Relationship between the demographic factors of patients' families and their satisfaction level with critical care in the intensive care units of neurology hospitals

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Abstract

Background:

Demography is the term used to describe the study of human populations and the fluctuations in size caused by migration, fertility, and mortality. The term demography comes from the Greek word demography, which meaning "describing people." In order to account for factors like the sex ratio, age distribution, composition, geographical distribution, and population density, this discipline investigates demographic features(1). Additionally, there is sometimes a distinction made between "formal demography," or "demographic analysis," which includes the statistical analysis of population parameters and their dynamics, and "population studies," which look at the causes and effects of changes in the population's structure in a larger context and in relation to other phenomena and processes(2) .

Aim of study

To find out the association between family satisfaction with their demographic characteristics

Method

The study used a predictive technique and involved 147 family members of patients in three hospitals. The sample included intensive care patients and their closest relatives. Initially, 120 participants responded positively.

Result

The study surveyed patients in intensive care units (N=120) about their overall satisfaction with the care provided. The results showed that patients were satisfied with the care provided, including the concern and care by ICU staff, symptom management pain,

breathlessness, agitation, emotional support, coordination of care, and the skill and competence of ICU nurses and doctors. The overall satisfaction score was 60.69, with a mean of 60.69. The study also found that patients were satisfied with the atmosphere in the ICU waiting room, participation in daily rounds, and the level of health care received by their family members. The study also found that the decision-making process was satisfactory, with patients feeling included and supported during the process. The study also found a good level of satisfaction with the decision-making process. The study also found a correlation between levels of family satisfaction and demographic characteristics among patients in intensive care units.

Conclusion

The study found that patients' relatives, mostly in their early adulthood, are more likely to provide care for their patients in the ICU. Male participants were found to be more responsible, and mothers were preferred to stay with their patients. Family members generally have good satisfaction with ICU care due to cooperation with healthcare staff. Age and kinship were significant factors influencing satisfaction. In addition, there is a relationship between the educational qualifications of the participants and their level of satisfaction with the critical care provided to their patients.

Recommendation

1. Implement training programs for healthcare staff to enhance sensitivity to familial dynamics. This could include understanding cultural norms, recognizing decision-making dynamics within families, and adapting communication styles accordingly
2. Create personalized care plans that take into account the preferences and needs of family members based on their relationship with the patient. For example, providing extended visiting hours or specific accommodations for immediate family members might enhance satisfaction.

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الملخص

الخلفية:

علم الديموغرافيا هو المصطلح الذي يستخدم لوصف دراسة السكان البشريين والتقلبات في الحجم ناتجة عن الهجرة والخصوبة والوفيات. تأتي كلمة الديموغرافيا من الكلمة اليونانية ديموغرافيا، والتي تعني "وصف الناس". تهدف هذه العلم إلى تحليل السمات الديموغرافية للسكان، بما في ذلك نسبة الجنس، توزيع الأعمار، التكوين، التوزيع الجغرافي، وكثافة السكان(١). بالإضافة إلى ذلك، في بعض الأحيان يتم عمل تمييز بين "الديموغرافيا الرسمية"، أو "تحليل الديموغرافية"، الذي يتضمن التحليل الإحصائي لمعلمات السكان وديناميكياتها، و"الدراسات السكانية"، التي تنظر إلى أسباب وآثار التغيرات في هيكل السكان في سياق أوسع وعلاقتها بظواهر وعمليات أخرى.(2)

هدف الدراسة

البحث عن العلاقة بين رضا الأسرة وسماتهم الديموغرافية.

الطريقة

استخدمت الدراسة تقنية توقعية وشملت ١٤٧ من أفراد العائلة للمرضى في ثلاثة مستشفيات. شملت العينة المرضى في وحدات الرعاية المركزة وأقرب الأقارب لهم. في البداية، استجاب ١٢٠ مشاركًا بشكل إيجابي.

