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Families' perceptions of support from health care professionals in the three emergency departments in KwaZulu Natal, South Africa

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ABSTRACT

Purpose: The purpose of this study was to investigate families' perceptions of support provided by health care professionals in three emergency departments in KwaZulu-Natal, South Africa.
Background: In low- and middle-income countries, engagement with families in emergency departments is often aimed at supplementing manpower for care provision rather than supporting the family. There does, however, need to be appropriate family support, provided through ongoing collaboration and capacity-building with the family.
Design and methods: A quantitative survey of 353 family members of patients admitted to emergency departments was conducted in three emergency departments in the province of KwaZulu-Natal, South Africa. A well validated instrument, the Iceland-Family Perceived Support Questionnaire, was used to collect data on family perceptions of cognitive and emotional support received from health care professionals in the emergency department. Mean scores for overall family support, and cognitive and emotional support subscales were calculated.
Results: Family members gave significantly lower scores average for perceived cognitive and emotional support (8.7; 14.5) respectively, as compared to other studies using the same questionnaire. The mean overall support score for the questionnaire was (*22.3*, *sd 12.4*).
Conclusions: Families perceived significantly lower overall support from health care professionals in the emergency department as compared to the findings of international studies using The Iceland-Family Perceived Support Questionnaire. Although emergency care settings can be very busy, health care professionals need to engage with families to provide appropriate support in order to enhance families' ability to cope effectively.

1. Introduction and background

In seeking to establish holistic, quality health services, family-centred care has become an important area of focus for many health organisations. Family-centred care is defined as an approach to health care delivery that seeks to heal the family rather than just the ill family member (Wright & Bell, 2009). According to Bell (2014), the underlying assumption in this approach is that illness is a family experience whereby the family often suffers more than the ill family member. Shields (2015) argues that if family-centred care is about caring for a family in its sum, then health care cannot be divided into separate parts. In all interactions with families, health care professionals (HCPs) must capitalize on opportunities to build relationships and find ways to engage with family members (Bell, 2009). HCPs must recognize that relationships are central to family-centred care and use their understanding of these relationships to guide the practice of family-centred care. According to Kohi, Obogo, and Mselle (2016), illness of a loved one creates vulnerability in a family and gives rise to needs that must be addressed. Family-centred care acknowledges these needs and goes further to identify families as active collaborators with HCPs in determining the support required to meet these needs. Supportive care for families includes both cognitive and emotional support (Sveinbjarnardottir, Svavarsdottir, & Hrafnkelsson, 2012). Cognitive support includes participatory information sharing and education of the family that will improve the family's coping skills and build family capacity during the illness experience (Bruce, Lindh, Erlingsson, Lindkvist, & Sundin, 2016). Emotional support includes relational listening, empathy, and respect on the part of the HCP that will enhance personal well-being for the family (Dunst, Trivette, & Hamby, 2007). Both cognitive and emotional support are equally important for positive family functioning outcomes (Chelsea, 2010).

Admission of a loved one to the emergency department (ED) is a

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daunting experience for families. Two of the hallmarks of appropriately family-centred care are acknowledgement that families find the ED experience traumatic and destabilizing (Hsiao et al., 2017) and collaborating with the family to form mutually beneficial relationships (Shields, 2015). According to Bell (2013), rather than being limited to each specific context, family-centred care should be a routine approach to care where HCP–family partnerships are present in all health care encounters. Families report higher levels of satisfaction with care if they believe that their suffering is recognized by HCPs (Loghmani, Borhani, & Abbaszadeh, 2014).

In South Africa, ED admissions are mostly related to violence and crime (Hardcastle et al., 2011). In these conditions families are extremely anxious, and supportive care from HCPs lessens much of this anxiety (Botes & Langley, 2016). But ED staff traditionally tend to focus on control rather than emotions, and this may impede collaboration with families (Mentis, Reddy, & Rosson, 2010). While the principal goal of the ED is efficient stabilization of the patient, taking cognizance of a family's needs for supportive care remains an important aspect of family–HCP collaboration. Nonetheless, in EDs where families participate in direct patient care, conflict with HCPs may cause difficulty, since family perceptions of provider care are likely to affect both application and efficacy of the care (Foster, Whitehead, & Maybee, 2010).

Shields (2015) highlights that infra-structure and human resources in health services have to be aligned to a family – centred approach, explaining that limited space and shortages of staff can pose difficulties in caring for a family comprising of many people. This poses significant problems for middle and low income countries where poor infrastructure, and high patient to HCP ratios are characteristic of their EDs (Almaze & de Beer, 2017; Baretto, de Arruda, Garcia-Viva, & Marcon, 2017). Shields, Çavuşoğlu, Pars, and Mamun (2015) state that in developing countries family members can often be seen in hospital units providing care to patients mainly due to staff shortages. They caution against assuming that family presence is an indication of HCPs collaborating with families.

