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Perception of Nurses' Support among Family Members of Hospitalized Patients in A Tertiary Health Facility in South-West, Nigeria

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Abstract

Introduction: Family members of hospitalized patients are often faced with challenges and may experience difficulty in coping without appropriate support. The aim of this study was to assess hospitalized patients' family members' perception of nurses' support.

Methods: A cross-sectional descriptive design was utilized. A total of 138 family members of hospitalized patients in a tertiary health facility were selected using a purposive sampling technique. Data were collected with an adopted structured questionnaire. Analyses of data were performed using frequency, percentage, mean, standard deviation, and multiple regression. The level of significance was set at 0.05 ($p < .05$. Also, age, gender, and type of family were the predictors of emotional support ($R2 = 84$, $F(6, 131) = 5.92$, $p < .05$.

Results: Twenty-seven qualitative studies were included in the review. A thematic synthesis showed over 100 themes and subthemes across the studies. A cluster analysis revealed positive elements and others that were seen in the studies as a barrier (hindrance) to clinical learning. Positive elements included supportive instructors, close supervision, and belonging (in the team). Unsupportive instructors, a lack of supervision and not being included were seen as a hindrance. Three key overarching themes that could describe a successful placement were revealed as "Preparation," "Welcomed and wanted" and "Supervision experiences". A conceptual model of clinical placement elements conducive to nursing students' learning was developed to enhance understanding of the complexities associated with supervision. The findings and model are presented and discussed.

Conclusion: A significant number of families of hospitalized patients reported poor perception of cognitive, emotional, and overall support from nurses. Adequate staffing is a prerequisite for effective family support. Nurses also need appropriate training in providing family support. The focus of family support training should emphasize practices that nurses can use in everyday interactions with patients and family members.

Keywords

nurses, support, hospitalized patients, family members, acute care setting

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Introduction

Families are primary support for members in health and sickness/illness (Jazieh et al., 2018). Hospitalization in the medico-surgical settings may be as a result of an acute or chronic illness or due to injury (Gwaza et al., 2017) The sick person is often accompanied by their family members for information and support (Gwaza et al., 2017). Hospitalization is very stressful for the patients and their families (Jazieh et al.,

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2018; Parsapour et al., 2011). The patient and their family members have many fears and worries about the sickness, trauma, or surgery that warrants the admission of their loved ones. Similarly, they are concerned about the outcome of care that they may not bother about their personal needs. The hospital environment is strange to both patient and the family members; the patient needs the support of the family members to sail through the hospitalization experience. Family members of hospitalized patients with critical conditions experiences mental stress and depression (Alsharari, 2019).

In Nigerian hospitals, family members of patients are involved in providing care for their sick member in the hospital (Gabriel et al., 2019; National Cancer Institute, 2019). Such care includes providing meals, feeding, bathing, meeting financial needs, and being available at the bedside of their loved one in order to be able to quickly notify health personnel in case of any deviation from normal state of health. As a result of these burden, family members of patients are often faced with many challenges which include anxiety, stress, emotional and health problems (Kaur et al., 2018; Liang et al., 2018) and may find it difficult to cope with the hospital experience (Chhetri & Thulung, 2018). Moreover, the hospital administration and policies do not make provision for support for family members to be able to cope with such experience (Chukwu et al., 2022). Botes and Langley (2016) suggested that supportive care from members of the health team reduces the stress and anxiety. Previous study reported that some family members developed post-traumatic stress disorder (Petrinec & Daly, 2016).

Nurses form the largest number of health care workers in the hospital setting, and they provide a round the clock bedside care for their patients. Nurses interact more with patients and families. Furthermore, they have the responsibility of providing supports to the family members in coping with the hospital experiences (Park et al., 2018; Petry et al., 2019). Nurses are usually divided between caring for the medically unstable patient and the family; with major focus on the patient (Coyne et al., 2016). Nurses must take the advantage of the participation of family in care to build interpersonal relationships and support for the family. Family-centered nursing care is the approach of providing support for both patient and family members in crisis such as hospitalization. Family-centered nursing care approach has become a routine care approach among health workers in many parts of the world (Okunola et al., 2017), this involves health workers collaboration with family members in their experience.