النتيجة

قامت الدراسة بمسح المرضى في وحدات الرعاية المركزة (N=120) حول رضاهم العام على الرعاية المقدمة. أظهرت النتائج أن المرضى كانوا راضين عن الرعاية المقدمة، بما في ذلك الاهتمام والرعاية من قبل موظفي العناية المركزة، وإدارة الأعراض مثل الألم، وصعوبة التنفس، والاضطراب، والدعم العاطفي، وتنسيق الرعاية، ومهارة وكفاءة ممرضات العناية المركزة والأطباء. كان معدل الرضا العام ٦٠.٦٩، مع متوسط ٦٠.٦٩. كما وجدت الدراسة أن المرضى كانوا راضين عن الجو في غرفة الانتظار في وحدة العناية المركزة، والمشاركة في الجولات اليومية، ومستوى الرعاية الصحية التي تلقاها أفراد عائلتهم. كما وجدت الدراسة أن عملية اتخاذ القرارات .

Introduction

Overview

An important component of evaluating the quality of healthcare is family satisfaction with the critical care given to patients in neurosurgical institutions' intensive care units (ICUs). This subject examines how successfully family members' wants and expectations are satisfied when their loved ones are hospitalized for serious conditions (1). Satisfaction levels can significantly impact the overall perception of care quality, influence the emotional and psychological well-being of family members, and affect their cooperation with healthcare providers. This evaluation aims to identify strengths and areas for improvement in the current care practices to enhance the support provided to both patients and their families (2).

Developing a partnership with clinicians to provide effective person-centered care requires taking into account the opinions of families and other designated decision-makers, as many patients admitted to an intensive care unit (ICU) are unable to make ongoing decisions about their care for themselves during their stay in the ICU (3). Patient satisfaction is a multifaceted and intricate concept. According to some studies, a key objective for every healthcare institution is to determine if patients are satisfied with their nursing care since this is the greatest indicator of their overall satisfaction with hospitalization (4).

Family members play a critical role in the patient's care both before and after their hospital stay since they promote psychological health and boost their will to resist disease (5). When a critically ill patient is admitted to an intensive care unit (ICU), close family members are typically involved. Several issues, such as a lack of knowledge, complexity, and the need to treat ill and unstable patients on short notice make it difficult to communicate uncertainty to patients and their families in the intensive care unit (ICU) (6).

Family members who are hospitalized in the intensive care unit (ICU) for critically sick patients sometimes take on the role of caretakers and run the risk of experiencing negative psychological

effects. It's important to comprehend how critical sickness affects family caregivers psychologically (8). Along with efficacy and justice, the humanity of healthcare—which is often gauged by the patient experience is being recognized as one of the three fundamental components of quality. It is currently believed that listening to patients' opinions and experiences is crucial to providing high-quality care (9).

Any humane healthcare system must give patients' needs and preferences first priority (10). Family satisfaction with the treatment received is a crucial indicator of the quality of the ICU. Due to the side effects of their drugs or their underlying disease, patients in the intensive care unit are either unable or very unlikely to be able to offer feedback about the treatment they got. Family members thus serve as proxies for patients while they are in the intensive care unit (11). The efficacy of critical care services has traditionally been evaluated using measures including outcome, length of stay, mortality, and residual morbidity. In recent years, the provision of high-quality healthcare has become a key problem (12). In a critical care setting, the family must be included in the overall satisfaction with the treatment received. However, while evaluating the quality of care, the needs of patients and their families—who are separate entities—are not taken into consideration (13).

Family members have a crucial role in supporting a patient's psychological health and helping them feel more motivated to resist disease both during and after their hospital stay (14).

Background

Family satisfaction in intensive care units is a complex matter that involves several factors, such as communication with medical staff, emotional support, participation in the decision-making process, and the general standard of care given to patients. Family members may feel especially high levels of stress and worry in neurosurgical intensive care units, where patients often have serious and life-threatening diseases (2).