According to Dieperink, Coyne, Creedy, and Østergaard (2018), perceptions of supportive care may differ between families and HCPs. Similarly Dudley, Ackerman, Brown, and Snow (2015) note that a family's perceptions of the risks and benefits associated with support provided by HCPs may differ from the perceptions of the care provider. These mismatched family–HCP perceptions can deter implementation of family-centred care (Wilson et al., 2015). Byczkowski et al. (2016) make the point that it is important for HCPs to appreciate what families require and value, and Espe-Sherwindt (2008: 136) advises that the 'voice of the family' must guide development of family care interventions so that the family's perceptions of supportive care feed directly into development of a supportive family intervention.

Health care professionals often believe that they are supporting families adequately, but when families are asked to evaluate this support problems become apparent. These considerations have led us to the question that frames our investigation: What are families' perceptions of support provided by health care professionals in three emergency departments in KwaZulu-Natal, South Africa?

2. Materials and methods

2.1. Study design

A quantitative survey of 353 family members of patients admitted to emergency departments was conducted in three emergency departments using as validated instrument the Iceland-Family Perceived Support Questionnaire [ICE -FPSQ] (Sveinbjarnardottir et al., 2012).

2.2. Settings

The study was conducted in two state hospitals and one private hospital, each with dedicated EDs. In each of these hospitals a philosophy of holistic and family care is a core value. As part of their policy, all three EDs encourage one family member to accompany the patient. The selected hospitals provide inclusive district, regional and tertiary health services to rural, urban and informal settlement populations in KwaZulu-Natal. According to Gundo, Bodole, Lengu, and Maluwa (2014), family perceptions of HCP support may be influenced by socioeconomic and cultural backgrounds (multicultural in this context) along with geographical factors such as distance from care. Hospitals in South Africa have a heterogeneous character that reflects these factors. Choice of the study settings was therefore intended to ensure representativeness of the population of KwaZulu-Natal.

2.3. Participants, sample and sampling

Permission was sought from hospital management to review the ED registers to establish total number of patients visiting each ED within a seven-day period: ED A (Private) = 351, ED B (State 1) = 1350, ED C (State 2) = 199, with an estimated total of 1900 patients. Using ± 5% precision levels, CI 95%, power 80% and p = 0.5, and based on estimated patient population in each ED and an assumption of one family member per patient, a minimum of 334 family members were purposively selected (Israel, 1992). Inclusion criteria were (i) family member expressly indicating a sense of belonging to a patient admitted to the ED, or person that a communicating patient has defined as family or being significant to them, (ii) age 18 years or older, (iii) accompanying the patient during the ED admission, and (iv) literate in English and/or isiZulu (the local indigenous language*).* This quantitative phase was the first part of a larger study, where participants had to have sufficient knowledge, experience and interest in the study to be invited to the interviews in the second phase. Hence the rationale for purposive sampling.

2.4. Measurement tool

The ICE-FPSQ was used with permission from the developers to measure perceptions of support. The questionnaire has a well-established existing Cronbach's alpha (α) reliability co-efficient of 0.96, with cognitive subscale $\alpha = 0.88$ and emotional subscale $\alpha = 0.95$ (Sveinbjarnardottir et al., 2012). The instrument has 14 statements divided into two support subscales: cognitive support (5 statements) and emotional support (9 statements). The cognitive subscale deals with the support provided by HCPS on capacity building with families that leads to self-reliance and empowerment (Sveinbjarnardottir et al., 2012). The developers define emotional support as HCPs engaging with families, to allow for open expression and acknowledgment of feelings associated with the illness experience. The statements were measured on a 5-point Likert scale ranging from 1 (almost never) to 5 (almost always). ICE-FPSQ scores range from a minimum of 14 to a maximum of 70 points, with a higher score predicting perceptions of greater support. The cognitive and emotional subscales have minimum and maximum scores of 5 to 25, and 9 to 45 respectively. A limitation of the questionnaire is that there are no exact scores specified to distinguish sufficient or insufficient support of HCPs (Dieperink et al., 2018). The questionnaire was selected on its suitability for the ED, as it has been tested in various clinical settings globally with families experiencing both chronic and acute illnesses. Of significance to the study is that the ICE –FPSQ was developed in Sweden, Iceland, where there is a stronger ethos of family centred care than in other countries (Saveman, 2010). Furthermore the Icelandic family researchers are leaders in translating family research findings evident in the establishment of a specialized tertiary university hospital where family care is implemented in all units (Svavarsdottir, 2008). The ICE-FPSQ was translated into isiZulu with permission from the developers. The translation was done by two bilingual translators, using the forward–backward method to ensure that the content and meaning of the translated isiZulu version matched the English version. Internal face validity was achieved by review of expert translators before being piloted in all three settings with 30 participants selected through a convenience sample. The reliability coefficient of the isiZulu questionnaire showed excellent overall internal consistency $\alpha = 0.95$, with cognitive support subscale $\alpha = 0.80$, and emotional support subscale $\alpha = 0.93$.