Illness of a family member increases the risk of physical and emotional harm to other family members which creates fresh needs that must be met (Kohi et al., 2016). Family-centered nursing care approach recognizes these needs and creates opportunity for the health workers to team up with family members to identify appropriate supports to meet these needs (Emmamally & Brysiewicz, 2019). Studies have been conducted to identify the important needs of families of hospitalized patients in different parts of the world (Izadpanah et al., 2021; Botes & Langley, 2016; Hsiao et al., 2017; Kohi et al., 2016). In view of the challenges of family members of hospitalized patients, previous studies also acknowledged the need for support of family members when their loved ones are hospitalized (Emmamally & Brysiewicz, 2019; Dieperink et al., 2018;). Despite the adoption of this aspect of family-centered nursing care in different parts of the world; there is paucity of studies on the needs of family members and appropriate behavior of nurses in providing support. Studies in Nigeria confirmed participation of family members in providing care for patients in the hospital (Mukoro, 2011; Alkali, 2019;). Studies also emphasized on the stressful impact of hospitalization on family members of hospitalized patients in Nigeria (Olabisi et al., 2020; Wina et al., 2021; Chukwu et al., 2022). However, there is dearth of information on nurses' support of family members to reduce the stressful experiences during their loved one's hospitalization. Shields et al. (2015) cautioned that the participation of family members in care should not be mistaken for health care workers collaboration with family members. Our study seeks to fill this knowledge gap by providing information on nurses' support.

Review of Literature

The family system theory presents the family as a system and explained the interactive and interconnectedness of the family members which may affect its functionality (Dieperink et al., 2018). Changes in a member have implications on other family members. When a patient experiences an illness event, all the family members are affected due to their interdependence and interconnectedness (Dieperink et al., 2018). This enables the nurse to view a patient as an active member of a broader family system. The functionality and dysfunctionality of a family member may result from stress and strains emanating from the internal and external environment (Emmamally & Brysiewicz) such as illness state. Nurses must provide appropriate support for families to regain and maintain stability (Park et al., 2018; Petry et al., 2019).

Support refers to various forms of behaviors and actions arranged in place to provide assistance to the families of the sick patient (Bruce et al., 2016). Such support includes cognitive and emotional support. Cognitive support involves providing information and educating families to improve their coping skills and build family capability throughout the period of the illness experience (Sveinbjarnardottir et al., 2012; Bruce et al., 2016). Emotional support includes giving families opportunities to openly express their feelings and their experience as regards their loved one's illness, showing empathy and respect to boost personal well-being and empowers the family member (Sveinbjarnardottir et al., 2012; Bruce et al., 2016). Both cognitive and emotional

supports are equally important for positive family functioning outcomes (Emmamally & Brysiewicz, 2019).

Perception of support may vary among families based on their values and also based on culture (Dieperink et al., 2018). In acute illness state of a family member, nurses must give attention to both patient and their family members by providing appropriate and prompt information, emotional support, promote family communication through collaborative and trusting relationship to ensure patient and families' satisfaction (Kranjnc & Berčan, 2020).

According to some authors assertions (Park et al., 2018; Petry et al., 2019; Kokorelias et al., 2019), provision of support to family members by health workers is an important aspect of family-centered care. Family-centered care is a model of care that recommends the provision of care to patient and their families to optimize best health outcomes. This is with a view that patients, families and health professionals are interlinked and their satisfaction is also connected to one another (Kranjnc & Berčan, 2020). Family-centered care model offers an organized way of satisfying all of them (Kranjnc & Berčan, 2020). Providing family support through family centered nursing care has not been a success in many parts of the world (Emmamally & Brysiewicz, 2019). Some authors (Kokorelias et al., 2019) suggested the need to establish policies that would enhance meeting the needs of patients and families by institutions. The objective of this study is to assess the perception of nurses' support among family members of hospitalized patients in a tertiary health facility in South-West region of Nigeria. Findings may provide focus on nursing actions and activities that are important and can be adopted as support for family members. Findings may also provide evidence that may be useful for advocacy and drive policy review or formulation as may be necessary, to facilitate provision of support services for family members during hospitalization of their loved ones.

