

CULTURALLY DIVERSE FAMILY MEMBERS AND THEIR HOSPITALISED RELATIVES IN ACUTE CARE WARDS: A QUALITATIVE STUDY

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ABSTRACT

Objective:

To describe the experiences of culturally diverse family members who make the decision to stay with their relatives in acute care wards.

Design:

A qualitative descriptive study.

Setting:

Medical and surgical wards in an acute care hospital with a 70% non-English speaking background patient population.

Subjects:

Eight culturally diverse family members who stayed with their hospitalised relatives for at least four shifts or the equivalent hours.

Method:

In-depth interviews of approximately 45 minutes.

Findings:

Three main categories described the experience of family members. These categories were carrying out in-hospital roles, adhering to ward rules, and facing concerns.

Conclusions:

Findings indicate nurses and family members could benefit from negotiating active partnerships; family friendly ward environments need to be fostered, supported by appropriate policies; and further research is needed into culturally diverse family members' partnerships with nurses in acute care settings.

INTRODUCTION

Australia is a multicultural country (Roach 1997) with culturally diverse people encompassing people of Indigenous and migrant backgrounds (Roach 1999). When culturally diverse patients are hospitalised they often have a preference for their family member to stay with them. This preference results in nurses managing family member access during their relative's stay in hospital. However, little is known about the experiences of these culturally diverse family members. This study describes the experiences of family members who have stayed with their relatives during their hospitalisation.

In many cultures, illness is a family affair and family members play an important role in care-giving (Chang and Harden 2002). Family members have a right to support their hospitalised relatives (Johnson 1988). According to Chang and Harden (2002) nurses and other health care providers need to be willing to share the act of caring with family members so hospitalisation does not interfere with, for example, family responsibility and customs. When culturally diverse patients are admitted to acute care settings their families need to feel comfortable with the access to their relative that is available to them.

Family members involved in caring for hospitalised adults have been shown to exhibit vigilance (Carr and Fogarty 1999). Studies found two main forms of care are provided by family members: emotional support (Li et al 2000; Astedt-Kurki et al 1997; Laitinen 1994, 1993, 1992; Halm and Titler 1990); and visiting and helping with activities of daily living or procedures (Li et al 2000; Astedt-Kurki et al 1997; Laitinen 1994, 1993, 1992; Collier and Schirm 1992; Haggmark 1990; Halm and Titler 1990; Sharp 1990). Family involvement has been studied with two main groups of adult patients: the hospitalised elderly (Li et al. 2000; Higgins and Cadd 1999; Greenwood 1998; Collier and Schrim 1992); and the patient in critical care (Soderstrom et al 2003; Walters 1995; Halm and Titler 1990). No studies were found that focused on culturally diverse patients in acute care settings.

Studies have examined the needs and involvement of family members in the care of their hospitalised elderly relatives in acute care settings (Li 2005; Li et al 2000; Higgins and Cadd 1999; Greenwood 1998; Collier and Schrim 1992). In general, the needs of family members have been found to be for information, emotional support, hope, a caring attitude and to be close to their relative (Rutledge et al 2000). Further, aspects of family member dissatisfaction that have been identified include a lack of respect for themselves and their hospitalised relative, a lack of information, and inadequate care (Von Eigung 2000; Athlin et al 1993). However, little attention has been given to the culturally diverse family member who wishes to be involved in the care of their hospitalised relative despite nurses regarding the relationship between patients and their family as core to nursing care (Suhonen et al 2002; Astedt-Kurki et al 2001). This study explored the experiences of culturally diverse family members who made the decision to stay with their relatives in acute care wards during their relatives' hospitalisation.

METHOD

Research approach

This qualitative study describes experiences of culturally diverse family members staying with their hospitalised relatives on medical and surgical wards in an acute care hospital with a 70% non-English speaking background patient population. An interpretive-descriptive design in the qualitative tradition (Thorne et al 1997) has been selected to address the question as it can capture the multiplicity of family member experiences in acute care hospital wards.

