

# Patient- and family-centred care practices of emergency nurses in emergency departments in the Durban area, KwaZulu-Natal, South Africa

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**Background.** Admission of a loved one to an emergency/critical care unit can result in role conflict, high levels of stress, interruption of normal routines and potential changes in relationships among family members (FMs). Other potential stressors that FMs can be exposed to are deterioration in the condition of the patient, an uncertain outcome for the patient, pain and suffering experienced by the patient, the unfamiliar environment, and the large amount of high-tech equipment. An approach to support FMs during this crisis period is patient- and family-centred care (PFCC).

**Objectives.** To describe PFCC practices of emergency nurses in emergency departments (EDs) in KwaZulu-Natal (KZN) Province, South Africa.

**Methods.** A descriptive survey was done among 44 emergency nurses (enrolled and registered nurses) from four EDs in the Durban area of KZN. The Self-Assessment Inventory Tool was used and adapted for a resource-constrained setting.

**Results.** The majority of emergency nurses (84%) acknowledged the importance of family participation in patient care, 87% reported that FMs were provided with information in a timely manner, and 77% indicated that they had the necessary skills to provide care to FMs.

**Conclusions.** The study showed that the majority of emergency nurses in EDs in the Durban area of KZN provided PFCC. The findings demonstrate that although PFCC is a challenge, nurses in EDs acknowledge the importance of this model of care.

*S Afr J Crit Care* 2017;33(2):59-65. DOI:10.7196/SAJCC.2017.v33i2.317

Patient- and family-centred care (PFCC) is an approach to the planning, delivery and evaluation of healthcare that focuses on a mutually beneficial partnership between patients, families and healthcare professionals.<sup>[1]</sup> An integral part of this approach is being responsive to the needs, values and cultural needs of the patient and family members (FMs).<sup>[2]</sup> Further to this, a PFCC approach in critical care in the emergency department (ED) recognises the needs of both the patient and FMs. This approach is central to delivering effective care, including prompt assessment of FMs' needs, that not only reduces FMs' stress and anxiety but also enhances the patient's satisfaction with care.<sup>[3]</sup>

FMs often find it a traumatic experience when a loved one is admitted to a critical care unit. They are not usually psychologically prepared for this event, as most of these admissions are emergencies.<sup>[4]</sup> Admission of a loved one can result in role conflict, high levels of stress, interruption of normal routines and potential changes in relationships among FMs.<sup>[5]</sup> Other potential stressors that FMs can be exposed to are deterioration in the condition of the patient, an uncertain outcome for the patient, pain and suffering experienced by the patient, the unfamiliar environment and the large amount of high-tech equipment that the patient is connected to. This can lead to emotional reactions in FMs such as shock, anger, fear, anxiety, guilt, frustration and depression.<sup>[6]</sup>

The primary goal of critical care is to help patients recover from acute threats to their health. However, despite this societal expectation, the mortality rate among patients in EDs is higher than in most other healthcare settings. As many as one in five patients in EDs do not survive.<sup>[7]</sup> This is very apparent in the South African (SA) context, where the mortality rate of trauma patients is six times and that of patients with road traffic injuries double the global rate.<sup>[8]</sup> In addition, SA is a violent

country, and injuries account for 12 - 15% of all deaths, as opposed to the global figure of 3.2%. Most penetrating injuries, for example, are due to interpersonal violence, and these are typical of patients presenting to EDs. The average age of victims of violence is 33.6 years, and they account for 30% of the patient load and 53% of deaths.<sup>[9]</sup> Motor vehicle accidents result in ~11 deaths per million kilometres travelled, which is ~10 times higher than the rate in developed countries. Management of patients receiving critical care in SA is also complicated by an increasing prevalence of infectious diseases such as HIV/AIDS and tuberculosis.<sup>[10]</sup>