Relatives of patients admitted to the intensive care unit (ICU) are crucial in ensuring that their loved ones get the finest treatment

possible. Once a patient is hospitalized to the intensive care unit (ICU), family members may become vulnerable to disorders like anxiety, depression, or post-traumatic stress disorder, which may create ethical concerns (15). Being in an intensive care unit (ICU) is an experience that has garnered less attention in the research as one of the nursing-sensitive outcomes, especially when considering family members' viewpoints. Though there isn't a set definition, family satisfaction (FS) in the intensive care unit (ICU) is often understood to be the degree to which family members' needs and expectations are met (16).

The uncertainty and dread surrounding the patient's critical illness, as well as the terrifying perceptions connected with the ICU setting, make family members of ICU patients a vulnerable group with a significant risk of health deterioration. However, family members regularly have to make decisions on behalf of ICU patients since they typically lack the mental ability to do so (14). It's likely that relatives of patients receiving treatment in an intensive care unit (ICU) are unaware of the ins and outs of ICU medicine. This might lead to a general dissatisfaction with the care received and a deterioration in trust towards the medical staff. Several studies have shown that treatments aimed at improving communication between family members and intensive care unit personnel result in a greater understanding of the care provided (17).

In order to enhance the quality of family care, professional guidelines recommend proactive family participation and help in the ICU. Using specific roles or consultations, as well as facilitating systematic communication, information sharing, and family support are some of these tactics (18).

As a result, giving customers high-quality treatment is becoming harder. It is anticipated that all healthcare professionals, but especially nurses, have all the necessary skills to handle the difficulties that have come before (19). Better results have been linked to including family members in the treatment of critically sick patients (20Family satisfaction with intensive care units (ICUs) is a significant element in determining the quality of treatment. As a

result, family members are now more involved in the treatment process and their needs are met throughout the patient's stay in the intensive care unit (21). Health Care Professionals (HCPs) should now see the role of the family as active participation rather than passive consultation in the Intensive Care Unit (ICU) due to the expansion of the idea of "family engagement" (22). If hospital health services can satisfy patients and their families, then they should be of high quality. Family satisfaction is a criterion for evaluating the quality of nursing services, as well as a reflection of family attitudes regarding such services. Families of patients receiving care in the Intensive Care Unit would seem to have received this reaction generally (23).

Intense Care Unit (ICU) patients are very ill or critically ill people who need intense care, round-the-clock monitoring, technological equipment utilization, and a highly skilled multidisciplinary team (24). In the hospital's intensive care unit (ICU), patients who are very ill are attended to by highly skilled healthcare professionals. Family members can help by providing information and support to patients who are in critical conditions. When a sick loved one receives high-quality care in the intensive care unit (ICU), family members—who often make medical decisions on their behalf—are happy (25).

Critically sick patients' family members have a substantial impact on their health; this phenomena is known as post-intensive care syndrome–family. (PICS-F) (26). Health professionals are increasingly aware of the importance of family inpatient care, which makes the introduction of family-centered care in intensive care facilities pertinent. However, there hasn't been much research done on the use of critical care in adults (27). Numerous scholarly articles and comprehensive reviews have shown the impact of ICU treatments on patient and family outcomes. Proactive techniques including palliative care and communication intervention enhanced family satisfaction, shortened ICU stays, and raised family members' psychological well-being. Evaluations of family

satisfaction with intensive care units often focus on three areas: communication, decision-making, and overall care (28).

Problem statement

For the treatment of serious illnesses, especially those involving difficult procedures or critical neurological abnormalities, the intensive care unit (ICU) is an essential component of the healthcare system. Because of their illness, family members frequently go through a lot of emotional stress, which affects how happy they are with the treatment they receive. Targeted study is necessary because there aren't many thorough studies on family satisfaction in Iraqi neurosurgical intensive care units.