Methods

Research Design and Setting

A descriptive cross-sectional survey was utilized for this study. The study setting was Federal Teaching Hospital Ido-Ekiti in Ekiti State, located in the South-West of Nigeria. This is a tertiary health care setting with about eighteen units/wards that are involved in pediatrics, obstetrics and gynecology, orthopedics, acute care for adults, theater, ophthalmic, ear/nose/throat, and psychiatry. At the time of conducting this study, the facility has 287 nurses, while nurse to patient ratio was 1:15. There was no specific policy as regards family members of hospitalized patients, except for the regulations that permit family visit at specific hours. Family members were allowed to stay around to give support to their loved ones also. The facility does not provide accommodation for family members as at the time of the conduct of this study. There were four main wards involved in the care of male and female adults with acute care cases in the medical and surgical wards. The medical/surgical wards have an average of 70 inpatients each in a month. The study population was family members of hospitalized patients in the acute care setting (medical and surgical units) of the hospital.

Research Question

What is the perception of nurses' support among family members of hospitalized patients in a tertiary health facility in South-West, Nigeria

Sampling and Sampling Technique

The sample size for the study was determined with Yamane Taro's formula $n = N1 + N(e)2$

where: n stands for desired sample size. N stands for population size which is 189 and e stands for sampling error (0.05 as acceptable error). The wards recorded a population size of 189 of inpatients' admissions monthly. Following calculation, a total of 138 respondents was obtained with 10% non-response rate or questionnaire with error added. All questionnaires administered were retrieved. The medical/surgical setting was purposively selected because there is dearth of information on support of families of inpatients in the acute care setting. Purposive sampling technique was also used to select respondents. Families of critically-ill patients were involved in the study.

Inclusion and Exclusion Criteria

Inclusion criteria were families of patient in critical conditions. Critical condition was described as patients who were confined to be in bed and were unable to perform activities of daily living (bathing, feeding, toileting, dressing) by themselves. The family member must be acknowledged by the patient or the nurse as family member; respondents must be age 18 years and above and must have stayed in the hospital for 48 h and above, and is willing to participate. Exclusion criteria include families of patients who were not in critical conditions, who gave only financial or other support but were not involved in care of patients in the hospital. Respondents' age of 18 years was considered appropriate to be able to understand and describe the variables the researcher intends to measure.

Instrumentation

The Iceland-Family Perceived Support Questionnaire (ICE -FPSQ) adopted from a previous study (Sveinbjarnardottir et al., 2012) was used to collect data. ICE-FPSQ is a standardized scale that was first developed in Sweden (Sveinbjarnardottir et al., 2012; Bruce et al., 2016). The ICE-FPSQ has been used globally with family members of patients that are suffering from acute and chronic health conditions; also with reported established Cronbach's alpha

reliability coefficient 0.96. The scale was translated into English language in a South African study (Emmamally & Brysiewicz, 2019). The English version was adopted for this study. ICE-FPSQ had been used for similar study in South Africa (Bruce et al., 2016; Emmamally & Brysiewicz, 2019). Items on the questionnaire are consistent with the African culture belief in communal living where family members provide care and support for their sick members in the hospital as part of their involvement in care.

