RJNMSR
Review Journal of Neurological & Medical Sciences Review

Volume 3, Issue 3, 2025

FAMILY NEEDS OF PATIENTS ADMITTED IN CRITICAL CARE UNITS OF TERTIARY CARE HOSPITALS, PESHAWAR

Mudassir Khan[1], Imran Waheed Ahmad[*2], Zeenat Ullah[2], Sabir Rehman[3], Sakina Jaffar[4], Shakil Nasar[5]

[1]*MSN Scholar, Official Shift Leader - Infection Control at Shoukat Khanum, Peshawar.*
[*2]*MSN, Lecturer, INS, Khyber Medical University, Peshawar.*
[2]*MSN Scholar, RN Officer Type D hospital Pashat Bajaur.*
[3]*MSN Scholar, RN Officer, DHQ Hospital Karak.*
[4]*MSN Scholar, Nursing lecturer, College of nursing SKBZ Balochistan.*
[5]*MSN Scholar, Nursing lecturer, Hussan College of Nursing Swat.*

[*2]imran.ins@kmu.edu.pk

Corresponding Author: *
Imran Waheed Ahmad

DOI: https://doi.org/10.5281/zenodo.15852508

Received	Accepted	Published
02 April, 2025	23 June, 2025	10 July, 2025

ABSTRACT

Background:
Critically ill patients in Intensive Care Units (ICUs) not only require clinical interventions but also demand attention to the psychological and informational needs of their family members. Families often endure extreme stress, anxiety, and emotional turmoil, especially in tertiary healthcare settings of low-resource countries like Pakistan. Addressing these needs is essential for enhancing both patient outcomes and family satisfaction.

Aim:
The study aimed to assess and explore the perceived needs of family members of critically ill patients admitted to critical care units in tertiary care hospitals in Peshawar, Khyber Pakhtunkhwa.

Methods:
A descriptive cross-sectional design was employed. Data were collected from 300 family members using a modified Critical Care Family Needs Inventory (CCFNI). Participants were selected through a convenience sampling technique from three tertiary hospitals: Lady Reading Hospital (LRH), Hayatabad Medical Complex (HMC), and Khyber Teaching Hospital (KTH). The responses were rated on a four-point Likert scale and analyzed using SPSS version 22.

Results:
The five most important perceived needs were assurance-related: hope (86.3%), feeling that hospital staff cared (84%), help with physical care (80.3%), discussions about the possibility of death (79.7%), and assurance of the best care (79.7%). Conversely, the least prioritized needs included comfortable furniture (20.4%) and the need to discuss guilt or anger (24%). Emotional, informational, and proximity-related needs were also highly emphasized.

Conclusion:
The findings highlight the need for healthcare institutions to prioritize emotional, informational, and logistical support for families. Integrating structured communication, empathy, and culturally sensitive care can significantly improve family satisfaction in ICUs.

Keywords: *Family needs, critical care, ICU, family-centred care, psychological support, tertiary hospitals.*

INTRODUCTION

Relatives are part and parcel of helping critically ill patients, particularly in highly emotional settings such as Critical Care Units (CCUs). Emotional, informational, physical, spiritual, and social are family needs that expectancy when a loved one is admitted to the hospital (Wilson & Davidson, 2023). Critical care units are hospitals where patients who need close monitoring and life support are specialized (Kynoch et al., 2021). The tertiary care hospitals provide a tertiary level of medical care, of art intensive care facilities. Patient-centered care focuses more on the needs of the patient and family. The fulfillment of needs will enhance emotional coping and communication. When they are not met, they may lead to stress and dissatisfaction in the family (Vincent & Creteur, 2022).

It has been found that 60-80 % of ICU patient families have unmet needs. The prevalence in low- and middle-income countries (LMICs) might be even greater because of poor resources and shortages in the workforce. Critical care unit in Pakistan is usually overcrowded, understaffed with no formal protocols to resolve family concerns. Families may face the problem of uncertainty and powerlessness because of minimal interaction with healthcare professionals (Prust et al., 2022). The culture dictates that family participation should be high and thus ignoring the needs imparts more emotional baggage. Nonetheless, scarcely Pakistani hospitals carry out formal needs assessment. This indicates a major loophole in the provision of family-centered care (Allen, et al., 2023).