Aim of study

To assess level of satisfaction with critical care of patients in the intensive care units.

Materials and methods:

Design of study

A descriptive study was employed to meet the study's objectives. The study commenced on September 20, 2023, and concluded on April 18, 2024.

Setting of the Study

This research was conducted at the HDU of Ghazi Hariri Hospital, the Neurological Teaching Hospital, Neurological Hospitals, and the critical care units of Dr. Saad Al-Watari Teaching Hospital. We included patients' relatives to evaluate their satisfaction with the treatment and nursing management received in the neurological critical care units. These hospitals were selected due to their specialization in neurological conditions.

The Sample of the Study

Convenience-based Non-Probability Sample:

There are 147 family members of patients who have the condition within the study group. They must spend a minimum of twenty-four hours in the critical care unit. If they are not yet eighteen, they must be listed as the patient's closest relative. In three different hospitals

in Baghdad, the patient's closest relative has been listed as a family member, friend, or other person in the critical care units. We gathered potential subjects, interacted with them, and filled out the questionnaire with research details. Additional requirements for inclusion were:

The patient must be listed as an "Intensive Care Patient," which denotes being in the ICU for more than 24 hours or longer as necessary.

For as long as it takes, the patient needs to be on assisted breathing, which includes mechanical ventilation, BiPAP, continuous positive airway pressure (CPAP) machine, a tube, or a ventilated mask. The patient is still receiving critical treatment.

The three ICUs in question are representative of two hospital health departments in Baghdad. Out of the sample of 147 people who were initially given the questionnaire, 120 replied favorably.

Data Collection Process:

The questionnaire was distributed to all target sample members (147 individuals). After collecting the data, it was found that only 120 individuals completed the questionnaire fully. The remaining 27 individuals had incomplete responses and were excluded from the final analysis.

Inclusion Criteria

1. Every family member who wants to participate voluntarily.
2. A family member or next of kin must be at least 18 years of age.
3. A patient's family member admitted to the ICU for more than 24 hours.

Exclusion Criteria

1. No more than two family members per patient
2. Prior participation
3. Age under 18 years old
4. Inability to read or write

The Study Instrument

Four elements make up the FS-ICU 24 questionnaire, which assesses family satisfaction with the care provided to the patient and their family throughout the ICU stay.

1. Satisfaction with Care

Patient care and the environment of the ICU waiting room are important determinants of patient satisfaction. Important aspects of the patient experience include the staff's concern, care, symptom treatment, attention to the patient's requirements, emotional support, and care coordination. The physicians' and nurses' proficiency and competence are also essential. Another key aspect of the ICU is the environment. The quality of treatment obtained in the intensive care unit is equally crucial. Other crucial elements are the regularity of contact with physicians, the accessibility and convenience of information gathering, the comprehension of information, honesty, completeness, and consistency of information. Overall, the patient's happiness depends on the ICU staff's concern, attention, and communication with them.

2. Family Satisfaction with Decision-Making Around Care of Critically Ill Patients

The purpose of the questionnaire is to gauge how satisfied families are with the decisions made about the treatment of very sick ICU patients. It inquires about how often you communicate with the physicians in the intensive care unit, how simple it is to get information, how well you comprehend it, how honest it is, and how consistently it is provided. The family members' information requirements are another item on the questionnaire. The findings indicate that although most family members are quite happy with the information, they get from ICU workers, the majority are extremely unhappy with the contact they receive from ICU physicians. In addition, questions about the accuracy, consistency, and comprehension of information supplied by ICU personnel are included in the questionnaire. The findings imply that the family

members are mostly happy with the care that the ICU personnel provides.