2.5. Data collection

Data were collected in February 2017, during a one-week period in each of the three EDs by a bilingual English/isiZulu research assistant and the researcher (WE). The research assistant was trained by the researcher so that their approaches to data collection were standardised. The researcher and/or research assistant approached family members in waiting rooms designated for patients who are mobile, in wheelchairs or on stretchers, and their accompanying family members awaiting prescriptions for medication, appointments for follow-up prior to discharge, or beds for admission. Family members who gave written informed consents were given the questionnaires to complete, which were returned directly to the researcher in sealed envelopes before the respondent left the waiting room.

2.6. Statistical analysis

Data were entered into SPSS (v26) as per instrument instructions, and mean scores were calculated for overall support and the cognitive and emotional support subscale items. The independent sample *t*-test and ANOVA test were performed to examine the influence of demographic characteristics (age, gender, relationship to patient and type of residence) on the subscale and overall support score, with a *p* value of < 0.05 being considered statistically significant. Missing data was evident in both subscales and scores. Data were computed based on the total number of non-missing cases.

2.7. Ethical considerations

Permissions were obtained from the ethics committee of the university (Ref HSS/1731/015D), the KZN Department of Health (HR KM44/16 KZ_2016 RP 22_946) and hospital management of all three hospitals. Respondents were clearly informed in an information sheet about their rights as participants in the study including the right to withdraw during the filling of the questionnaire with no consequences. Confidentially was fully maintained throughout the study.

3. Results

A 100% response rate was obtained for the 353 questionnaires administered: ED A (9.3%; $n = 33$), ED B (82.2%; n = 290) and ED C (8.5%; $n = 30$).

3.1. Demographic characteristics of family members

Roughly two thirds of the respondents spoke isiZulu (68.0; $n = 240$) and were female (62.3%; $n = 220$). In relationship to patient, mothers dominated (21.8%; $n = 77$), consistent with findings in previous studies (Balbino, Balieiro, & Mandetta, 2016; Stuart & Melling, 2014). Majority of family members (60.3%; $n = 213$) were in the age range 30 to 49 years. Nearly three quarters of the respondents were from urban areas (70. 3%; $n = 248$), similar to findings in the study by Byczkowski et al. (2016) in which family members from urban areas comprised 59% of the participants (Table 1).

3.2. Overall perceptions on support (Table 2)

The average family support score for the questionnaire was 22.3 (*sd* 13.7), noting that the questionnaire has minimum and maximum scores of 14 to 70. Family members responses per statement were in the lower part of the rating scale at 1.6 (1.3 ± 1.8).

Table 1
Demographic characteristics of family members *(n = 353)*.

Characteristics	Categories	Frequency (%)
Gender	Male	133 (37.7)
	Female	220 (62.3)
Age	< 30	66 (18.7)
	30–49	213 (60.3)
	≥507	4 (21.0)
Relationship to patient	Mother	77 (21.8)
	Father	52 (14.7)
	Spouse	53 (15.0)
	Child	42 (11.9)
	Grandparent	17 (4.8)
	Sibling	14 (4.0)
	Guardian	33 (9.3)
	*Other	65 (18.4)
Type of residence	Informal	60 (17.0)
	Rural	45 (12.7)
	Urban	248 (70.3)

* Other category includes participants indicated as significant by patient but who not did not fit into the other categories.

3.3. Perceptions of cognitive support (Table 2)

The cognitive support subscale had a mean score of 8.7 (*sd* 5.2), with minimum and maximum scores of 5 and 25 respectively. The mean scores for each statement was low (1.2, *sd* 0.7; 1.9, *sd* 1.3). The most highly rated statements in this subscale were CS2 and CS3 (mean 1.9, *sd* 1.2). The lowest rated statement was CS5 (mean 1.2, *sd* 0.7).