The instrument contained 14 question items that were divided into two subscales, namely, cognitive and emotional supports. The subscales contained five and nine items, respectively. The instrument measured perceived cognitive and emotional supports using a Likert scale: Never = 1, Rarely = 2, Sometimes = 3, Often = 4, and Always-5. The highest score on the scale is 70 points while the lowest score is 14. The minimum score of cognitive subscale is 5 and maximum score is 25 while the minimum score of emotional subscales is 9 and maximum is 45. Higher score indicates higher support. Support was classified as good (high) and poor (low) support. Scores below or equals to mean score were regarded as poor support while scores above mean score were regarded as good support. Cognitive support scores (poor = 5.0–9.9; good = 10.0–25.0), emotional support scores (poor = 9.0–15.5; good = 15.6–45.0) and grand support scores (poor = 14.0–39.4; good = 39.5–70.0) Face and content validity of instrument were achieved by giving the questionnaire to three experts in the field of family health for scrutiny. Content validity refers to the extent to which items on a tool are relevant and captures the experience of the population the researcher is interested in and also covers all aspect of the construct (Boateng et al., 2018) Experts were asked to determine the relevance of items for the construct the researcher is measuring and its appropriateness for our setting and family system. Experts rated all items as relevant and appropriate. Items on the questionnaire were accepted as valid. To ensure reliability of instrument, a test-retest was conducted using 10 respondents from similar setting. Test-retest reliability assessment involves the application of test items on two different occasions while the scores are correlated. It indicates the temporal stability of the instrument (Morgado et al., 2017). The result yielded a Cronbach's alpha reliability coefficient of 0.86. A pilot study was conducted with 20 family members of hospitalized patients with different diagnosis and with varied socio-demographic characteristics from similar setting but different from the research setting. The purpose of the pilot test is to see how family members perceive and interpret the questionnaire. Families were allowed to fill the questionnaire at the same time, while the researcher allowed them to ask questions or raise issues on any area they need clarification. Family members considered items on the tool clear with meanings that they were familiar with.

Table 1. Distribution of Socio-Demographic Characteristics of Families of Hospitalized Patients.

Variables	Frequency (n = 138)	Percentage (%=100)
Age: Mean 31.18 ± 8.04; Min 16, Max 56		
21–30	61	44.2
31–40	47	34.1
41 and above	30	21.7
Gender		
Male	66	47.8
Female	72	52.2
Relationship to patient		
Mother	24	17.4
Father	16	11.6
Spouse	22	15.9
Child	28	20.3
Grandparent	9	6.5
Siblings	30	21.7
Guardian	9	6.5
Marital status		
Single	56	40.6
Married	75	54.3
Divorced	7	5.1
Religion		
Christianity	96	69.6
Islamic	42	30.4
Type of family		
Nuclear family	109	79.0
Extended family	29	21.0

Data Collection

Respondents were recruited within the hospital. After meeting the inclusion criteria, the full details of the study were explained, and allowed to fill out the questionnaire after obtaining their consent for participation. Completed questionnaires were retrieved immediately, coded and kept safe with access to only the researchers. Data were collected within 3 months, between 2nd of March and 3rd of June 2022.

Ethical Consideration

Ethical approval for data collection was obtained from Human Research and Ethical Committee, Federal Teaching Hospital Ido-Ekiti with Protocol Number ERC2022/03/02/737B. Detailed information about study was provided for respondents and verbal and written consents were obtained. Confidentiality and anonymity were maintained throughout the process of the study.

Data Analysis

Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 25. Respondent's socio-demographic characteristics were analyzed using Frequency and Percentage. Family support was analyzed using Mean and Standard

Table 2. Perception of Nurses' Cognitive Support among Families of Hospitalized Patients.