3. Process of Making Decisions

Important choices about your family member's medical treatment were made when they were in the intensive care unit. Feelings of inclusion or exclusion, support, control over care, and enough time for inquiries and concerns were all factors in the decision-making process. The replies showed a spectrum of emotions, including extreme exclusion, extreme inclusion, and extreme lack of support. Some felt they had little influence over their care, while others felt they had plenty of control. Another element was the amount of time spent making decisions; some felt it was more than sufficient, some felt it was more than adequate, and others felt it took a significant amount of time. The whole event was a jumble of feelings and encounters, emphasizing how crucial it is to recognize and handle issues while making decisions.

4. Demographics

We ask the patient's family members to provide demographic information. The patient's family members include the patient's wife, husband, partner, mother, father, sister, brother, daughter, son, and other family members. Before the recent incident, the patient's family member has been involved in an ICU. The patient's family member currently lives with the patient, and the average frequency of visits is more than weekly, weekly, monthly, yearly, or less than once a year. The patient's residence is either in the hospital's city or out of town. Either the patient has not completed their highest level of education, they have completed some university education, or they have successfully completed a community college, technical college, or post-secondary program. The highest level of education can be a university degree or a graduate degree.

Result

Table (3-1): Distribution of Samples According to Their Socio-demographic Characteristics

ist	Characteristics		f	%
	Age M±SD= 35.71±10.872	18 – 27	39	32.5
		28 – 37	31	25.8
		38 – 47	29	24.2
		48 and over	21	17.5
		Total	**120**	**100.0**
	Sex	Male	68	56.7
		Female	52	43.3
		Total	**120**	**100.0**
	kinship	Wife	6	5.0
		Husband	4	3.3
		Mother	23	19.2
		Father	5	4.2
		Sister	6	5.0
		Brother	22	18.3
		Daughter	19	15.8
		Son	18	15.0
		Other	17	14.2
		Total	**120**	**100.0**
	Level of education	Did not complete secondary school or high school	58	48.3
		Completed secondary or high school	20	16.7
		Had some university education or completed a community college	22	18.3
		University degree (for example; BA, BSc, BSN)	16	13.3
		Graduate degree (for example; MD, DDS, DMD, DVM, Master's, or Ph	4	3.3
		Total	**20**	**100.0**
	Role of family member in admitted of patient in ICU	Yes	2	76.7
		No	8	23.3

		Total	**20**	**100.0**
	Do you currently live with the patient	Yes	2	76.7
		No	8	23.3
		Total	**20**	**100.0**
	Where do you live	In the city or town where the hospital is located	8	65.0
		Out of town	2	35.0
		Total	**20**	**100.0**

The data presented in Table 3-1 reveal that the patients' average age is 35.71 ± 10.872 years, with 32.5% falling within the age group of 18–27 years. The male population accounts for 56.7% of the samples, while the female population accounts for 43.3%. The analysis indicates that the majority of participants (19.2%) are mothers of patients. Regarding the level of education, 48.3% of participants did not complete secondary school or high school. Concerning the role of family members in the admission of patients to the ICU, 76.7% of participants answered yes. Regarding the statement, "Do you currently live with the patient?" asked to participants, 76.7% of them answered yes. Additionally, 65% of participants stated that they live in the city or town where the hospital is located.

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Table (3-6): Correlation between levels of Family Satisfaction and Demographic Characteristics among Family Member of Intensive Care Units' Patients (N=120)