The process of admission to a critical care unit is a traumatic event to the family. It causes the psychological reactions including anxiety, fear, helplessness, and even post-traumatic reactions. All these emotional reactions may hinder their capacity to make informed decisions or assist the patient effectively (Li, et al., 2025). Their stress worsens when their family needs are neglected and this acts on their well-being. Thus, it is important to know these needs and respond to them. The nurses and doctors should also be sensitized to detect the emotional distress that families undergo. There has to be support networks to help the families go through this painful period (Duque-Ortiz & Arias-Valencia, 2022).

In critical care, one of the family needs is communication. The families would require proper information in understandable form, on time, and condition of patient, treatment plan, and prognosis. In absence of this, they consider themselves to be ignored, nervous and also tend to misunderstand medical scenarios. There is open communication which encourages trust and mutual decision making (Greenberg et al., 2022). Research supports the idea that the more access to information a family has, the less stressed it is and the more satisfied it is. Healthcare teams that practice transparency allay fear and confusion. It also promotes family collaboration and trust on the process of care (Leong et al., 2023).

Families in CCUs have a critical emotional need of reassurance. The families get reassurance when they see competent staff or the conditions of stable patients or positive news. It eases panic and makes them feel that the loved one is under the best care. On the other hand, family anxiety grows when the staff appears callous or dismissive (Scott, 2021). Updated information and practiced care are seen and provide comfort. Families can be calmed by even simple acts such as listening or explaining the equipment. Hence, emotional presence is important as medical procedures (Molelengoane, 2021).

Since critical illness is associated with emotional, cultural, and practical complexity, family-needs assessment is essential. The families of the CCU patients experience tremendous stress and assume a vital supportive role. The present study is an attempt to examine these needs in a systematized way in tertiary care. Evidence-based interventions and policy suggestions will be made with regard to the findings. The improvement of these needs will help in the improvement of patient care, family satisfaction, and efficiency of the health care. It is also aligned with the bigger picture of compassionate and culturally responsive critical care. It is not an option but a necessity to understand the needs of the family.

Methodology

The study utilized a descriptive cross-sectional study design to evaluate family member needs of critically ill patients. The research was carried out in the intensive care units (ICUs) in three tertiary care hospitals in Peshawar; Khyber Teaching Hospital (KTH), Hayatabad Medical Complex (HMC), and Lady Reading Hospital (LRH). A sample size of 300 was calculated using the Raosoft calculator with 1500 as the population, 95% confidence level and 5 margin error. Limited resources and time constraints caused the use of a non-probability convenient sampling method, It involved family members who had spent at least 24 hours with the ICU patient. Participants who did not want to participate, visitors to their relatives, and patients in rooms not part of the ICU were not

included. Information was based on a standard, transformed questionnaire, which consisted of three parts that included section A, which captured demographic information and section B which consisted of 40 questions which explained patient family needs. Respondents were informed about the purpose of the study, signed informed consent, and ranked items on a scale of 1 (disagree) to 4 (strongly agree) without pressure.

SPSS software version 22.0 was used to analyze data after the end of data collection. The data were analyzed to obtain descriptive statistics like frequencies and percentages that summarized the answers. The resulting data were then presented in tables and graphical form to support easier interpretation of findings and clarity.

Results and analysis

Socio-demographic characteristics of research participants

The majority of participants were aged 26–35 years (44%), male (66%), and married (70.7%). Most were educated above matric (35%) and resided in rural areas (58.3%). In terms of occupation, 39% were unemployed, while 42% had a monthly income of less than 20,000 PKR. Parents (28.7%) and brothers (24%) were the most common caregivers, with many patients staying in the hospital for 1–3 days (42%) [Table 1].