Sampling

Eight family members who volunteered to join the study and met the inclusion criteria formed the purposive sample. The criteria for recruitment of a family member to the study were: had stayed with their hospitalised relative for at least four shifts or the equivalent hours; and were culturally diverse. The resultant sample of cultural diverse family members had lived in Australia for more than 10 years with seven having previous experience of hospitals (see table 1). Their hospitalised relatives were public patients in hospital from three to eight days with five being hospitalised for a surgical procedure and three for a medical condition.

Study sampling was based on the estimation of Kuzel (1992) that six to eight family members are required for a sample that is homogeneous with regard to a common experience. This experience was staying with a hospitalised relative on an acute care ward. Ethics approval was obtained from both the area health service and university human research ethics committees. All appropriate ethical aspects of the study were addressed to ensure the rights of participants were protected.

Table 1: Characteristics of family members

Characteristic	f=
Ethnicity	
- Lebanese	4
- Tongan	2
- Turkish	1
- Vietnamese	1
Gender	
- Male	1
- Female	7
Relationship	
- Spouse	4
- Daughter	3
- Son	1
Age Range (in years)	
21-40	2
41-60	4
61-80	2

Table 2: Main categories and subcategories that described family members' experiences

Category	Sub categories
Carrying out in-hospital roles	- being with their relative - helping the nurses - acting as an interpreter - being the family representative
Adhering to the ward rules	- going with the rules - recognising access as a privilege - tension around rules
Facing concerns	- person-centred - relative-centred

Data collection procedure

Each participant interview was scheduled at a time and place convenient to them. Interviews were approximately 45 minutes in duration and were audiotaped. All interviews were carried out by the investigator and commenced with the open-ended question, 'Can you tell me about your experience of staying with your hospitalised relative on the ward?' Participants were encouraged to talk freely about their experiences and feelings and asked to clarify, extend or explain further, if able, particular aspects of relevance to answering the research question. When the participant indicated they had no more to share pertinent to the question the interview was concluded. Each participant was asked if they were willing to be contacted when the findings of the study were available to consider their credibility in light of their experiences. Contact details of three participants were obtained.

Data preparation and analysis

Transcribed tapes were checked for accuracy then all transcriptions were read until a full understanding of their meaning was grasped (Thorne et al 1997).

Data were analysed using Lincoln and Guba (1985) approach with units of meaning being identified, then grouped into categories and subcategories based on similarity. Following this the resultant findings were presented to the three participants who had indicated a desire at the interview to be involved in the verification process. These participants considered their experiences were captured by the categories and subcategories. Bilingual health care workers who liaised with non-English speaking patients, their families and nursing staff on a daily basis were also shown the findings and indicated they reflected their experiences of working with culturally diverse family members.

FINDINGS

The family members described their experience of staying with their hospitalised relative within three main categories. These categories are: carrying out in-hospital roles; adhering to the ward rules; and facing concerns. The categories and subcategories are presented in table 2 followed by each category and its subcategories being described in detail.

Carrying out in-hospital roles

In-hospital roles identified were: being with their relative; helping the nurse; acting as an interpreter; and being the family representative. The role of being with their relative involved staying with their relative for various lengths of time. From family member descriptions this was in the form of a presence and occurred during the day and into the evening most usually. Below are examples of the nature of this presence for family members.

'It's sort of like a duty for us to come and look after her ... it's in the blood of us. Especially when we are sick ... in my heart I have to be here for her ...'

'In our culture when our loved ones come into hospital... we include ourselves in the situation. I'm here for him for everything he wants.'

Another role family members assumed when staying with their relatives was *helping the nurses*. For most family members this involved caring for their relative when at the bedside. A typical description is:

'Sort of helping, giving a hand to the nurses, helping daily living plan, things like that. It's our culture ... work all together ...'

As culturally diverse hospitalised relatives often experienced difficulties with language family members identified they were required to act as an interpreter for their relatives, for example:

'... he likes to have someone here to translate for him. Sometimes he has a question to ask and his English isn't good so he feels that he hasn't fully explained it to the doctor and that the doctor is not picking up on everything that he wants him to know. That's when he gets concerned.'

'My mum wouldn't like the ... interpreter. It's easier for her if one of her children is here. ... When we are here she can just tell us everything and we can tell the doctors and nurses.'

All the family members disclosed their families expected them to be the family representative. A typical comment by a family member was:

'The family depends on me, all of them. Whatever I will say they will say yes. I have to tell the family what's going on with our dad.'

