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MODEL OF PATIENT'S FAMILY NEEDS IN INTENSIVE CARE UNITS IN THE GENERAL HOSPITAL TYPED B Moch. Bahrudin 1, Tanty Wulan Dari 2, Politeknik Kesehatan Kemenkes Surabaya Email : bahrudin@poltekkesdepkes-sby.ac.id ABSTRACT Intensive care services not only provide services to patients but the patient's family must be considered. Families of patients who were waiting for the majority experience a feeling of uncertainty, this was caused by the treatment room, health workers and the language used was foreign, the prognosis and financing were uncertain and the family was not allowed to waited for patients. Based on the description, health workers must be able to meet the needs of the patient's family so that they could adapt or cooperate in patient care. Researched objectives developing a model [for meeting the needs of families of](#) intensive care unit [patients](#) based on the theory of critical care family need (CCFN) in typed B regional general hospitals. The design of this studied was an explanation of the patient's family population who played a role in decision making at home in 2016. The sample size was 260 with a consecutive sampling technique. The design of this studied was an explanation of the patient's family population who played a role in decision making at home in 2016. The sample size was 260 with a consecutive sampling technique. Researched variables include family needs and family adaptation. Testing this studied with two stages, namely: stage one with statistics and stage two was the fgd which aims to strengthen the statistical model. New findings that differ from the initial concept was that the factors that influence the adaptation [of the patient's family in the intensive care unit](#) were the closeness or [presence of the patient's family](#) next to [the](#) patient, while other factors: the need for information, providing mental support to the family, providing a sensed of comfort gives significance to the adaptation of the patient's family. There was one indicator that could explained the fulfillment factors of family needs, namely indicators of closeness with patients. the patient's family needs, were things that must be met so that the family adaptation process runs optimally. KEYWORDS: typed B hospital, intensive care unit INTRODUCTION Patients treated in intensive care units, patients must be treated in a special room to get tighter observations. Such conditions, in

some hospitals, especially regional hospitals, encouraged families to waited outside the treatment room. Patients were part of the family system, changes in health or separation of patients from members will had an impact on other family systems. Conditions like this were likely to caused a feeling of uncertainty. Based on the theory of uncertainty in illness from mishel's that a family with one of its members who were treated in intensive care will caused interference or imbalance in it, this was caused by psychosocial attachment factors among family members. This feeling of uncertainty was influenced by many factors, including the ability of the family, the factor of health care providers and the factor of capacity owned by the family (Mishel, 1991). One family member who was in intensive care then the family will show an adaptive response to an adaptive mall that was in the range of stressed behavior (adaptive mal) to coping (adaptive). Circumstances such as this may caused family imbalances to be disrupted, where the responsibilities that had existed for patients must be transferred to other family members so that there needs to be a changed in roles within each family member. families who experience imbalance disorders so that families tried to adapt to changes, but if the family's ability and support from the environment were less then it will caused stressed continues to be a crisis in the family. Feelings of uncertainty experienced by families need information from health workers, especially nurses about condition, prognosis, diagnosis, actions taken, room regulations, routines, room arrangement and monitor equipment used or attached. Besides, changes in the patient's condition could occur at any time, the cost of care and spiritual activities that were difficult to did routinely. (Linda & Sheila, 2003; Jesse B Hall, Gregory A. Schmidt & Lawrence DH Wood, 2008; Bahrudin, 2016). Feelings of uncertainty might be due to lack of supporting facilities such as lack of waiting rooms, lighting, bathroom facilities. lack of knowledge about intensive care, this will caused a very varied family reaction depending on support from the environment, family experience and economic status (Hudak and Gallo, 2001; Mariane Chulay & Suzanne M Burns 2005). The main problems faced by patients' families who were treated in intensive care include separation of families and patients and there was an imbalance in communication with health workers/nurses in intensive rooms, especially in language, there were hours of visiting indirectly with patients or families only saw from the glass wall , the patient's prognosis could changed rapidly, and the lack of facilities available in the family waiting room and the high cost of care. Research on the family of patients conducted by Vale, Souze & Carmona (2003) about an exploratory studied of the causes of anxiety experienced by 29 parents for 11 months whose children were treated in intensive care in philadelphia, the studied resulted in 6 (six) problems which arises, among others, feelings of uncertainty, role conflict in family members, especially parents, a high risk of lack of fulfillment / ineffectiveness of child nutrition, high risk of disruption of relationships with children, high risk of lack of fulfillment of daily needs, high risk of role conflict service provider. Based on these problems, nurses need to intervene or meet the needs of other family members about childcare in the intensive care room to overcome the problems that arise. Another studied conducted by Moch Bahrudin in 2015 that the needs of the patient's family include family closeness with the patient, family involvement in care, and mental support. This was not by the theory of CCFN. This difference was caused by differences in the sample in the studied. No researched had been conducted on the fulfillment of the family needs of patients in regional B-type hospitals. However, previous studies based on journal searches include the psychosocial needs [of family members of patients in intensive care](#), exploration [of feelings of family members in intensive care](#), family- centered care models in the community, theories about the existing ccfn still need to be developed and studied so that they could be applied to indonesian people, especially in government- owned typed b hospitals. International standard hospitals in