Sociodemographic \ Family Satisfaction		Score					Total	Statistical Method (result)	Sig. (P value)
		Poor	Fair	Good	Very good	Excellent			
Age	18 – 27	0	6	25	8	0	39	Chi-square 22.007	.037
	28 – 37	0	14	11	5	1	31		
	38 -47	4	6	13	6	0	29		
	48 years and more	2	6	8	5	0	21		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Sex	Male	2	14	36	15	1	68	Contingency Coefficient .211	.23
	Female	4	18	21	9	0	52		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Kinship	Wife	0	2	2	2	0	6	Chi-square 54.24	.008
	Husband	2	2	0	0	0	4		
	Mother	2	5	9	7	0	23		
	Father	0	0	1	4	0	5		
	Sister	0	2	2	2	0	6		
	Brother	0	6	13	3	0	22		
	Daughter	2	7	6	3	1	19		
	Son	0	4	13	1	0	18		
	Other	0	4	11	2	0	17		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Level of education	Did not complete secondary school or high school	0	12	31	14	1	58	Chi-square	.002
	Completed secondary or high school	4	4	5	7	0	20		
	Had some university education or completed a community college	2	6	11	3	0	22		
	University degree (for example; BA, BSc, BSN)	0	6	10	0	0	16		
	Graduate degree (for example; MD, DDS, DMD, DVM, OD, Master's, or Ph	0	4	0	0	0	4		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Role of family member in admitted of patient in ICU	Yes	6	24	44	18	0	92	Contingency coefficient .204	.267
	No	0	8	13	6	1	28		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Do you currently live with the Patient	Yes	4	27	40	20	1	92	Contingency coefficient .172	.457
	No	2	5	17	4	0	28		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		
Where do you Live	In the city or town where the hospital is located	2	26	31	18	1	78	Contingency coefficient .287	.029
	Out of town	4	6	26	6	0	42		
	Total	**6**	**32**	**57**	**24**	**1**	**120**		

Table 3.6. revealed that there were significant relationships between age, kinship, and education level with level of satisfaction at p-values of .03, .008, and .002 respectively.

Discussion

4.1. Discussion of Demographic Characteristics of the Study Sample

Results in Table 1 showed that the mean age of the study sample was about 35 years, with the highest percentage within the age group of 18–27 years. In a qualitative study conducted to measure the experiences of relatives of ICU patients, the study was conducted on 13 relatives who expressed their need for support from nurses to care for their patients. In this study, most of the sample's ages were within the range of 41–65 years (2).

In another prospective study conducted to measure family satisfaction in the ICU during COVID-19, 168 family members were included. The mean age of the study sample was 52 years, and most of them were satisfied with the quality of care. In a study conducted to measure family satisfaction in the ICU, 553 family members were included. The results reflected that approximately 59 percent of the study sample were within the age group of 35–60 years, and most of them were satisfied with the comfort and trust provided by the nurses (5). A study conducted in Iraq to determine family satisfaction in the ICU at Baghdad Medical City found that the mean age was approximately 50.9 years. This result revealed that most of the study sample, consisting of patients' relatives, were in early adulthood and possessed the physical ability to be present and provide care for their patients. The results of the proposed study revealed that the majority of the study sample were males, accounting for more than half of the total sample, while the remainder were females. In contrast, a study measuring family satisfaction in the ICU during COVID-19 found that the majority of the study sample were females, accounting for 69 percent. Similar results were found in other studies where females constituted the majority of family members of patients admitted to the ICU. However, a cross-sectional study measuring the satisfaction of 100

family members with ICU care found that more than half of the included sample were males, accounting for 52 percent. This result may suggest that male participants feel a greater responsibility to stay with their patients in the ICU than females. The results reflected that the majority of the family members were mothers of the patients admitted to the ICU. In contrast, other cross-sectional studies conducted to measure the satisfaction of 318 families with ICU care found that the highest percentage of the study sample were the spouses of the patients. Additionally, it was found that partners were more frequently the relatives of patients in the ICU. This result may suggest that mothers, being more emotional, prefer to stay with their patients during their ICU stay more than other family members. Approximately half of the study sample had not completed secondary school or higher education. In contrast, previous studies found that the majority of the study sample had completed secondary school, and other studies found that the highest percentage of the study sample had attained a college level of education. This demographic variable could influence the level of satisfaction based on the information the participants possess.