3.4. Perceptions of emotional support (Table 2)

The mean score on the emotional support scale was 14.5 (*sd* 9.6), with a minimal and maximum scores of 9 to 45 respectively. Average scores for each statement ranged between 1.3 (*sd* 0.9) to 1.7 (*sd* 1.1). The most highly rated statements in this subscale were ES1 and ES3 (mean 1.7, *sd* 1.2). The lowest rated statement was ES7 (mean 1.3, *sd* 0.9).

3.5. Influence of demographic characteristics on family support scores (Table 3)

Female respondents had statistically significantly lower mean cognitive support scores compared to males (8.2; $p = 0.035$). Similar lower mean scores for females compared to males were noted in the emotional support subscale and the overall support scores (13.9; 21.3), however these were not statistical significant. There were also statistically significant differences between the age group and relationship to patient categories and the subscales and overall support scores.

The mean subscales and overall support scores were significantly lower for the age group ≥50 years (7.6; 12.8; 19.7) compared to the other age groups. Regarding relationship to patient, children of patients obtained lower mean scores for the subscales and overall score (6.2; 10.3; 16.2) compared to other family relationships to patients. Study respondents residing in informal areas had lower subscale and overall support scores than urban and rural residents (7.9; 13.8; 20.3) suggesting that families residing in informal areas perceived low family support from HCPs working in the ED. Statistically there were no significant differences between families' perceived support and type of residence.

4. Discussion

The mean overall support score for the questionnaire was 22.3. This

Table 2
Families perceived mean subscale and overall support scores *(N = 353, unless otherwise stated, in bold print)*.

Statements	Mean Score (*sd*)
Cognitive support (CS) subscale	8.7 *(5.2)*
CS1. The staff offered us information and their professional opinion	1.8 *(0.3)*
CS2. The staff provided available and easy-to-read literature about the health problem	1.9 *(1.2)*
CS3. The staff informed my family about the resources available in the community that helped families in similar situations	1.9 *(1.2)*
CS4. The staff provided ideas, information and thoughts in a manner which allowed us to learn from them and think about them ***(n = 351)***	1.7 *(1.2)*
CS5. The staff highlighted the use of family rituals (acts/prayers) to promote our health ***(n = 327)***	1.2 *(0.7)*
Emotional support (ES) subscale	**14.5*(9.6)***
ES1. The staff offered us family discussions ***(n = 350)***	1.7 *(1.1)*
ES2. The staff helped family members recognize that our emotional response is acceptable and helped us to normalize family members' emotional response ***(n = 352)***	1.5 *(1.1)*
ES3. The staff encouraged my family to become involved with the health care team in the care of our family member and have offered us support	1.7 *(1.2)*
ES4. The staff encouraged family members to share their illness stories -not only stories of illnesses and suffering, but also stories of strength and ability to tolerate illness	1.4 *(1.0)*
ES5. The staff drew out our family strengths ***(n = 350)***	*1.6 (1.1)*
ES6. The staff helped family members understand how our emotional response is related to the family member's illness ***(n = 352)***	1.5 *(1.1)*
ES7. The staff encouraged my family to take a break from caregiving sometimes ***(n = 335)***	1.3 *(0.9)*
ES8. The staff understand how family members affect one another, the patient's health and also the illness itself ***(n = 350)***	1.5 *(1.1)*
ES9. The staff looked for the family's strengths and opportunities to commend family members when their strengths have been revealed ***(n = 350)***	1.6*(1.1)*
OVERALL SCORE	***22.3 (12.4)***

was in significant contrast to the findings in a Danish and Australian study on oncology patients and families, in which Dieperink et al. (2018) reported an overall average family support score of 44.3. In another study in outpatient clinics in Sweden, parents score for overall family support by nurses was 33.8 (Bruce et al., 2016). Using different family support questionnaires, low HCP support was revealed in a cross-sectional Australian study (Gill et al., 2013) and a North Queensland study (Smyth, Abernethy, Jessup, Douglas, & Shields, 2017). These findings appear unsurprising in view of the numerous challenges in putting family-centred care into effect in clinical practice (Dudley et al., 2015; Hsiao et al., 2017). Notably, when family research findings were translated into practice in an interventional study in Iceland, a significant increase in perceived family support was evident post intervention. This reinforces the suggestion that family care interventions may produce a measurable improvement in family support (Svavarsdottir & Sigurdardottir, 2013).

In this study, participants' perception of cognitive support from HCPs in the ED scored alarmingly low at 8.7, in comparison with studies by Dieperink et al. (2018) and by Bruce et al. (2016) in which the corresponding figures, respectively, for family members' average perceived cognitive support from nurses and parents' perception of cognitive support were 19.8 and 14.0.