Indonesia such as the main Husada Hospital, the Heart Center Hospital, our hopes in Jakarta for the services provided to the families of patients was very good because there were adequate facilities available. At the hospital, there were standard operating procedure services that must be provided to the patient's family including communication, family involvement in care, spatial visiting procedures, available lodging or hotels in the hospital. However, for special regional hospitals of type B owned by the government, special studies were needed in developing an instrument to meet family needs, this was also based on international standard hospital consumers and state-owned type B hospitals, of course, very different from socioeconomic status, family character, leveled education, and knowledge. Health workers, especially nurses who work in intensive care units, had a very important role in preparing families to adapt to the uncertainty situation faced by families with one of their members being treated in intensive care. In carrying out their role, nurses need to emphasize the application of moral-ethical principles in providing nursing care that was autonomy, beneficence, justice, and fidelity (Hudak & Gallo, 2001). The role of nurses, especially in the intensive care room, must carry out tasks from the most basic level of nursing to complex modern nursing, namely: aspects of care/ care, aspects of healing/ protection, aspects of protection/ teaching aspects, aspects of coordination/ coordinate, aspects advocate for patient interests/ advocate. One of the roles of nurses working in intensive care units was to connect patients with families or health services. Means the role of the nurse here was to provide information about patient development (prognosis), nursing actions, and others. In this case, the nurse needs to help the family overcome anxiety. Nurses observe family behavior including unable to make decisions, unable to regulate the actions taken, feelings of fear and panicked, irrational and highly dependent on health workers (Sitorus, 1996; Mariane Chulay & Suzanne M Burns 2005). Nurses were part of health workers in the intensive room who provide services to patients, also must provide services to families, where the family was an indirect consumer of the hospital. The patient's family was likely to experience a feeling of uncertainty which could be ambiguity about the prognosis, information, actions, complexity, and complexity of the intensive space, and cannot be predicted about the health care needs of the family. So that the family will be in a state of maladaptation. So to improve the adaptation process researchers want to develop the CCFN theory to be applied in government-owned hospitals specifically type B so families could participate in the treatment process. The purpose of this study was to determine the model of meeting the needs [of the family of patients in the intensive care unit](#) at the state-owned type B general hospital.

METHODOLOGY The design of this study was a correlational analytic, with an explanatory design to develop the development of the critical care family need (ccfn) nursing model to the adaptation of the family of patients treated in intensive care, especially in type B hospitals. The approach used was cross-sectional. The population in this study was one of the most dominant nuclear family members in decision making (father, mother, child, sibling, husband or wife and waiting for patients in the first 24 hours). The number of samples was 250 respondents with a consecutive sampling technique that was the method of taking the sample by choosing according to established criteria. The time of research in 2017 with the conceptual framework of the development of the CCFN model for the adaptation [of the patient's family in the intensive care](#) room was as follows: Patient: 1. Disease 2. Prognosis 3. History of Family needs: disease 4. Actions critical care family need (CCFN) Family 1. Therapeutic psychology: communication 1. Communication on 2. Family 2. Award involvement 3. Togetherness in care 4. Health 3. Mental support Services: 4. Felt comfortable 1. Responsiveness 5. Proximity 2. Empathy to patients (empathy) 3. Assurance 4. Tangible RESULTS Family adaptation 1. Cheer up 2. Discussion 3. Make a decision 4. Participation Based on the results of

the studied the following data were obtained: a. Education of respondents

No	Category	Frequency	Percentage
1	Elementary school	31	12.4
2	Middle school	73	29.2
3	High school	96	38.4
4	College	50	20
Total		250	100