Table 1: Socio-demographic characteristics of research participants

S.N	Sociodemographic variable	Frequency	Percentage	Cumulative percent
1.	Age categories (in years)			
	a). 15-25	63	21.0	21.0
	b). 26-35	132	44.0	44.0
	c). 36-45	74	24.7	24.7
	d). 46-55	31	10.3	10.3
2.	Gender			
	a). Male	198	66	66
	b). Female	102	34	34
3.	Qualification			
	a). Uneducated	53	17.7	17.7
	b). Primary	43	14.3	14.3
	c). Middle	59	19.7	19.7
	d). Matric	40	13.3	13.3
	e) Above Matric	105	35.0	35.0
4.	Marital status			
	a) Un-married	72	24.0	24.0
	b) Married	212	70.7	70.7
	c) Divorced	16	5.3	5.3
5.	Occupation			
	a) Un-employed	117	39.0	39.0
	b) Employed	83	27.7	27.7
	c) Self-employed	100	33.3	33.3
6.	Residence			
	a) Urban	125	41.7	41.7
	b) Rural	175	58.3	58.3
7.	Relationship with patient			
	a) Parent	86	28.7	28.7
	b) Brother	72	24.0	24.0
	c) Sister	57	19.0	19.0
	d) Daughter/Son	53	17.7	17.7
	e) Any other	32	10.7	10.7
8.	No of days of patient in hospital			
	a) 1-3	126	42.0	42.0
	b) 4-6	105	35.0	35.0
	c) More than 6	69	23.0	23.0
9.	Income status			
	a) <20,000	126	42.0	42.0
	b) 20,000-50,000	122	40.7	40.7
	c) >50,000	52	17.3	17.3

OVERALL NEEDS OF PARTICIPANTS

The result highlights that the highest priority for family members was assurance-related needs, such as hope (86.3%), staff compassion (84%), and confidence in care (79.7%). Information needs also scored high, especially the desire to talk to doctors daily and understand care procedures. Proximity needs like visiting hour flexibility and location of facilities were moderately to highly valued. Support and comfort needs varied, with some like discussing death and financial help rated high, while emotional expressions and spiritual visits showed lower importance [Table 2].

Table 2: OVERALL NEEDS OF PARTICIPANTS

Category	Examples of Needs	High Agreement (%)	Moderate Agreement (%)	Low Agreement (%)
Assurance (A)	Hope, honest answers, best care, prognosis	To feel hope (86.3%), best care (79.7%), feel cared for (84%)	Know prognosis (70.7%), honest answers (69%)	–
Information (I)	Knowing what/why care is done, daily updates, talking to doctor	Talk to doctor daily (69.6%), reasons for care (67.4%)	Know which staff gives info (59.3%), contact person (55.6%)	Know exact care (62%), help with care (80.3%)
Proximity (P)	Visiting patient, room/facilities near ICU	Transfer info (76.6%), visiting hours on time (77.4%)	Waiting room close (74%), daily updates (77.3%)	Visit anytime (41.6%), same nurse daily (45%)
Comfort (C)	Furniture, bathrooms, acceptance by staff	Bathroom near (77%), feel accepted (69.3%)	Food availability (64.3%)	Comfortable furniture (20.4%), phone near (30%)
Support (S)	Emotional, spiritual, and social support	Talk about death (79.7%), financial help (66.3%)	Friends nearby (53.6%), be alone (55.7%)	Encouraged to cry (29%), pastor visit (26.6%)