HCP support regarding family rituals and prayer was also perceived as low by participants. This is contrary to the findings of De Beer and Brysiewicz (2016) South African study of family needs in an intensive care setting, where it was revealed that nurses and doctors were extremely sensitive and co –operate regarding family's rituals and prayer. In a study in Ghana, within the ED setting, parents of road traffic accident victims also expressed that HCPs encouraged them to complement medical management with prayer and rituals (Ohene, 2017).

Majority of the family members perceived that the cognitive support from HCPs regarding meaningful communication that allowed for capacity building was lacking. HCPs received low scores on support regarding communicating of information and their professional opinions to families. Similar dissatisfaction with lack of communication was also expressed by family members in another study conducted in an ED in South Africa by Botes and Langley (2016); it was therefore flagged as an area for further research. In a study in Taiwan that compared family members' perceptions with emergency nurses' perceptions in regard to meeting of family needs, Hsiao et al. (2017) likewise identified effective communication as a gap in ED care of the family. According to Obringer, Hilgenberg, and Booker (2012), effective communication in the ED improves family understanding of the illness and reduces the cognitive gap between family members and HCPs.

Again family members in the current study perceived lower emotional support from HCPs (14.5) as compared to international studies by Bruce et al. (2016), where parents in their study perceived average emotional support from nurses (19.0, *sd* 10.3) and Dieperink et al. (2018). According to Dieperink et al. (2018) families that indicate low emotional support from HCPs have unmet emotional needs that impact negatively on their ability to cope. Coco, Tossavainen, Jääskeläinen, and Turunen (2013) suggest that training programmes need to be developed to equip HCPs with better skills to help families that are experiencing difficult emotions.

The majority of the participants (79%) in the current study indicated lack of HCP support in regard to families taking a break from caregiving and in understanding their emotional responses. Nygårdh, Wikby, Malm, and Ahlstrom (2011) point out that family members who support a sick relative have feelings of frustration and guilt that they need to express. MacKean, Thurston, and Scott (2005) noted that family members feel guilty about revealing that they need a break from caregiving that leaves them overwhelmed with responsibility and suffering from emotional and physical strain. Our study participants also failed to respond to most of the statements in the questionnaire that dealt with sharing emotions with HCPs. According to Nelms and Eggenberger (2010), family members' efficacy in coping is increased when they are able to share their emotions through empathetic collaboration with HCPs.

Perceived levels of HCP support were lower as reported by female family members in the study than as reported by male family members.

Table 3
Influences of demographic characteristics on family support scores.

Demographic Categories	*Cognitive support subscale* scores (*p* value)	*Emotional support subscale* scores (*p* value)	Overall support scores (*p* value)	Test
Gender	0.035	0.126	0.076 *t*-test	
Age	< 0.001	0.026	< 0.002	ANOVA
Relationship to patient	< 0.001	< 0.001	< 0.001	ANOVA
Type of residence	0.481	0.766	0.403	ANOVA

Tedford and Price (2011) surmise that mothers, as the chief carer, accompany their children to hospital more often and it could be assumed that as primary carers they have greater expectations of support from HCPs.

Our data indicated that older family members perceived HCP support as low compared to other age groups. Hsiao, Chu, Sung, Perng, and Wang (2014) suggest that because elderly caregivers are not physically strong as younger caregivers they may display fewer caring behaviours; it could therefore be assumed that reduced physical ability also results in older family members needing more support from HCPs.

With all categories of participant relationship to patient, family members perceived overall support from HCPs as low ($p = 0.001$). This finding of strong family member relationships needs to be seen in the context of the South African family, which is characteristically extended rather than nuclear and in which members share emotional ties (Koen, 2013). The South African family is defined furthermore by Erlingsson and Brysiewicz (2015) as individuals who are happy together and among whom family members are emotionally or physically dependent, or resource dependent, on each other. Notably, children of patients in this study perceived overall support from HCPs as low. This is reiterates the findings of LaVela et al. (2016) in which older caregivers perceived better FCC compared with younger caregivers.

Study participants living in informal areas had an overall perception of support provided by HCPs as low. Type of residence was considered indicative of socioeconomic status and accessibility to ED services. The 2012 status report on informal settlements noted that informal settlements in South Africa are inappropriately located and beset by poverty (Africa & Agency, 2012). Family members residing in informal settlement may consequently have both health vulnerabilities and deficient social support networks that result in heightened expectations of needed support from HCPs.