The finding that approximately half of the study sample had not completed secondary school or higher education contrasts with previous studies, where the majority of participants had attained higher levels of education. This difference could be attributed to several factors, including the socioeconomic background of the study population, access to education in the region, and cultural attitudes towards education. Individuals with lower educational attainment may have different expectations and understanding of the care provided in the ICU, which could affect their level of satisfaction. Additionally, educational background may influence how effectively family members communicate with healthcare providers, understand medical information, and engage in the decision-making process, all of which are critical components of their overall satisfaction with care. This suggests the importance of tailoring communication strategies to accommodate the educational

levels of family members to ensure that they are adequately informed and supported throughout the care process.

The study revealed that most of the participants were responsible for admitting the patients to the ICU and lived with the patients, with the majority residing near the hospital. In contrast, previous studies reported that more than half of the participants lived with the patients before their ICU admission, but the majority of them resided far from the hospital.

Discussion of the Association between Demographic Characteristics of the Study Sample with their Satisfaction

Results indicated significant relationships between age, kinship, education level, and residence of participants with their satisfaction in the ICU. Previous studies have reported that sex and length of stay in the ICU were associated variables affecting satisfaction (13, 14). Another study found that family members' satisfaction with ICU care for their patients was associated with their age, education level, occupation, and kinship to the patient, while no association was found with sex, marital status, or race (41). Previous research has reported a significant association between family members' satisfaction with ICU care for their patients, the length of their stay, and the trustworthiness of the information they receive (3, 9, 19). Another study reported that higher satisfaction levels among family members of ICU patients were associated with their ability to stay with patients for longer periods, proximity to the hospital, and older age of the participants (15).

A descriptive analytical study was conducted on 80 family members of patients admitted to the ICU. This study aimed to measure family satisfaction with care both inside and outside healthcare settings. The results revealed that family members expressed some level of dissatisfaction with the quality of care, particularly in relation to communication with nurses and receiving support from nurses (49).

The age of participants in their second and third decades of life was associated with their level of satisfaction, as this age range

may be most appropriate for bearing responsibilities for their relatives in patients. Additionally, kinship of participants to their patients was identified as a significant emotional factor associated with satisfaction levels. Moreover, the level of education of participants was found to be associated with their level of satisfaction, as higher levels of education tended to lead to increased satisfaction (the researchers).

4.3. Discussion of the Association between Demographic Characteristics of the Study Sample with their Satisfaction

The results indicated significant relationships between participants' age, kinship, education level, and residence with their satisfaction in the ICU. Previous studies have reported that sex and length of stay in the ICU were associated variables affecting satisfaction (13, 14). Another study found that family members' satisfaction with ICU care was associated with their age, education level, occupation, and kinship to the patient, while no association was found with sex, marital status, or race (41). Additionally, previous research has reported a significant association between family members' satisfaction with ICU care, the length of the patient's stay, and the trustworthiness of the information they received (3, 9, 19). Another study reported that higher satisfaction levels among family members of ICU patients were associated with their ability to stay with patients for longer periods, proximity to the hospital, and older age (15).

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relatives in patients. Additionally, kinship of participants to their patients was identified as a significant emotional factor associated with satisfaction levels. Moreover, the level of education of participants was found to be associated with their level of satisfaction, as higher levels of education tended to lead to increased satisfaction (the researchers).

Conclusion:

The study highlights the importance of demographic characteristics, such as age, education level, and kinship, in influencing family satisfaction levels in intensive care settings. This suggests that these factors play a crucial role in shaping how family members perceive and evaluate the quality of care provided.

Since most participants were mothers and their satisfaction levels were reported as good, it indicates that mothers, as primary caregivers, are generally content with the care provided in intensive care units. This emphasizes the critical role of mothers in the care process and suggests that healthcare providers should continue to focus on addressing their specific needs and concerns to maintain high satisfaction levels.

Recommendation:

1. Healthcare providers should develop and implement communication strategies that are tailored to the demographic characteristics of family members, such as age, education level, and kinship.
2. Given that most of the study participants were mothers with high satisfaction levels, it is recommended to continue and expand support services specifically aimed at maternal caregivers.

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