Figure 1: FIVE MOST IMPORTANT NEEDS

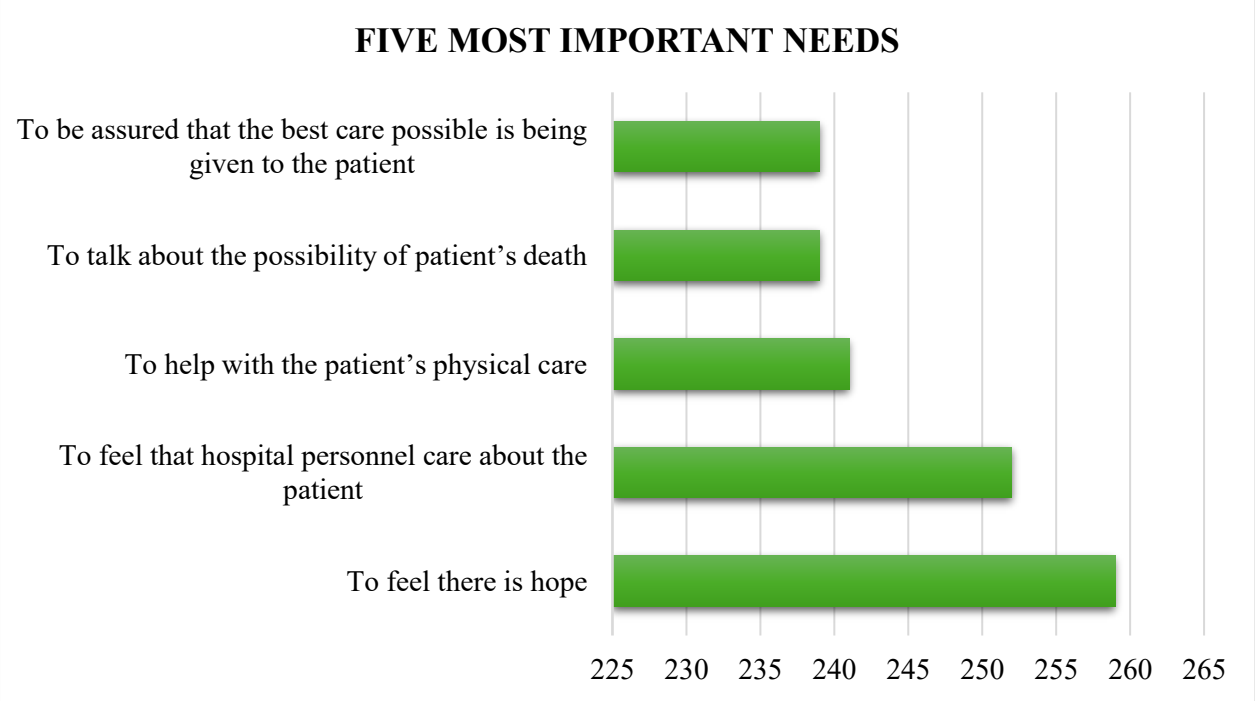

Figure 1 shows that the most frequently identified need was "to feel there is hope" (86.3%, 259 respondents), followed closely by the need for emotional assurance and involvement in care. Key concerns also included staff compassion, being assured of quality care, and discussing the possibility of patient death.

Discussion

Following the outcomes of the current study, it can be outlined that the requirement of assurance is of the utmost concern among family members of ill people in critical condition. According to the data, the following responses (to feel there is a hope, to feel that hospital personnel care about the patient, to be assured of the best care possible being given to the patient) were among the most necessary revealed needs. This indicates support of other past studies that have focused on the need of emotional reassurance to suppress anxiety and psychological distress among members of the family when transferring patients in ICUs. More than a sense of comfort, assurance will generate trust in the healthcare staff as family members wager they are helpless or not directly involved with patient care (Gill, 2023).

In this study, information and proximity had also been seen to be of very high importance as a need. Issues like, to "be informed about the patient once in a day" got 77.3 percent and to be informed about the transfer arrangements got 76.6 % which were taken to be critical. These results reflect those of a study conducted by Ruppel et al. (2022), worldwide that illustrates that the necessity to stay an informed person and the desire to feel close to th e patient are the key factors assisting families to deal with uncertainty as mentioned by Abdul Halain et al. (2022), Poor communication or misunderstood transparency may add confusion, frustration and an emotional load. Most of this distress can be relieved by clear, consistent communication strategies that can be employed by healthcare providers and enhance the overall family experience when going through a crisis.

Emotional and practical needs are closely related in critical care, as is demonstrated in needs related to support, namely Lange et al. (2022), to talk about the possibility of patient death (79.7%) and to have someone to help with financial problems (66.3%). The fact that families are ready to discuss end-of-life decisions means that there exists an unmet need of compassion and honest discussions. Tavares et al. (2022), Financial burden, as well, was addressed as an urgent issue, which points to the multidimensional side of helping that families need. These factors imply that not only the treatment of patients is to be performed in ICUs, but the emotional, social, and economic support of the relatives is to be provided.