In addition to these challenges, there is inadequate distribution of emergency services, especially in rural and periurban areas with poor infrastructure, resulting in poor communication systems and poor access by emergency services. This often results in the ideal of the 'golden hour' not being possible.<sup>[11]</sup> There are also staff shortages as a result of emigration to other countries, and staff who remain behind often experience threats of violence. EDs are often staffed with junior and sessional doctors, and in rural areas with part-time general medical practitioners. This means that nurses have to function without the necessary training, potentially leading to burnout, which is reflected in unemotional involvement in work and development of a cynical attitude towards patients and their FMs.<sup>[11]</sup>

Despite these challenges, healthcare organisations have a responsibility to care for the physical and emotional health of severely stressed FMs. Healthcare practitioners have the responsibility to create a sympathetic environment for FMs of patients admitted to EDs, by showing awareness of their feelings, thoughts and needs and implementing interventions to reduce stress levels.<sup>[12]</sup> FMs need to support the patient, and in some cases to speak for patients who are unable to communicate

themselves.<sup>[13]</sup> Support of the patient and FMs in the ED can be achieved through a PFCC approach.<sup>[14]</sup>

Since the seminal work of Molter (1979),<sup>[15]</sup> the needs of FMs have been studied extensively, with the quantitative evidence<sup>[16-18]</sup> being supplemented to a lesser extent by qualitative studies.<sup>[19,20]</sup> Although implementing PFCC has been shown to increase staff satisfaction, decrease costs and improve patient outcomes internationally,<sup>[21]</sup> little attention has been paid to this field in the SA context, and most studies have been done in the paediatric setting.

## Objectives

To describe PFCC practices of emergency nurses in the EDs in the Durban area of KwaZulu-Natal (KZN) Province, SA, with a particular focus on: (i) the status of PFCC in the EDs in the Durban area; and (ii) challenges in providing PFCC in the EDs.

## Methods

### Design

A descriptive, quantitative, non-experimental survey design was used.

### Setting

The study was conducted in the EDs of four hospitals (two public and two private) in the Durban area. The public hospitals included one regional and one tertiary referral hospital. All four hospitals had level 1 emergency units, responsible for providing total care of injury from prevention to rehabilitation.

### Study population

Enrolled and registered nurses in the EDs in the study hospitals, with at least 6 months' experience working in an ED, were eligible for inclusion. A convenient non-probability sampling method enabled the researcher to recruit emergency nurses who were available and willing to participate.

### Data collection tool

The Self-Assessment Inventory Tool<sup>[22]</sup> was used. The tool was developed by the Emergency Medical Services for Children National Resource Center in Washington, DC, to help healthcare professionals and FMs to assess PFCC relating to paediatric care in EDs in the USA. Although this tool was developed for paediatric patient settings, it included adult patients in our study. The original tool is only available in English, and no documented research to date has shown any translation into other languages. The tool is organised into seven sections (vision, mission and philosophy of care; family participation in care; family support; information and decision-making; service co-ordination and continuity; personnel practices and training; and environment and design, evaluation/continuous quality improvement, and community partnerships).

The tool was adapted for the SA context, and certain items were excluded to make it relevant in a resource-constrained environment. Some of the items on the tool were not relevant to the SA context, so only the sections on family participation in care, information and decision-making, and personnel practices were used in the study, as these sections directly related to its objectives.

### Data collection process

The researcher was given 10 minutes at the beginning of each day and night shift handover to explain the purpose of the study to the nurses present. Questionnaires were left with nurses who verbally agreed

to participate in the study. The completed questionnaires were then collected at the end of the shift.

## Validity and reliability

**Validity.** A pilot test was conducted with five participants, who were asked to comment on the content of the tool in relation to the subject of the study to ensure that it was appropriate in terms of wording, layout and questions asked. Furthermore, the ED study sites cared for all age groups in the SA context, thereby providing a comprehensive description of PFCC in this context.

**Reliability.** The pilot test revealed a Cronbach alpha of 0.92, indicating a high reliability coefficient.

## Statistical analysis

The data were analysed using the Statistical Programme for Social Science (SPSS), version 16 (IBM, USA). Descriptive statistics were used to describe the research phenomena. Tests included frequencies, percentages and Cronbach alpha >0.70 as acceptable.