Adhering to the ward rules

Family members showed they were extremely aware of the ward rules that arose from hospital policy. They showed they considered them when making decisions to be with their relatives. The need to go by the rules, to recognise access as a privilege and tensions associated with this situation were described by all family members. Typical descriptions of *going by the rules* are as follows:

'The hospital has its own rules ... have to go with them'

'... in my heart I know I want to sleep here with her but I have to go with their rules.'

They recognised access as a privilege that was extended to them most usually by nurses. The description below is an example.

'Usually I come every morning and stay up to eight hours. They allow me in just to look after him. I don't think that I'm in a position to ask for any more than that.'

Some tension around access that created discomfort for family members was described. These tensions were associated with obtaining permission and their actual presence at the bedside. The extracts below show that they were careful not to upset the access privileges they had been given. Examples are:

'When Mum's resting, I try to sneak out for a cup of tea but it's mainly just to get out of the way. I'm just very happy that they allow me to be here with her outside the visiting hours.'

'I never annoy them. I come here and give him his lunch then go downstairs. I come back at two. I didn't want them to see too much of me because some of them might say, "Why is she here?" I never disturb them.'

Facing concerns

Concerns family members had to face when they stayed with their relatives on the ward were both person- and relative-centred. Each family member expressed *person-centred concerns* about their experience of being with their relative that were varied and include: recognising they were not able to manage some aspects of their relative's care; being uncomfortable about situations they witnessed; finding the strength to continue to support their relative; and being worried.

Examples of personal concerns were:

'My Vietnamese isn't as good as my English so I find it hard to translate for my dad some of the stuff.'

'The nurses are short staffed and too busy to take care. ... they are trying their best. If I push them too much some of them are very, very short-tempered. They are not patient.'

'In my heart I just say things to God. He gives me the energy to come to the hospital and still have more energy to help, comfort him and keep him company during the day before I go home and have a rest in time for the next day.'

Family members were strongly aware of relative-centred concerns associated with being hospitalised. Expressed concerns involved their relatives' preferences, beliefs and emotional responses. Concerns focused on preferences included visiting and gender of attendants, for example:

'She finds it really hard as her visitors come in large numbers about ten or more at once. She knows how it is here and that makes her uncomfortable. In her heart she wishes that they come and go quickly.'

'As he is Tongan letting a male nurse wash a male is really a bit hard. He prefers a woman. So he just tells the male person who showers the men my wife will shower me.'

The beliefs that hospitalised relatives held for example about sickness were endorsed by the family members and in some cases influenced the interactions of family members with their relatives in the ward situation as demonstrated in example extracts below.

'He believes this illness is from God and God gives you the illness to clean up many things in a person. He really fears God so he is happy the sickness comes and he doubles his thanks to God with prayer. I help him to go to the end room to pray.'

'In the Tongan way if no one is around him he will feel lost. He'll feel I'm lost they've forgotten me he won't say it to me but I know the feeling because we're born with that feeling. So I need to be here for him.'

The emotional responses of relatives were often of concern to family members. Typical comments from family members were:

'He gets upset that some of the nurses don't try harder to listen and understand him. Their tone of voice, the way they looked down when he can't explain what he wants to say sometimes. He gets a bit upset about that.'

'My mum ... is one of those who is really, really scared when she is sick. That's why it is important we are here for her.'

The ward experience of a family member being with their hospitalised relative as described shows family members assume a series of roles that are supportive, pay attention to the rules of the ward and/or hospital and experience a number of concerns that are generated both from their relationship with their relative and the in-hospital situation.

DISCUSSION

The main findings that describe family members' experiences in-hospital provide insight into their bedside experiences including their involvement with their hospitalised relatives. In many instances this involvement epitomised vigilance as identified by Carr and Fogarty (1999, p.433) who described it to be a 'close protective involvement with a hospitalised relative'. Previous studies have shown positive outcomes for hospitalised relatives can be affected with such involvement (Hendrickson 1987; Simpson and Shaver 1990; Suhonen et al 2002). Further, the individualisation of patient care can be fostered (Suhonen et al 2002). This strongly indicates that family members at the bedside are very beneficial and nurses need to include family members when planning and implementing care for patients. With culturally diverse families this may well be more critical considering possible language and cultural difference.