The needs related to comfort were considered as of rather low importance but still important. As an example, the desire to have a bathroom near the waiting room (77.0%), or to be accepted by hospital staff (69.3%) were considered as something necessary, whereas having comfortable furniture in the waiting room (20.4%) was not important at all. Dost (2024) mentioned in the study the responses are based on the notion that though physical comforts may contribute to family coping, they are a close second priority behind emotional reassurance and effective communication. Families can accept physical discomfort provided that they feel that their loved one is being treated properly and paid due attention throughout the care process.

The responses given especially on the expression of emotions had cultural influences. Such needs as to talk about negative feelings such as guilt or anger (24%) and to be encouraged to cry (29%) were regarded as of lower significance. It can be explained by the cultural traditions of Pakistan and South Asia when people view emotionality as a sign of weakness and it is rather unacceptable to talk about grief or express personal weaknesses in front of others (Ghazal et al., 2021). Such results imply that there is a requirement in relation to the development of culturally sensitive models of care that would identify different manifestations of emotional distress that are specific to distinct cultures and how the cultures define ways to cope with the distresses.

The issue of nurses in addressing these needs became one of the key themes in the study. Such needs as: to talk to the doctor every day (69.6%), to know about the staff who takes care of the patient (67.7%) were of high value to the family members pointing out to the significance of readable and kind communication. Nurses can serve as the much-needed source of communication and emotional support to families because of their constant presence at the bedside. Earlier studies indicated that family support initiatives facilitated by nurses have the capacity to enhance satisfaction, stress and family members left alone and at the lack of information (Shafiq, 2024).

On the whole, this study indicates that there is a lot to work on to meet needs of a family in the context of intensive care in Pakistan. Although medical care is important, the emotional, informational and psychological needs of the members of the family are not sufficiently addressed. Institutions can manage to assess these needs on a regular basis by use of standardized tools such as the Critical Care Family Needs Inventory (CCFNI) aiming at coming up with policies that gear towards family centered care. The meeting of these needs, on the one hand, can add value to family satisfaction and on the other hand, can

be potentially helpful in the state of critically ill patients during the recovery process.

Conclusion

The research findings show that the needs of family members of ICU patients are heterogeneous, and the most significant ones are assurance, information, and proximity. Emotional reassurance, good communication and being physically close to the loved ones were priority needs. Emotional expression and comfort were also significant and are representative of cultural coping styles in Pakistan. Empathy, communication, and involvement in decisions related to care are crucial roles that nurses can perform to meet these needs. Anxiety and dissatisfaction can arise because of unmet needs, particularly support and information needs. It is important to implement structured family support programs and culture sensitive communication. Family needs should also be periodically assessed as a part of ICU protocols. The priority of family-centered care needs to be increased to improve patient outcomes and care quality. Hospitals ought to prepare proactive policies and employees to support family needs. The solution to providing comprehensive ICU care rests with the empowerment of healthcare professionals.

Recommendations

1. **Enhance Communication Strategies:** To make the change, hospitals need to adopt a formal family communication plan that will guarantee frequent, timely and understandable family update on the situation with the patient. This involves the use of very basic and non- medical terminologies and provision of specific members of staff (including liaising nurses) when communicating with the families.

2. **Develop Family-Centered Policies:** ICU policies have to be changed so as to accommodate family-centered care. This involves having all day visiting times, including family members in making decisions and cultural, emotional and religious sensitivities among others.

3. **Provide Psychological Support:** Families in critical care units should make mental health support services available. Families may experience anxiety, fear and trauma on ICU admissions, and trained counselors or psychologists can address this.

4. **Use of Technology for Engagement:** Virtual updates, use of video calls, or mobile applications should be used to make the distant family or the working family aware and emotionally present with their loved ones in the ICU, especially when there are restricted access settings.

5. **Improve ICU Environment**: The physical space of the ICUs ought to be made family-friendly. Waiting areas should be quiet, there should also be lounges and individual meeting rooms and connections to spiritual care that can alleviate stress and increase satisfaction.

References

Abdul Halain, A., Tang, L. Y., Chong, M. C., Ibrahim, N. A., & Abdullah, K. L. (2022). Psychological distress among the family members of Intensive Care Unit (ICU) patients: A scoping review. Journal of clinical nursing, 31(5-6), 497-507.