## Ethical considerations

Ethical approval was obtained from the Research and Ethics Committee of the University of KwaZulu-Natal (ref. no. FECHSC 05009). Permission was also obtained from the KZN Department of Health (ref. no. HRKM088/09) and the management of all the hospitals. Informed consent was obtained from the respondents, and they were assured that all participation was voluntary. Confidentiality, privacy and anonymity were maintained by ensuring that the questionnaires were anonymous. No names were indicated on the questionnaire. In addition, the completed questionnaires were kept in a locked office and any electronic data sets were kept on a computer that required access using a password.

## Results

The total population of emergency nurses targeted for the study at the four hospitals was 60. Fifty-five nurses were given questionnaires, excluding the five nurses who were involved in the pilot test. Eleven nurses did not consent to participate in the study and were excluded. Finally, 44 nurses from the four study sites, 18 (40.9%) from private and 26 (59.1%) from public hospitals, were included in the final analysis (Table 1), giving a response rate of 80.0%.

## Demographic details of respondents

The largest proportion of respondents were aged 36 - 45 years (34.1%), and most respondents were female (86.4%) (Table 2). A diploma in nursing (88.6%) was the most common qualification, with most respondents having 16 - 20 years' experience in nursing. Most of the emergency nurses included in the study were registered nurses (70.5%).

## The PFCC Self-Assessment Inventory Tool

The four categories, comprising 58 items, that were included in the questionnaire are shown in Tables 3 - 7. The overall reliability coefficient

**Table 1. Sampling per hospital (N=44)**

	<i>n</i> (%)
Hospital 1	8 (18.2)
Hospital 2	10 (22.7)
Hospital 3	15 (34.1)
Hospital 4	11 (25.0)

**Table 2. Demographics of respondents (N=44)**

	<i>n</i> (%)
Age (years)	
20 - 25	3 (6.8)
26 - 35	14 (31.8)
36 - 45	15 (34.1)
46 - 55	7 (15.9)
56 - 65	5 (11.4)
Gender	
Male	6 (13.6)
Female	38 (86.4)
Qualifications	
Diploma	39 (88.6)
Bachelor's degree	4 (9.1)
Master's degree	1 (2.3)
Experience (years)	
0 - 5	9 (20.5)
6 - 10	6 (13.6)
11 - 15	8 (18.2)
16 - 20	12 (27.3)
>20	8 (18.2)
Information missing	1 (2.3)
Current position held	
Staff nurse	13 (29.5)
Registered nurse	31 (70.5)

**Table 3. Items and categories in the Self-Assessment Inventory Tool**

Item	Items, <i>n</i>	Mean (SD)	Cronbach alpha
Family participation in care	7	9.3 (2.0)	0.75
Family support	17	22.2 (4.7)	0.88
Information-sharing and decision-making	22	30.3 (6.2)	0.91
Personnel practices	12	16.0 (3.8)	0.88
Total	58		0.88

**Table 4. Family participation in care (N=44)**

	Yes, <i>n</i> (%)	No, <i>n</i> (%)	Cronbach alpha
1. Does ED staff recognise that FMs are important sources of information on the patient and the patient's condition?	44 (100)	0	
2. Are policies/procedures flexible enough for a family to decide for themselves if and who stays with the patient during:			
Invasive procedures?	23 (52.3)	21 (47.7)	0.68
Critical care including resuscitation?	20 (45.5)	24 (54.5)	0.65
3. Are FMs encouraged and supported in staying with the patient?	33 (75.0)	11 (25.0)	0.74
4. Are FMs encouraged to provide support and to assist with care for the patient in the ED?	26 (59.1)	18 (40.9)	0.67
5. Are FMs provided information/assistance on:			
How to facilitate the patient's coping during painful or stressful procedures?	37 (84.1)	7 (15.9)	0.78
The use of stress- or anxiety-reducing techniques?	39 (88.6)	5 (11.4)	0.78

ED = emergency department; FMs = family members.

of the items used in this study was 0.88, with all categories showing acceptable reliability of >0.70 (Table 3).<sup>[23]</sup>

#### Family participation in care (Table 4)

All respondents (100%) agreed that FMs are important sources of information on the patient and the patient's condition, with 52.3% of respondents indicating that policies and procedures in their unit were flexible during invasive procedures and 54.5% disagreeing that FMs should be allowed to be present during resuscitation. In addition, 75.0% of respondents agreed that FMs should be encouraged and supported to stay with the patient, while 59.1% indicated that FMs should be encouraged to provide support and assist with patient care.