5. Strengths and limitations

The study findings indicate family members' concerns regarding support from HCPs in resource-limited emergency departments. The findings can potentially inform development of specific practices of supportive care engineered to accommodate families' expressed concerns. The tool was also validated in both English and isiZulu. A limitation was that data collection was conducted in the waiting rooms of the EDs after the patients had received treatment, and there is a concern that their interaction with HCPs may have produced biased responses to the questions. Missing data in both subscales was also identified as a limitation and some investigation is needed to establish the relevance of the statements where families did not respond to the South African setting. Due to the small sample size of the private setting, the authors acknowledge that a comparative study across the three settings was not possible.

6. Conclusions

The study indicates that overall support from health care professionals in the ED as perceived by families was lower than in comparable international studies in which the questionnaire was used. This indicates a possible gap in family support and family engagement in the ED and need for more focused supportive care in the ED. Emergency departments in both developing and developed countries face challenges in implementing the family-centred care approach. The challenges centre mainly on resource constraints and a rapid-pace, patient-focused clinical environment, but at the same time they reinforce the need to support families in their experience of these circumstances. The study acknowledges this need and addresses it.

7. Relevance to clinical practice

Initiatives for both cognitive and emotional support should be formulated for better promotion of family engagement and empowerment in emergency departments. Emergency nurses must encourage families to talk about their ED experience, eliciting suggestions from family members that will help to cultivate family partnerships with HCPs. Family policies and guidelines may need to be reviewed to show family support in the ED.

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Ethical approval details

The study has complied with the code of ethics of the World Medical Association in accordance to international ethical standards. Permission was obtained from all gatekeepers and the department of health. Ethical approval was obtained from the relevant ethics committee/ref HSS/1731/015D.

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References

Almaze, J. B. P., & de Beer, J. (2012). Patient and family-centred care practices of emergency nurses in emergency departments in the Durban area, KwaZulu-Natal, South Africa. *Southern African Journal of Critical Care, 33*(2), 59–65. https://doi.org/10.7196/SAJCC.2017.v33i2.317.

Balbino, F. S., Balieiro, M. M. F. G., & Mandetta, M. A. (2016). Measurement of Family-centered care perception and parental stress in a neonatal unit. *Revista Latino-Americana de Enfermagem, 24*, 1–8. https://doi.org/10.1590/1518-8345.0710.2753.

Baretto, M. D. S., de Arruda, G. O., Garcia-Viva, C., & Marcon, S. S. (2017). Family centred care in emergency departments: perceptions of Brazilian nurses and doctors. *Escola Anna Nery, 21*(2), 1–7. https://doi.org/10.5935/1414-8145.20170042.

Bell, J. M. (2009). Family systems nursing: Re-examined. *Journal of Family Nursing, 5*(2), 123–129. https://doi.org/10.1177/1074840709335533.

Bell, J. M. (2013). Family nursing is more than family centered care. *Journal of Family Nursing, 19*(4), 411–417. https://doi.org/10.1177/1074840713512750.

Bell, J. M. (2014). Creating a culture of feedback in family nursing. *Journal of Family Nursing, 20*(4), 383–389. https://doi.org/10.1177/1074840714559505.

Botes, M., & Langley, G. (2016). The needs of families accompanying injured patients into the emergency department in a tertiary hospital in Gauteng. *Curationis, 39*(1), 1–7. https://doi.org/10.4102/curationis.v39i1.1567.

Bruce, E., Lindh, V., Erlingsson, C., Lindkvist, M., & Sundin, K. (2016). Translation and testing of the Swedish version of the Iceland-Family perceived support questionnaire with parents of children with congenital heart defects. *Journal of Family Nursing, 22*(3), 298–320. https://doi.org/10.1177/1074840716656343.

Byczkowski, T. L., Gillespie, G. L., Kennebeck, S. S., Fitzgerald, M. R., Downing, K. A., & Alessandrini (2016). Family-centred pediatric emergency care: A framework for measuring want parents want and value. *Academic Pediatrics, 16*, 327–335. https://doi.org/10.1016/j.acap.2015.08.011.

Chelsea, C. A. (2010). Do family interventions improve health? *Journal of Family Nursing, 16*(4), 355–377. https://doi.org/10.1177/1074840710383145.

Coco, K., Tossavainen, K., Jääskeläinen, J. E., & Turunen, H. (2013). The provision of emotional support to families of traumatic brain injury patients: Perspectives of Finnish nurses. *Journal of Clinical Nursing, 22*, 1467–1476. https://doi.org/10.1111/jocn.12136.

De Beer, J., & Brysiewicz, P. (2016). The needs of family members of intensive care unit patients: A grounded theory study. *Southern African Journal of Critical Care, 32*(2), 44–49. https://doi.org/10.7196/SAJCC.2016.v32i2.298.