Allen, B. C., Cummer, E., & Sarma, A. K. (2023). Traumatic brain injury in select low-and middle-income countries: a narrative review of the literature. Journal of neurotrauma, 40(7-8), 602-619.

Dost, G. (2024). Students' perspectives on the 'STEM belonging' concept at A-level, undergraduate, and postgraduate levels: an examination of gender and ethnicity in student descriptions. International Journal of STEM Education, 11(1), 12.

Duque-Ortiz, C., & Arias-Valencia, M. M. (2022). The family in the intensive care unit in the face of a situational crisis. Enfermería Intensiva (English ed.), 33(1), 4-19.

Gill, R. A. (2023). Environmental Affordance Index: Measurement Scales to Evaluate the Spatial Needs of Family Members within Adult ICUs (Doctoral dissertation, Arizona State University).

Ghazal, L., Arthur, D., Hussain, S., Khudadad, U., Malik, G., & Ali, Z. Z. (2021). Cry for help: perceptions of young adults on suicide from northern Pakistan.

Greenberg, J. A., Basapur, S., Quinn, T. V., Bulger, J. L., Schwartz, N. H., Oh, S. K., ... & Glover, C. M. (2022). Challenges faced by families of critically ill patients during the first wave of the COVID-19 pandemic. Patient Education and Counseling, 105(2), 297-303.

Kynoch, K., Ramis, M. A., & McArdle, A. (2021). Experiences and needs of families with a relative admitted to an adult intensive care unit: a systematic review of qualitative studies. JBI Evidence Synthesis, 19(7), 1499-1554.

Lange, S., Mędrzycka-Dąbrowska, W., Friganović, A., Religa, D., & Krupa, S. (2022). Family experiences and attitudes toward care of ICU patients with delirium: A scoping review. Frontiers in public health, 10, 1060518.

Leong, E. L., Chew, C. C., Ang, J. Y., Lojikip, S. L., Devesahayam, P. R., & Foong, K. W. (2023). The needs and experiences of critically ill patients and family members in intensive care unit of a tertiary hospital in Malaysia: a qualitative study. BMC Health Services Research, 23(1), 627.

Li, T., Wu, Y., Li, R., & Wang, S. (2025). Traumatic Memories and Nursing Experiences of ICU Discharged Patients: a systematic review and meta-synthesis of qualitative studies.

Molelengoane, N. S. (2021). Development of a Workshop to Assist Nurses to Meet the Needs of Family Members of Patients in the Critical Care Unit in a Private Hospital in Gauteng (Master's thesis, University of the Witwatersrand, Johannesburg (South Africa)).

Prust, M. L., Mbonde, A., Rubinos, C., Shrestha, G. S., Komolafe, M., Saylor, D., & Mangat, H. S. (2022). Providing neurocritical care in resource-limited settings: challenges and opportunities. Neurocritical care, 37(2), 583-592.

Ruppel, C., Stranzl, J., & Einwiller, S. (2022). Employee-centric perspective on organizational crisis: how organizational transparency and support help to mitigate employees' uncertainty, negative emotions and job disengagement. Corporate Communications: An International Journal, 27(5), 1-22.

Scott, P. (2021). Effects of a structured communication strategy on anxiety, uncertainty and satisfaction with care in families of critically ill adults.

Shafiq, S. (2024). An exploration of psychological and socio-cultural facets in perinatal distress of Pakistani couples: a triangulated qualitative study. BMC Pregnancy and Childbirth, 24(1), 596.

Tavares, A. P., Martins, H., Pinto, S., Caldeira, S., Pontífice Sousa, P., & Rodgers, B. (2022, November). Spiritual comfort, spiritual support, and spiritual care: A simultaneous concept analysis. In Nursing forum (Vol. 57, No. 6, pp. 1559-1566).

Vincent, J. L., & Creteur, J. (2022). Appropriate care for the elderly in the ICU. Journal of Internal Medicine, 291(4), 458-468.

Wilson, D., & Davidson, J. E. (2023). Family and cultural care of the critically ill patient. Critical Care Nursing, 180