#### Family support (Table 5)

Of the respondents, 79.5% agreed that ED staff effectively promoted family/patient relationships, 68.2% agreed that staff supervision was provided for patients in the waiting area, and 70.4% both viewed interactions with FMs as an opportunity to support FMs, and viewed interactions with FMs as being respectful. In addition, 79.5% of respondents indicated that they were available to assist FMs when they first arrived in the ED, and 75.0% that they were available to help and support FMs as they waited for routine care and information; 72.7% reported that there was a procedure in their unit for initiating family support and providing frequent information updates during a crisis or life-threatening situation, and 54.5% that a specific individual was designated to co-ordinate the exchange with FMs.

#### Information-sharing and decision-making (Table 6)

Most respondents (56.8%) reported that bereavement information in their unit did not include hospital and community bereavement groups, and 52.8% that information on funeral services, planning a service and other resources was not provided; 84.1% of respondents indicated that FMs were provided with timely information in order to make decisions regarding the patient's treatment, 90.9% that FMs' choices about patient care were respected, and 72.7% that FMs were given information about follow-up care and were supported in obtaining information through educational materials.

#### Personnel practices (Table 7)

Most respondents (65.9%) reported that orientation and/or in-service programming included discussions about PFCC principles. Only 59.1%

**Table 5. Family support (N=44)**

	Yes, n (%)	No, n (%)	Cronbach alpha
1. Do ED staff, in the way they deliver services, effectively promote and support family/patient relationships?	35 (79.5)	9 (20.4)	0.88
2. Is staff supervision provided for the patient in the waiting area?	30 (68.2)	14 (31.8)	0.87
3. Do staff view interactions with FMs as opportunities to support FMs in the care and nurture of the patient?	31 (70.4)	13 (29.5)	0.87
4. Do staff interact respectfully with all FMs?	31 (70.4)	13 (29.5)	0.87
5. Are the following available to support patient and FMs in the ED:			
Translators/interpreters?	26 (59.1)	18 (40.9)	0.87
Sign language interpreters?	26 (59.1)	18 (40.9)	0.87
Social workers?	30 (68.2)	14 (31.8)	0.87
Spiritual advisors?	33 (75.0)	11 (25.0)	0.88
Mental health professionals?	34 (77.3)	10 (22.7)	0.87
Patient representatives?	34 (77.3)	10 (22.7)	0.87
6. Are staff members available to help and support FMs at the following times:			
When they first arrive in the ED?	35 (79.5)	9 (20.4)	0.89
As they wait for routine care and information?	33 (75.0)	11 (25.0)	0.88
7. Is there a procedure for initiating family support during a crisis or life-threatening situation?	32 (72.7)	12 (27.3)	0.87
8. In trauma and other crises or life-threatening situations, are frequent information updates (every 5 - 10 minutes) provided to the family when they are outside the room as well as when they are present with the patient?	32 (72.7)	12 (27.3)	0.88
Is a specific individual designated to co-ordinate the exchange of information with the family?	24 (54.5)	20 (45.5)	0.87
Does this individual remain involved as a support person throughout the crisis or resuscitation?	25 (56.8)	19 (43.2)	0.88

FMs = family members.

of respondents reported that staff were trained in working with FMs and children in emergency situations, 68.2% agreed that the cultural and ethnic diversity of patients and FMs were met, 70.5% reported that they were encouraged to learn the languages of the main communities served by their hospital, and 72.7% reported that there were opportunities for staff to debrief and share feelings and concerns after critical incidents.