Dieperink, K. B., Coyne, E., Creedy, D. K., & Østergaard, B. (2018). Family functioning and perceived support from nurses during cancer treatment among Danish and Australian patients and families. *Journal of Clinical Nursing, 27*, 271–278. https://doi.org/10.1111/jocn.13894.

Dudley, N., Ackerman, A., Brown, K. M., & Snow, S. K. (2015). Patient- and family-centered care of children in the emergency department. *Pediatrics, 135*(1), 255–277. https://doi.org/10.1542/peds.2014-3424.

Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). Meta-analysis of family-centered help giving practice research. *Mental Retardation and Developmental Disabilities Research Reviews, 13*, 370–378. https://doi.org/10.1002/mrdd.20176.

Erlingsson, C., & Brysiewicz, P. (2015). Swedish and South African nursing students' description of family. *Journal of Nursing Scholarship, 47*(3), 228–236. https://doi.org/10.1111/jnu.12133.

Espe-Sherwindt, M. (2008). Family-centred practice: collaboration, competence and evidence. *Support for Learning, 23*(3), 136–143. https://doi.org/10.1111/j.1467-9604.2008.00384.x.

Foster, M., Whitehead, L., & Maybee, P. (2010). Parents' and health professionals' perceptions of family centred care for children in hospitals, in developing and developing countries. *International Journal of Nursing Studies, 47*(9), 1184–1193. https://doi.org/10.1016/j.ijnurstu.2010.05.005.

Gill, F. J., Pascoe, E., Monterosso, L., Young, J., Burr, C., Tanner, A., & Shields, L. (2013). Parents and staff perception of family-centered care in two Australian children's hospitals. *European Journal for Person Centered Healthcare, 1*(2), 317–325. https://doi.org/10.5750/ejpch.v1i2.665.

Gundo, R., Bodole, F., Lengu, E., & Maluwa, A. (2014). Comparison of nurses' and families' perception of family needs in critical care unit at referral hospitals in Malawi. *Open Journal of Nursing, 4*, 312–320. https://doi.org/10.4236/ojn.2014.44036.

Hardcastle, T. C., Steyn, E., Boffard, K., Goosen, J., Toubkin, M., Loubser, A., ... Wallis, L. (2011). Guideline for the assessment of trauma centres for South Africa. *South African Medical Journal,, 101*(3), 189–194. Retrieved 20 January 2013 http://www.samj.org.za/index.php/samj/article/view/4682.

Hsiao, P. C., Chu, C. M., Sung, P. Y., Perng, W. C., & Wang, K. Y. (2014). Differences in COPD patient care by primary family caregivers: an age-based study. *PLoS One, 9*(9), 1–10. https://doi.org/10.1371/journal.pone.0107870.

Hsiao, P. R., Redley, B., Hsiao, Y. C., Lin, C. C., Han, C. Y., & Lin, H. R. (2017). Family needs of critically ill patients in the emergency department. *International Journal of Emergency Nursing, 30*, 3–8. https://doi.org/10.1016/j.ienj.2016.05.002.

Israel, G.D. (1992). Determining sample size. University of Florida, 1-5. < https://www.psycholosphere.com/Determining%20sample%20size%20by%20Glen%20Israel.pdf > Retrieved 20 March, 2016.

Koen, V. (2013). Psychosocial well-being of families in a South African context: A prospective multifactorial model. *Journal of Psychology in Africa, 23*(3), 409–418. https://doi.org/10.1080/14330237.2013.10820645.

Kohi, T. W., Obogo, M. W., & Mselle, L. T. (2016). Perceived needs and level of satisfaction with care by family members of critically ill patients at Muhimbili National Hospital intensive care units, Tanzania. *BMC Nursing, 15*(18), 1–7. https://doi.org/10.1186/s12912-016-0139-5.

LaVela, S. L., Turcios, S., Malhiot, A., Etingen, B., Hill, J. N., & Miskevics, S. (2016). Do perceptions of family-centered care differ in older and younger family/caregivers of U.S. veterans? *Families, Systems, & Health, 34*(2), 136–149. https://doi.org/10.1037/fsh0000173.

Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the nurse-patients' family communication in intensive care unit of Kerman: A qualitative study. *Journal of Caring Sciences, 3*(1), 67–82. https://doi.org/10.5681/jcs.2014.008.

MacKean, G. I., Thurston, W. E., & Scott, C. M. (2005). Bridging the divide between families and health professionals' perspectives on family-centred care. *Health Expectations, 8*, 74–85. https://doi.org/10.1111/j.1369-7625.2005.00319.x.