Variables	Never F (%)	Rarely F (%)	Occasionally F (%)	Often F (%)	Always F (%)	Mean (SD
1. Nurses offered us information and their professional opinion	8 (5.8)	47 (34.1)	27 (19.6) F (%)	45 (32.6)	11 (8.0)	2.87 ± 0.94
2. Nurses provided available and easy-to-read literature about the health problem	32 (23.2)	52 (37.7)	27 (19.6)	22 (15.9)	5 (3.6)	2.30 ± 1.00
3. Nurses informed my family about the resources available in the community that helped families in similar situations	19 (13.8)	50 (36.2)	41 (29.7)	21 (15.2)	7 (5.1)	2.49 ± 0.92
4. Nurses provided ideas, information and thoughts in a manner which allowed us to learn from them and think about them	35 (25.4)	45 (32.6)	37 (26.8)	14 (10.1)	7 (5.1)	2.27 ± 0.98
5. Nurses highlighted the use of family rituals (acts/prayers) to promote our health	11 (8)	56 (40.6)	38 (27.5)	26 (18.8)	7 (5.1)	2.62 ± 0.89

deviation. Composite score was obtained and Mean was used as cutoff point to classify support. The mean score of cognitive support was 9.9, respondents who scored above the mean were classified as good perception of cognitive support and those equals to or below the mean score were classified as poor perception of cognitive support. The mean of emotional support was 15.5, respondent's score below the mean score were classified as poor perception of emotional support and above mean as good perception of emotional support. The grand mean was also computed for support (cognitive and emotional). The mean score was 39.4. respondent's score above the mean score was classified as good perception of family support and below the mean score was classified as poor perception family support. Associations between support and socio-demographic characteristics of respondents were tested using multiple regression analysis. Level of significance was considered at p value of <0.05.

Results

Sample Characteristics

Table 1 showed the distribution of the socio-demographic characteristics of the respondents. Majority (44.2%) were within age 21–30 years. More than half (52.2%) were females. More than 1 out of 5 (21.0%) were siblings while majority were from were married and were from nuclear families.

Research Question Results

Table 2 shows family members' perceptions of nurses' cognitive support (Mean = 12.55 ± 2.63). Fewer than 10% of the family members reported that the nurses always offered information and gave professional opinions (Mean = 2.87 ± 0.94). Moreover, more than half (60.9%) of the respondents said that nurses never or rarely provided available and easy-to-read literature (Mean = 2.30 ± 1.00). Furthermore, more than half (58.0%) of the respondents reported that the nurses never or rarely provided ideas, information, or thoughts that allowed family members to think and learn. (Mean = 2.27 ± 0.98).

Table 3 shows family member's perceptions of nurses' emotional support. Less than 10% (8.0%) of family members reported that nurses always offered avenue for family discussion (Mean = 3.03 ± 0.85). Also, less than 1/3rd (30.4%) reported that nurses never or rarely understand how family members affect one another, the patient's health, and also the illness itself (Mean = 3.03 ± 0.89).

In addition, more than half (56.6%) respondents reported that nurses never or rarely helped family members recognize that their emotional response is acceptable nor helped to normalize family members' emotional response" (Mean = 2.32 ± 0.98). Furthermore, more than half (55.8%) respondents reported that nurses never or rarely encouraged family members to share their illness stories and also stories of their strength and ability to tolerate illness, and that family members should not share only stories of illnesses and suffering (Mean = 2.34 ± 1.13). The categorization of family members' perception of nurses' support is shown in figure 1. This was based on the mean score of each subscale. The mean score of cognitive was 9.92 ± 2.63. The mean score of emotional support was 15.59 ± 4.21. And the grand mean for support was 39.42 ± 8.87. Score above grand mean was considered good perception while below or equals to grand mean was termed poor perception. Findings showed that majority (67.4%) reported good perception while close to 1/3rd (32.6%) reported poor perception of cognitive support. In addition, just less than half (45.7%) reported poor perception of emotional support. The grand mean showed that more than 2 out of 5 (41.3%) had poor perception of family support.

Multiple regression analysis was used to test if socio-demographic as shown in Table 4 characteristics significantly predicted family members' perception of nurses' cognitive and emotional support. The results of the regression analysis indicate that the three predictors (age, gender, and relationship) explained

Table 3. Perception of Nurses' Emotional Support among Family Members of Hospitalized Patients.