## Discussion

### Family participation in care

All the emergency nurses agreed that FMs are important sources of information on the patient and the patient's condition. According to De Beer and Brysiewicz,<sup>[24]</sup> although there has been a movement in recent years to promote the patient as a partner in care, this is not always possible, as critically ill patients are often sedated and ventilated, and unable to make decisions for themselves. This results in FMs being involved in these partnerships. They are important sources of information and are able to make decisions on behalf of the patient when necessary.<sup>[25]</sup>

Most emergency nurses agreed that policies and procedures during invasive procedures were flexible, but the majority reported that this was not the case during critical care interventions, including resuscitation. According to Goldberger *et al.*,<sup>[26]</sup> many institutions have adopted policies that allow family presence during resuscitation in the hope of addressing the needs of FMs. In addition, Jabre *et al.*<sup>[27]</sup> highlight the fact that FM presence during resuscitation confers psychological benefits for FMs regardless of the treatment outcome. However, FM presence during resuscitation may also intimidate and

cause increased emotional stress to medical staff.<sup>[28,29]</sup> In terms of practicalities, family presence during attempts at resuscitation can be implemented if environmental, staff and spatial conditions are met. However, it should only be allowed if there is adequate staff to support the FMs' emotional and physical needs.<sup>[30]</sup>

This study also revealed that 75% of emergency nurses encouraged and supported the general presence of FMs in the unit, and that FMs were encouraged to provide support and assist with the care of the patient. McKieran and McCarthy<sup>[31]</sup> noted that FMs expressed a strong desire to be closer to the patient in order to see first-hand how the patient was progressing.

### Family support

This study showed that the majority of emergency nurses reported promoting family/patient relationships. Family/patient therapeutic relationships are central to many health-related disciplines, and in nursing, a therapeutic relationship is described as one that allows for the meeting of nursing needs to the mutual satisfaction of the nurse, patient and FMs.<sup>[32]</sup> According to Leininger,<sup>[33]</sup> such relationships are pertinent to the delivery of individualised and holistic nursing care, and it is the responsibility of the nurse to encourage the development of such relationships. Brunero *et al.*<sup>[34]</sup> state that engaging with patients is seen as a critical part of the therapeutic relationships between healthcare professionals, patients and FMs, with empathy and respect being reported as an integral part of this relationship.

Of the emergency nurses, 75% indicated that they were available to help and support FMs as they waited for routine care and information.

**Table 6. Information-sharing and decision-making**

	Yes, <i>n</i> (%)	No, <i>n</i> (%)	Cronbach alpha
1. Does bereavement information include hospital and community bereavement support groups?	19 (43.2)	25 (56.8)	0.91
2. Does bereavement information include information on funeral services, planning a service and available community resources?	21 (47.7)	23 (52.8)	0.90
3. Does bereavement information include telephone number of a contact person at the hospital if the family has questions after discharge?	25 (56.8)	19 (43.2)	0.90
4. Are families provided, in a timely manner, with the information they need to make decisions about the patient's treatment?	37 (84.1)	6 (13.6)	0.91
5. Are families asked how they would like medical and other information provided to them?	31 (70.5)	11 (25.0)	0.91
6. Are family choices and decisions about the patient's care respected and honoured by staff?	40 (90.9)	3 (6.8)	0.92
7. Is there a process for resolving conflicts between families and providers?	35 (79.5)	9 (20.5)	0.91
8. Are families given information about follow-up care for their loved one, and pharmaceutical and other supplies or equipment they may need?	32 (72.7)	12 (27.3)	0.90
9. Does the ED support families in obtaining information through:			
Educational material in the ED?	32 (72.7)	12 (27.3)	0.91
Access to translators?	29 (65.9)	15 (34.1)	0.88
The medical library?	21 (47.7)	23 (52.3)	0.81
The internet?	24 (54.5)	20 (45.5)	0.76

ED = emergency department.