Mentis, H. M., Reddy, M., & Rosson, B. M. (2010). Invisible emotion: Information and interaction in the emergency room. *Computer Supported Cooperative Work* 10.1.1.377.9457&rep = rep1&type = pdf.

Nelms, T. P., & Eggenberger, S. K. (2010). The essence of the family critical illness experience and nurse-family meetings. *Journal of Family Nursing, 16*(4), 462–486. https://doi.org/10.1177/1074840710386608.

Nygårdh, A., Wikby, K., Malm, D., & Ahlstrom, G. (2011). Empowerment in outpatient care of patients with chronic kidney disease – from the family member's perspective. *BioMed Central Nursing, 10*(21), 1–8. https://doi.org/10.1186/1472-6955-10-21.

Obringer, K., Hilgenberg, C., & Booker, K. (2012). Needs of adult family members of intensive care unit patients. *Journal of Clinical Nursing, 21*(11–12), 1651–1658. https://doi.org/10.1111/j.1365-2702.2011.03989.x.

Ohene, L.A. (2017). Perceptions of Family Centred Care for Children in Ghana Hospitalised through Road Traffic Accident. A Thesis Submitted in Partial Fulfilment of the Requirements for the Award of Doctor of Philosophy, Health and Life Sciences De Montfort University, Leicester, UK. Retrieved from file:///E:/article%201/FCC%20STUDY%20FOR%20e-thesis%20.pdf.

Saveman, B. (2010). Family Nursing Research for Practice: The Swedish Perspective. *Journal of Family Nursing, 16*(1), 26–44. https://doi.org/10.1177/1074840709360314.

Shields, L. (2015). "What is family-centered care"? *European Journal for Person Centered Healthcare, 3*(2), 139–144. Retrieved 18 January 2016 ubplj.org/index.php/ejpch/article/download/993/993.

Shields, L., Çavuşoğlu, H., Pars, H., & Mamun, A. A. (2015). Measuring family-centred care: working with children and their parents in a Turkish hospital. *European Journal for Person Centred Healthcare, 3*(3), 327–333. https://doi.org/10.5750/ejpch.v3i3.985.

Smyth, W., Abernethy, G., Jessup, M., Douglas, T., & Shields, L. (2017). Family-centred care in cystic fibrosis: A pilot study in North Queensland, Australia. *Nursing Open, 4*(3), 168–173. https://doi.org/10.1002/nop2.84.

South Africa. Housing Development Agency. (2012). South Africa: Informal settlements status, Research Reports: Research Series. Johannesburg: Housing Development Agency. www.thehda.co.za/uploads/files/HDA_Informal_settlements_status_South_Africa.pdf. Retrieved 17 January, 2017.

Stuart, M. S., & Melling, S. (2014). Understanding nurses' and parents' perceptions of family-centered care. *Nursing Children and Young People, 26*(7), 16–20. https://doi.org/10.7748/ncyp.26.7.16.e479.

Svavarsdottir, E. K. (2008). Excellence in nursing: a model for implementing family systems nursing in nursing practice at an institutional level in Iceland. *Journal of Family Nursing, 14*(4), 456–468. https://doi.org/10.1177/1074840708328123.

Svavarsdottir, E. K., & Sigurdardottir, A. O. (2013). Benefits of a brief therapeutic conversation intervention for families of children and adolescents in active cancer treatment. *Oncology Nursing Forum, 40*(5), 346–357. https://doi.org/10.1188/13.ONF.E346-E357.

Sveinbjarnardottir, E. K., Svavarsdottir, E. K., & Hrafnkelsson, B. (2012). Psychometric development of Iceland-Family Perceived Questionnaire (ICE-FPSQ). *Journal of Family Nursing, 18*, 328–352. https://doi.org/10.1177/1074840712449203.

Tedford, J., & Price, J. (2011). Role of the nurse in family-centred care. *Cancer Nursing Practice, 10*(2), 14–18. https://doi.org/10.7748/cnp2011.03.10.2.14.c8392.

Wilson, M. E., Kaur, S., Gallo De Moraes, A., Pickering, B., Gajic, O., & Herasevich, V. (2015). Important clinician information needs about family members in the intensive care unit. *Journal of Critical Care Nursing, 30*(6), 1317–1323. https://doi.org/10.1016/j.jcrc.2015.07.028.

Wright, L.M., & Bell, J.M. (2009). Beliefs and illness: A model for healing. Calgary, Alberta, Canada: 4th Floor Press. Beliefs and illness_2009.pdf; jsessionid = 85C4DA60ADBA573E510186C325BFD587. Retrieved 29 February 2013.