Variables	Never F (%)	Rarely F (%)	Occasionally F (%)	Often F (%)	Always F (%)	Mean (SD)
1. Nurses offered avenue for family discussions	4 (2.9)	36 (26.1)	45 (32.6)	46 (33.3)	7 (5.1)	3.03 ± 0.85
2. Nurses helped family members recognize that our emotional response is acceptable and helped us to normalize family members' emotional response	31 (22.5)	47 (34.1)	32 (23.2)	20 (14.5)	8 (5.8)	2.32 ± 0.98
3. Nurses encouraged my family to become involved with the health care team in the care of our family member and have offered us support.	20 (14.5)	44 (31.9)	39 (28.3)	24 (17.4)	11 (8)	2.58 ± 0.98
4. Nurses 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	40 (29)	37 (26.8)	26 (18.8)	28 (20.3)	7 (5.1)	2.34 ± 1.13
5. Nurses draw out our family strengths in care of our member	17 (12.3)	48 (34.8)	29 (21)	36 (26.1)	8 (5.8)	2.71 ± 1.04
6. Nurses help family members understand how our emotional response is related to the family member's illness	8 (5.8)	51 (37)	29 (21)	46 (33.3)	4 (2.9)	2.86 ± 0.97
7. Nurses encourage family member to take a break from care-giving sometimes	7 (5.1)	47 (34.1)	43 (31.2)	36 (26.1)	5 (3.6)	2.82 ± 0.89
8. Nurses understand how family members affect one another, the patient's health and also the illness itself	5 (3.6)	37 (26.8)	42 (30.4)	50 (36.2)	4 (2.9)	3.03 ± 0.89
9. Nurses looked for the family's strengths and opportunities to commend family members when their strengths have been revealed	18 (13)	47 (34.1)	38 (27.5)	32 (23.2)	3 (2.2)	2.65 ± 1.00

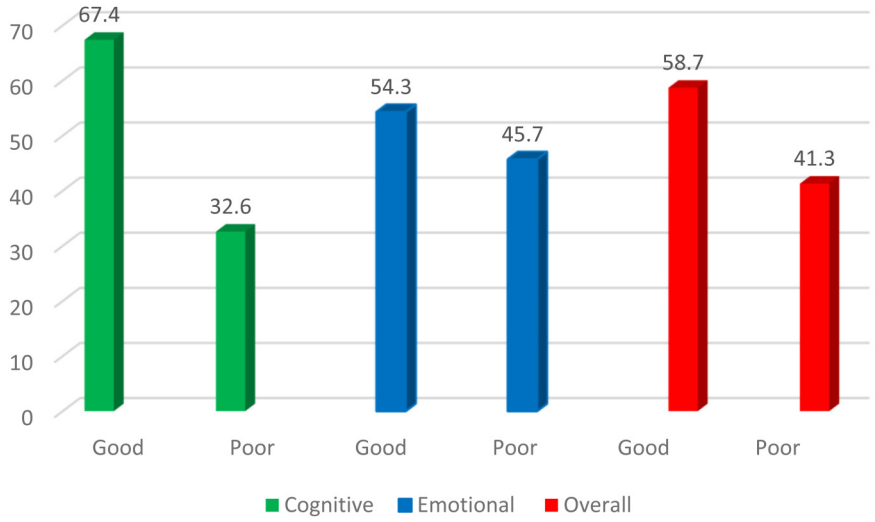

Figure 1. Overall Perception of Nurses' Support among Family Members of Hospitalized Patients on the Support Domains and the Overall.

63.0% of the variance (R2 = .63, F (6,131) = 4.46, p < 0.05) for cognitive support. Also, age, gender, and type of family were the predictors of family members' perception of nurses' emotional support (R2 = .84, F (6,131) = 5.92, p < 0.05).

