was nurse manager collaboration.³⁴ In this Iranian study, when the nurse participants were empathetic they described their interactions with patients as positive. Empathic nurses absorbed the negativity of their patients. Most nurses stated that effective communication occurred when they listened with kindness and empathy and used appropriate non-verbal behaviors.³⁵ O'Brien³⁶ studied friendliness and friendship within the nurse-patient relationship and identified nurses, who smiled, joked, spoke in warm tones of voice and showed interest in patients as those who promoted nurse-patients' family communication. According to Norris et al., exceptional nurses raised patients' morale when they responded promptly to patients' treatment needs and promoted their autonomy. Interpersonal conflict occurred between individuals, especially between

those who differed with regards to beliefs, values and goals.³⁷ Hupcey³⁸ emphasized that teamwork and cooperation between nurses and family members benefitted the patient. However, nurse participants' interactions with patients' family members strongly influenced the development of negative interactions in this Iranian study. Non-observance of visiting hours by family members and family disagreement with the choice of treatment was the source of much conflict. In this Iranian study, participants have used their power in unacceptable ways. The literature is complete with research on the power differential between nurses and patients' family. This unequal relationship is a significant barrier to effective nurse-patients' family interactions.³⁹ In addition, staffing problems did not allow nurses adequate time for their patients and patients' families in this study. Meilman⁴⁰ and Holyoake⁴¹ also acknowledged that the provision of first-rate services to students and other health consumers in and around a large university hospital required the best possible staff in the university health service. A task-orientation toward providing nursing care made it difficult for nurses to give quality care to patients in this study. The nurses were always busy and unable to effectively communicate with their patients' family. The majority of nurse-patients' family interactions were related to tasks and routines.⁴² Lapses in professional ethics and adherence to professional nursing standards affected nursing interactions with patients.⁴³

Conclusion

From the perspective of nurses, factors that facilitated communication and barriers to communication between nurses, patients and their family members have been illuminated. The findings of this study and their analyses have provided some guidance. Nurses need to put themselves in the patient's position which will enable them to practice and render good quality care to patients and

patients' families. The findings, especially with regard to nurses' poor attitudes toward patients and their families, suggest that a code of ethics needs to be enforced and the use of disciplinary procedures when necessary in order for nurses to be aware that patients' family abuse is certified by their professional organization. Finally, nurses should know that as health professionals their beliefs should not affect their ability to establish positive communication with patients and patients' families. Nurses can explain their professional point of view in a therapeutic manner while hearing and valuing their patient's point of view. It can be concluded that communication is contextually complex, and is a controversial, risky component of any nursing practice. Different workplaces and cultures may affect the findings of a study. Additional research is needed to further our understanding of the barriers and facilitators of patients' family communication in nursing.

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Ethical issues

None to be declared.

Conflict of interest

The authors declare no conflict of interest in this study.

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