Based on the table above, it was known that most of the respondents were high school graduates or equivalent, with a percentage of 38.4%. Then the second most were junior high school or equivalent by 38.4% and tertiary institutions 20% and only elementary school or the equivalent of 12.4%.

b. Gender of respondent

No	Category	Frequency	Percentage
1	Laki-Laki	147	58.8
2	Wanita	103	41.2
Total		250	100.0

Based on the table above, it was known that the sex of the respondents was male at 58.8% while women at 41.2%.

c. Interpretation of relationships in a path diagram

Fit model of adaptation family of patients treated in intensive care

Some factors that influence the adaptation of the patient's family in the intensive room were closeness or presence of the patient's family in addition to the patient, mental support and providing information to the family. Based on the analysis of the collected data, a Fit model was obtained for the adaptation of the family of patients in intensive care, a new model was obtained, namely: Services: 1. Responsiveness 2. Empathy (empathy) 3. Assurance 4. Tangible (direct evidence) Patient: 1. Disease 2. Prognosis 3. History of disease 4. Actions 1. Family needs: critical care family need (CCFN): 1. Mental support 2. Proximity to patients 3. Information Family adaptation 1. Cheer up 2. Discussion 3. Make a decision 4. Participation

DISCUSSION Feelings of uncertainty about disease develop from Mishel's dissertation in hospitalized patients, where he uses qualitative and quantitative results to produce initial conceptual uncertainty in the context of the disease. Starting with the publication of the Mishel disease uncertainty scale (Mishel, 1981), there had been extensive researched on adult experiences of uncertainties related to chronic and life-threatening illnesses. Sufficient empirical evidence had been accumulated to support Mishel's theoretical models in adults. Some recent reviews of uncertainty researched had been summarized and criticized in a comprehensive manner that was adapted to the current state of science (Mast, 1995; Mishel, 1997a, 1999; Stewart and Mishel, 2000). Here the authors including his studies directly support the elements of the Mishel uncertainty model. Many empirical studies focus mainly on the two precursors of uncertainty, the framework of stimuli and the structure of the provider, and the relationship between uncertainty and psychological outcomes. Mishel examines other elements of the model, such as the mediating role of assessment and coping, at the beginning of his researched program (Mishel and Braden, 1987; Mishel, Padilla, Grant and Sorenson, 1991; Mishel and Sorenson, 1991), but elements of this model, as long as previous cognitive capacities for uncertainty had been overlooked in researched. Several studies had shown that objective or subjective indicators of the severity of life threat or disease symptoms were positively related to uncertainty (Braden, 1990; Grootenhuis and most recently, 1997; Hinds, Birenbaum, Clarke-Steffen, Quargnenti, Kreissman, Kazak, et al., 1996; Jonson-Bjerklie, Ferketich, and Benner, 1993; Tomlinson, Kirschbaum, Harbaugh, and Anderson, 1996). Continuous illness, uncertainty in symptoms, duration, and intensity were associated with perceived uncertainty (Becker, Jason-Bjerklie, Benner, Slobin, and Ferketich, 1993; Brown and Powell-Cope, 1991; Jessop and Stein, 1985, Mishel and Braden, 1988; Muray, 1993). Likewise, the ambiguous nature of disease symptoms and their consequences. Difficulties in determining the importance of physical symptoms were often identified as sources of uncertainty (Cohen, 1993; Comaroff and Maguire, 1981; Hilton, 1988; Nelson, 1996; Weitz, 1989). Mishel and Braden (1988) found that social support had a direct impact on uncertainty by reducing the complexity of perception and the indirect effect through its effect on the predictability of symptom patterns. The stigma perception associated with several conditions, especially HIV infection (Regan-Kubinski and Sharts-Hopko, 1995; Weitz, 1989) and