Discussion

This study assessed 132 family members of hospitalized patient's on their perception of nurses' support. Majority of respondents were within age 21–30 years. Minimum age of family members was 16 years, while maximum age 56 years. Also, most prominent relationship of family members were siblings and child while majority were females, Christians, married and from nuclear families. This is similar to previous studies of families of hospitalized patients (Khosravan et al., 2014; Chhetri & Thulung, 2018), which reported that majority of family members were females and were within age 20–29 years. This is dissimilar with previous study conducted in

Table 4. Association of Socio-Demographic Characteristics with Perception of Nurse's Support among Family Members of Hospitalized Patient Using Multiple Regression Analysis.

	Cognitive support subscale scores			*Emotional support subscale* scores		
Demographic Categories	β	t	p-value	B	t	p-value
Age	−0.21	1.85	0.04	0.19	2.77	0.01
Gender	−0.39	2.45	0.01	−0.27	2.57	0.03
Relationship to patient	−0.34	1.98	0.02	−0.89	−0.44	0.65
Marital status	−0.01	0.19	0.87	−0.17	−0.86	0.38
Religion	−0.10	−1.11	0.26	−0.08	−0.44	0.65
Type of family	0.41	−1.85	0.06	−0.09	3.78	0.01
F = (6,131) 4.46				F = (6,131) 5.92		
p = 0.03				p = 0.01		
R = 0.25				R = 0.29		
R^2 = 0.63				R^2 = 0.84		

emergency department (Emmamally & Brysiewicz, 2019), which reported that majority of respondents were females but age was between 30 and 49 years and most prominent relationship were father and spouse. Females are the most popular gender involved in hospital support of family members. This indicates that females were more involved in the care of their sick loved ones in the hospital. In view of other responsibilities that women are involved in within families. Getting involved in care in the hospital could be very stressful and burdensome.

Our study showed that respondents reported poor perception of cognitive support with low mean score. This finding are similar to findings in the study carried out in the emergency dept in South Africa (Emmamally & Brysiewicz, 2019) where respondents had low mean scores also. This is contrary to findings in a study conducted among families of cancer patients in Danish and Australia (Dieperink et al., 2018) with higher mean scores. Item with highest mean score in our study on cognitive support was on support regarding provision of information and their professional opinion, this is contrary to findings in similar study (Emmamally & Brysiewicz, 2019) where families obtained low scores on this item. Previous studies of perceived needs of family members of hospitalized patients in Intensive and cardiac care units (Elay et al., 2020; Asemeh et al., 2021) reported that provision of information was considered as one of the most important needs of family members. Information serves as education and may enhance family coping skills and capability all through the hospital experience. Also, our study reported a higher mean score for support on family rituals (acts/prayers) to promote the health of family members. Similarly, a study that assessed family needs in intensive care unit in South Africa (Beer & Brysiewicz, 2016) reported that health workers demonstrated awareness of family religious practices and traditional rituals and this builds the confidence of family members and helped them to be in control of situations. Also, a study conducted in Ghana (Ohene et al., 2017) among parents of road traffic accidents in the emergency unit reported that health workers supported family belief and inspired them to engage in prayers and rituals to support the medical care they are receiving. Beer and Brysiewicz (2019) in development of a theory to guide caring for family members when their loved ones are suffering from critical health conditions, emphasized the importance of the concept of religious and cultural collaboration in family care. According to health belief model, belief that people hold may influence behavior; perceived benefits of rituals/prayers may influence positive coping behavior of families (Tsai et al., 2021).

Furthermore, this study reported a low mean score in emotional support. This finding is similar to scores obtained by family members in previous study (Emmamally & Brysiewicz, 2019). The study on oncology (Dieperink et al., 2018) reported a higher mean score. Nurses may lack the use of appropriate phrases and words that indicates empathy. Meeting the emotional needs of family members enhances their ability to cope with stressors emanating from hospitalization of loved ones. The grand mean of family support (both cognitive and emotional) in our study though very low is higher than the grand mean in the study of Emmamally and Brysiewicz (2019) whereas the study of Dieperink et al. (2018) had a higher grand mean than our study. Findings in our study is similar to findings in the study conducted in South Africa but different from the one conducted in Danish and Australia which are international/developed countries. The differences in the scores may be related to differences in culture, research setting, and how critical the condition of the patients was. Similar to previous studies (Emmamally & Brysiewicz, 2019), our study reported association of support with age, gender, and relationship of family members with patient.