**Table 7. Personnel practices**

	Yes, <i>n</i> (%)	No, <i>n</i> (%)	Cronbach alpha
1. Does orientation and/or in-service programming include discussion about family-centred principles?	29 (65.9)	15 (34.1)	0.77
2. Does orientation and/or in-service programming include discussion about cultural competence and overcoming language barriers?	28 (63.6)	16 (36.4)	0.88
3. Does orientation and/or in-service programming include discussion about sharing medical and other information with FMs?	27 (61.4)	17 (38.6)	0.76
4. Are staff trained in working with FMs and children with special needs/disabilities in emergency situations?	26 (59.1)	18 (40.9)	0.84
5. Do staff and volunteers reflect the cultural and ethnic diversity of patients and FMs served by the hospital?	30 (68.2)	14 (31.8)	0.86
6. Are staff encouraged to learn the languages of the primary communities served?	31 (70.5)	13 (29.5)	0.69
7. Are FMs who have experienced emergency care involved in providing orientation and/or servicing for staff?	27 (61.4)	17 (38.6)	0.75
8. Is there sufficient space for staff support, including a staff lounge accessible for frequent short breaks?	31 (70.5)	13 (29.5)	0.75
9. Is there a staff support group or other regularly occurring opportunities for peer support?	31 (70.5)	13 (29.5)	0.94
10. Are there opportunities for staff to debrief and share feelings and concerns after critical incidents?	32 (72.7)	12 (27.3)	0.71
11. Are there staff recognition and appreciation initiatives?	33 (75.0)	11 (25.0)	0.91

FMs = family members.

According to Washington,<sup>[35]</sup> the 'golden hour of trauma' does not only apply to the trauma or emergency patient, but also includes FMs. Most of the emergency nurses acknowledged the importance of regularly updating FMs with information about the patient's condition while they are waiting in the ED, and reported that information was usually given by a designated individual who was allocated to co-ordinate the exchange of information. Cypress<sup>[6]</sup> reported that psychosocial support

of FMs was fulfilled through the sharing of information, and that providing information to FMs about the care of the patient lessened their anxiety. In addition to this, lack of information negatively affects emotion, with uncertainty about the outcome of the patient, fear and apprehension.<sup>[35,36]</sup> Providing accurate and timely information is respectful, and without this information FMs are left in a void that has the potential to affect them both physically and emotionally.<sup>[37]</sup>



## Information-sharing and decision-making

The majority of emergency nurses indicated that bereavement information was not available to FMs or the community at large. A study by Brysiewicz and Uys<sup>[38]</sup> highlighted the fact that health professionals in the ED had difficulties in managing sudden death, and that guidelines would therefore help in the therapeutic management of the dying patient and the bereaved FMs. Although nurses provided support to the FMs while in the ED, 52% did not follow up on FMs following a patient's death. Brysiewicz and Uys<sup>[38]</sup> stated that a follow-up call to FMs is beneficial and that a bereavement co-ordinator could be responsible for this. In the resource-constrained SA context, ED managers have taken on the bereavement co-ordinator role.

Most emergency nurses agreed that information should be provided to FMs. Accurate and complete information has been reported to be the most essential need of FMs during a sudden critical illness, for them to comprehend what is happening and to have realistic expectations.<sup>[39,40]</sup> Information in this study was shared by the majority of emergency nurses using written departmental resources. It is vitally important to provide comprehensible written information for FMs to refer to at a later stage, as they are often unable to take in information during a loved one's sudden critical illness.<sup>[40]</sup>

Most emergency nurses in this study reported that FMs were provided with information in a timely manner, in order to make decisions about the patient's treatment. According to Shorofi *et al.*,<sup>[41]</sup> FMs need timely, honest and factual information. Quinton *et al.*<sup>[42]</sup> explain that they feel immobilised and helpless in their inability to control the outcome of the patient, and excluding them from decision-making creates further stress. They suggest that FMs should be included in the decision-making process, as this climate preserves the family as a unit.

Our study also revealed that information was provided to FMs both verbally and in writing, in various languages. However, a deficiency in grief and bereavement information was noted. According to Brysiewicz and Uys,<sup>[38]</sup> health professionals need to be provided with the necessary knowledge and skills in the management of the dead or dying patient.