Nurses are mainly responsible for managing the access of visitors to patients in wards where family members are with their relatives. This places nurses in a position where they are able to grant exceptions to the hospital visiting policy for family members. Whitis (1994) reported a similar authority existed in a study of visiting policies. Family members were very aware that access was a privilege granted to them by nurses. Violation of this privilege was an issue for them and they took care 'to go with the rules' and not aggravate or draw attention to their presence by the strategies they adopted. This indicates that culturally diverse family members were not comfortable with their access conditions.

There is an opportunity for nurses to negotiate an approach to access that respects cultural ways associated with illness and family care giving as recognised by Chang and Harden (2002). Further, a patient's right to the supportive presence of their family as identified by Johnson (1988) and Suhonen et al (2002) suggests this ethical imperative needs to be uppermost in the decision-making process.

The family member role of helping the nurse by giving care to their relatives confirms findings from other studies with intensive care patients (Halm and Titler 1990) and elderly patients in acute care settings (Collier and Schirm 1992; Laitinen and Isola 1996; Laitinen 1994, 1993, 1992). Family members in this study were carrying out caring activities on a voluntary basis and recognised there were elements of care giving they were unable to give or unfamiliar with and required nurses to provide. This aspect was not found in any previous study reviewed. Family members did not indicate they had negotiated their helping role with nurses. As well as the previously identified need to negotiate clearly defined access conditions nurses need to also determine with each family member how they wish to be involved in their relative's care. For example the aspects of care family members feel comfortable to provide and those they would like nurses to provide.

These details need to be documented to ensure all staff are familiar with the agreed plan of family member involvement in care.

The finding of the family member acting as an interpreter in the hospital setting was a role not previously identified in other studies and can be attributed to the culturally and linguistically diverse nature of the family members and their relatives. The informal use of family members as interpreters is a concern and needs careful consideration particularly in light of the family member who identified he had difficulty with translation. When family members are acting as interpreters for patients, nurses and other health professionals need to acquaint themselves with relevant policies and provide a formal means of using qualified interpreters by booking regular sessions during each patient's episode of care.

Some family members actually identified that nurses were short staffed, very busy and at times short-tempered. According to McQueen (2000) when nurses have heavy workloads, as is often the case today with higher patient acuity and short lengths of stay, they are prone to conveying their stress to others. Family members described nurses reacting in ways that suggest nurses were at times overwhelmed by work conditions as indicated by their responses in wards where their hospitalised relatives were. Interactions between family members and nurses have been found to be complicated by ward conditions (Astedt-Kurki et al 2001). Nurses need support to manage their work conditions appropriately and to build caring partnerships with a family focus.

Within family members' descriptions of their experiences there was little reference to the personal support they had received from nurses whilst at the bedside. This supports Greenwood's (1998) assertion that family members do not receive the attention and time they need on general wards. A finding by Hardacre (2003) provides insight into this situation as nurses indicated they felt inadequately prepared to address this aspect. Not only do nurses need to provide care for their patients they also need to pay attention to the emotional and other needs of family members particularly when providing support to their hospitalised relatives.

This study is small and only involves family members from a limited number of ethnic backgrounds. The focus on family members of adult patients in acute care settings requires more in-depth understanding than has been captured in this study. Difficulties with recruiting and interviewing family members who were at the bedside resulted from their in-hospital commitments to their relatives. Interviewing family members after their relative's discharge may result in improved recruitment and increased duration of each interview.

IMPLICATIONS AND RECOMMENDATIONS

Accommodating family members demands nurses immediately meet the challenge to engage with them in active partnerships sharing common goals and understandings. These partnerships need to be fostered in a family friendly environment where co-operation and equality are hallmarks of caring relationships. To support this, hospital policies need to be reviewed to increase their family friendly focus including flexible visiting times that facilitate family involvement. Further, nurses need to be prepared through continuing education programs to develop and sustain collaborative partnerships with family members with documentation of family involvement in clinical pathways, care plans and daily reports. Research into family members' involvement in the care of adult culturally diverse patients is required to explore, for example, access conditions and joint partnerships between nurses, family members and their relatives including family members from other ethnic backgrounds

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