Despite evidence of family involvement/participation in care in many health facilities in Nigeria, there is poor practice of family support among nurses. Adequate resources are very important to achieve nurses support of family members of patients. Most importantly, adequate staffing is crucial for adequate family support. Shield (2015) and Emmamally

and Brysiewicz (2019) stressed the need for alignment of number of nurses with patient number to achieve family care as staffing may make supporting families a difficult task. In corroboration, nurses in a qualitative study (Hetland et al., 2018) reported that inadequate staffing hinders their interaction with families. They also stated that inadequate spaces to facilitate good communication with family members were a major barrier to family interaction. Büyükcoban et al. (2021) in a study in Turkey concluded that nurses underrate the needs of family members of hospitalized patients and may mistake their daily interaction with families as support. Nurses need training in order to develop necessary skills to provide appropriate support for families. The focus of family support training should emphasize practices nurses can use in everyday interactions with patients and family members.

The findings from our study are not unexpected in view of the gross inadequate number of nurses to meet the current demand of patients and family members. Despite nurses' orientation of family-centered nursing care in training, the nurse/patient ratio may jeopardize efforts to implement the approach. There is increased workload and nurses are burdened with caring for the sick and highly demanding patients, leading to neglect of essential tasks and engagement in routines and ritualistic tasks. Nurses interact and engage with family members daily; such opportunities can be used to engage in actions and activities that serves as supports when appropriate staff strength are available. In addition, appropriate infrastructure such as reception area, counseling rooms and spaces that will facilitate family-centered nursing care practice is not in place in hospitals.

There is need to conduct constant training to update nurses with appropriate skills required to provide support for both patient and relatives to be able to cope with hospitalization experience.

Limitation of Study

The findings from this study were based on self-reported information which may have been over or under reported

Implication for Practice

Quality care in nursing should target meeting the needs of families of patients and not only meeting the needs of the patients. Implementing family-centered nursing care is a challenge in developing countries. Limitations are majorly from inadequate nursing personnel and infrastructure. Despite these limitations, providing support for families in hospitals is crucial. There is need for advocacy. Policies that address nursing skill mix and provision of basic infrastructure that enhance practice of family-centered nursing care in our hospitals should be formulated. Those behaviors that have been suggested and confirmed through research to indicate family-centered care behaviors should be incorporated into nursing education. There is also need for continuous training and education of nurses on appropriate behaviors that are considered as support for family members of hospitalized patients in order to update nurses' skills in family-centered nursing care.

Conclusion

This study showed that the perception of nurses' support among families was poor generally. In the same vein, cognitive and emotional support rated low. More families reported low emotional support. Nurses must take up the responsibility of providing appropriate support for family. Adequate staffing of nurses is a pre-requisite for effective family support. Nurses also need appropriate training to provide family support. The focus of family support training should emphasize practices nurses can use in their everyday interactions with patients and the family members. Appropriate infrastructures such as reception area, counseling room should be in place. A future study is recommended using a qualitative method in order to have an in-depth understanding of perception of nurse's support among families during hospitalization of their loved ones.

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Authors Contributions

Author C.B.B. conceptualized the study, approved the methodology, conducted literature search, wrote the first draft of the manuscript. Author **D.T.E** designed the methods, analyzed and interpreted the data and contributed to the manuscript draft. Author **O.A.I.** carried out literature search, analyzed and interpreted data. **E.O.O.** carried out literature search, and contributed to the manuscript draft. **A.C.B.** collected data, conducted literature search and contributed to the manuscript draft. All authors approved the final draft of manuscript.

Data Availability

The data that supports the findings of this study is available with the corresponding author and will be made available immediately on request.

Declaration of Conflicting Interests

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