## Personnel practices

The majority of the items in this category indicated that most in-service and orientation programmes included some content regarding PFCC principles. According to Moghaddasian *et al.*,<sup>[43]</sup> one of the principles of the nursing process is that care should be holistic, and developing a care programme requires nurses to have a comprehensive training of FMs' needs. According to Neuman's<sup>[44]</sup> model focusing on a family approach, the nurse's function is to help the family to achieve and maintain a steady state after a stressor, and nurses have a crucial role in assisting people develop coping strategies. This requires the nurse to be knowledgeable about family dynamics. Interacting with relatives is a challenging task that requires complex skills, and critical care nurses must be knowledgeable about the individual needs of both patients and FMs to be able to provide proper care and support for both. Some critical care nurses reported that gaining expertise and acquiring technical competence, knowledge and professional experience helped them to become more confident to provide PFCC. Ongoing learning and acquisition of knowledge is seen as vital in enhancing caring.<sup>[40]</sup> Some emergency nurses stated that learning from experience is essential, and this was also expressed by Brysiewicz and Bhengu,<sup>[12]</sup> who reported that lack of training led to critical care nurses using their own experiences in dealing with FMs.

Most emergency nurses reported that staffing in their units reflected the cultural and ethnic diversity of the patients served by the hospital.

As stated by Davidson *et al.*,<sup>[45]</sup> culture can have an impact on the nursing profession, because it is a pattern of shared values and beliefs, including language, styles of communication and practices. According to Leininger,<sup>[33]</sup> care and culture are inextricably intertwined. Healthcare professionals around the world are faced with the challenge of the need to learn about culturally appropriate healthcare. An appreciation of the influence of culture on health, illness and care is important if patients are to be managed effectively by nurses. Leininger<sup>[33]</sup> states that knowledge of meanings and practices of diverse cultures is vital to guide nursing decisions and actions in providing culturally congruent care. In order to overcome cultural barriers, the nurse should have knowledge of the FMs' cultural beliefs; 64% of nurses in this study were aware of the cultural beliefs of the families, as opposed to 36% who reported that they were not culturally competent. In addition, most emergency nurses reported that they were encouraged to learn their patients' primary language. According to Bradby,<sup>[46]</sup> nurses may be skilled in interpreting patients' needs, but the professional language that they use can be difficult for patients to understand, so they need to simplify complex terminology and avoid medical jargon. Not understanding the language of healthcare professionals could limit access to healthcare for patients and FMs, as it is difficult for them to communicate their needs and find out what services are available or what treatment they require. This situation is further compounded for patients and FMs who already feel anxious about the illness.<sup>[47]</sup>

## Recommendations

We recommend that a family needs assessment be included as part of every patient's assessment. In addition, evaluation of hospital policies and procedures for congruency with PFCC, especially in relation to family-witnessed resuscitation and invasive procedures, is needed to promote family participation in patient care. More formal education for staff regarding the needs of families is needed, particularly in view of SA's diverse cultural context. Bereavement programmes to support staff in dealing with bereavement issues would be beneficial. Further research is warranted to improve PFCC in the SA critical and emergency care context.

## Study limitations

A small sample size of only 44 emergency nurses makes it difficult to generalise the findings. The questionnaire was lengthy and could have been time consuming in the context of the ED, as the average time taken to complete the questionnaire was 15 minutes. Respondents completed the questionnaire indicating yes/no responses to questions. The questionnaires did not include a section for comments, making it difficult for the researcher to identify strengths, weaknesses and ideas for possible changes.

## Conclusions

This study highlights that some aspects of PFCC services are provided by emergency nurses in EDs in the Durban area of KZN. PFCC is a challenge, but to provide such care it needs to be kept in mind that caring is the essence of nursing. As much as the world is advancing in terms of medical technology, nurses should remember the importance of caring and communication with the patient and their FMs, which is essential for the nurse-patient-family therapeutic relationship.

**Acknowledgements.** We thank Prof. Petra Brysiewicz of the School of Nursing and Public Health at the University of KwaZulu-Natal for proposing the idea of using the Self-Assessment Inventory Tool in this study.

**Author contributions.** JPA: student; JdeB: supervisor (manuscript preparation).

**Funding.** None.

**Conflicts of interest.** None.

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Accepted 5 September 2017.