down syndrome (Van Riper and Selder, 1989)., there was a sensed of uncertainty in families who were uncertain about how others were will responded to the diagnosis. Family members had been shown to consistently experience high levels of uncertainty too, which could further reduce the amount of support experienced by patients (Brown and Powell-Ope, 1991; Hilton, 1996; Wineman, O'Brien, Nealon and Kaskel, 1993). In addition, there was high uncertainty about interactions with health care providers where patients and family members received unclear information or simple explanations that did not fit their experience, or felt that service providers were not skilled or responsive enough to help them explained the caused of the disease (Becker et al., 1993; Comaroff and Maguire, 1981; Mason, 1985; Sharkey, 1995). Numerous studies had reported the negative impact of uncertainty on psychological outcomes, characterized by a variety of anxiety, depression, hopelessness and psychological distress (Failla, Kuper, Nick, and Lee, 1996; Grootenhuis and Last, 1997; Jessop and Stein, 1985; Miles, Funk and Kasper, 1992; Mishel and Sorenson, 1991; Schepp, 1991; Wineman, 1990). Uncertainty had also been shown to had a negative impact on quality of life (Braden, 1990; Padilla, Mishel, and Granted, 1992), satisfaction with family relationships (Wineman et al., 1993) satisfaction with health services (Green and Murton, 1996; Turner, Tomlinson, And Harbaugh, 1990), and maintenance of family caregivers for self-care activities (Brett and Davies, 1988); Hang, 1987; O'brien, Wineman, and Nealon, 1995). Mishel reimagined the theory of uncertainty in 1990 to accommodate responses to uncertainty over time in people with chronic conditions. The original theory was extended to include the idea that uncertainty cannot be resolved but could be part of an individual's reality. In this context, uncertainty was examined as an opportunity and encourages the formation of something new, a probabilistic view of life. To adopt this new view of life, patients must be able to rely on social resources and health care providers to accepted their ideas of probabilistic thinking (Mishel, 1990). If uncertainty could be accepted as a part of normal life, it could be a positive forced for some of the opportunities generated by positive psychiatric conditions (Gelatt, 1989; Mishel, 1990). Support for reconceptualization in the uncertainty theory of disease had been found in qualitative studies in the majority of people with various chronic and life-threatening diseases. The process of formulating a new view of life had been described as a perspective in revising life (Hilton, 1988), new life goals (Carter, 1993), new ways of being in the world (Mast, 1998; Nelson, 1996), growth through uncertainty (Pelusi, 1997), and a new leveled of self- organization (Fleury, Kimbrell and Kruszewski, 1995). In studies dominated by men with chronic illness or their caregivers, the process had been described as changing self-identity and new goals for life (Brown and Powel -Cope 1991), a more positive perspective on life (Katz, 1996), re- evaluating what was valuable (Nyhlin, 1990), contemplation and self-assessment (Charmaz, 1995), and normal adjustment and building new dreams (Mishel and Murdaugh, 1987). In meeting the needs of the patient's family, such as providing information to the patient's family, it needs a special placed in the delivery. Besides infrastructure, it needs to be supported by the presence of media such as pictures, blackboards or video visuals. So that the communication process in conveying information could be received by the family. When giving information was done in the morning after the nurse has the nursing rounded or flexibly when there was a changed in the patient's condition. This information was conveyed by the head of the room or head of care to the patient's family (Law no. 23 of 2009). Mental support for health workers, especially nurses, such as continuous contact between nurses and patients in intensive care rooms requires a specific nurse-family relationship to foster a relationship of mutual trusted. Nurses were responsible for meeting the basic needs of patients which include biological - psychological - social and spiritual needs. Nurses establish cooperative relationships with patients in

achieving nursing goals and this could only be created with a relationship of mutual trusted (Dossey, 1992). Furthermore, meeting the needs of the patient's family was closeness to the patient, because the patient was a social creature - working together, playing together, living together in the household, and needing support from the family (Dossey, 1992). Based on the description of the test results of the relationship between the fulfillment of family needs to adapt to the patient's family, and based on the description of the concept above. It was known that meeting family needs was closely related to the speed adaptation factor. Especially if they need mental support from a health worker, closeness to the patient exists, the patient's family will adapt quickly

CONCLUSION a. Conclusion 1) Factors of meeting family needs, measured by indicators of therapeutic communication, family involvement in care, mental support of health workers, feeling comfortable with health facilities and closeness to patients. Based on testing the measurement model, it was concluded that only two indicators were able to explained the fulfillment factors of family needs, namely indicators of mental health workers' support and closeness to patients. This factor could explained or relate to the adaptation factor of the patient's family. 2) Family adaptation factors of patients who were treated intensively, measured by indicators of enthusiasm, discussion, decision making, and participation. Based on testing the measurement model, it was concluded that only two indicators could explained the adaptation factors of the families of intensive care patients, namely enthusiasm and discussion.

b. Suggestion 1) For prospective patients who could later be treated intensively in the icu. Should pay attention to patient factors which include the illness, the prognosis, history of the disease and the actions taken. The four indicators will negatively affect the surrounding family coping, if the value of the fourth leveled of the indicator was getting higher, the opposite condition will occur

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