ORIGINAL RESEARCH

Families as hospital care givers: A pilot in Turkey

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ABSTRACT

Objective: It is a common tradition that families as caregivers have been in the hospital in order to support patients. This study describes the services performed by family caregivers in surgical and medical wards of hospital.
Methods: This is a descriptive study. The study includes 442 family caregivers selected by the simple random sampling, who agreed to participate in, and who have been providing care for their relatives at least 48 hours in a university hospital. Data were collected through a questionnaire conducted during face-to-face interviews and were analyzed by descriptive statistics methods.
Results: It has been found out that family caregivers met almost all needs of hospitalized patients with their own will. The results show that family caregivers met the care needs of their hospitalized relatives mainly upon their own and patients' will (relatively 51%, 22.9%). It has also been observed that some of these requirements were met upon doctors' and nurses' demands.
Conclusions: It is important to know the requirements met by family caregivers at the hospital in terms of defining boundaries of care which can be provided by family caregivers and evaluating its results. Our findings could influence future plans of nursing managers, policy makers and/or health authorities.

Key Words: Family caregivers, Caregiver role in hospital, Services carried out by family caregivers, Turkey, Patient needs

1. INTRODUCTION

A family caregiver is considered to be anyone who provides informal care to a family member who is hospitalized. Informal care is often an important part of the total care provided to patients.[1,2] It is also a common phenomenon across many countries.[1,3] It has been found in one study that 77% of patients had family caregivers and satisfactions of these patients were higher than others.[4]

People in some cultures may prefer to accompany and support their ill family members.[1–3,5] People feel better, happier and safer when they are with their ill relatives in hospital rather than waiting for them at home. These relatives make sure that their ill relatives are taken care of. They may feel uncomfortable when they are not involved in taking care of their ill relatives.[1]

In Turkish society, it is a common tradition that a family member of the patient stays with him/her while in hospital. The patient without a family caregiver in hospital is considered as "abandoned patient". It is a common belief in Turkey that the system needs to include family member as caregiver to accompany patient during entire hospital stay and each patient needs to be taken care of by their own family members.[6] Therefore, it is very common for family caregivers to stay by their bedside for 24 hours and extensively involve in patient care. According to the study by Bektas and colleagues[7] it has been found out that 91.9% of caregivers at the hospital consist of family members and 71.4% of them stay at the hospital with their own or patient's will 24 hours

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a day. In Turkey, not only the health institutions allow the family member to do so, but also the health care staff demand from the family members to meet the patients' needs and take part in health personnel responsibilities.[8–10] In the studies carried out in Turkey, it has been found out that health staff and family members consider family caregiver at the hospital is essential[11] and that 90% of the patients requested to be cared by their own family members.[12] It has also been found out that in England relatives of old patients with mental health problems are willing to give care to their family members who are hospitalized.[13] For instance, they will assist with transportation and movement (e.g., getting out of the bed, toileting, and changing position to prevent bed sores), provide morning care and bed bath, monitor intravenous medication administration, and feed patients.[6, 8, 10, 14] This phenomenon is also highly correlated with the nursing staff shortage. In U.S. hospitals, family visitors and hospital-hired sitters are not expected to participate in most of these activities (e.g., transportation and transfers) because of nursing staff's judgment or preferences and hospital policies (e.g., the job description of sitters). It is also reported that these common traditions in eastern societies is completely different than western societies.[15]

Many studies have shown the benefits of including family members in care in inpatient and outpatient settings, especially when there's an emphasis on hands-on participation.[3, 16, 17] Therefore family members can be asked to help patients for eating, going to the restroom, exercising, showering, and carrying out skin care. It has also been pointed out that the participants helped ill family members for eating, going to the restroom, showering, caring for nails, applying cream to the skin and changing body position.[1, 18, 19] A family caregiver does not only provide informal care to his/her family member who is hospitalized but also takes care of the patients at home during recovery period. This is why family caregivers need to be studied.[11, 13]

This descriptive study aimed to investigate the role of family caregivers in surgical and medical wards to meet patient needs and the role of health professionals asking family caregivers to perform those services, and the support which patients need. This study addresses the patients' care and operations completed by the patients' family and relatives in Turkish hospitals. Moreover, there is no other study about the question "how, why, and who exactly asks for and requests from family members to complete such cares, procedures, and operations in hospital". In most of the Turkish hospitals, patients' family takes a bigger role in patients' care and meets nearly all needs. However, some of the care given by non-professionals may cause some problems and an increase in the cost of treatment. Patient safety has an increasing importance and safe care is professional care. There are many studies showing that nursing shortages affect patient safety and quality of care.[20–22]

The questions about patients' care given by family members in hospitals have not been completely defined even in western societies.[15] This study may raise a question like "can hospitals benefit from family caregivers to perform some of caring activities in societies where patients are traditionally taken care of by family members?" Understanding the situation of the family caregivers will utilize sorting out the problems and also help in shaping precautions and managements.

2. METHODS

2.1 Study setting and design

In our study, 'family caregiver' was considered as relatives who provide informal care in hospital. The study was performed in the University Hospital, which is the biggest hospital in Antalya, a city in the Mediterranean region of Turkey. The number of patients per nurses in the University Hospital is 20. There are no law or legal arrangements regarding nurse to patient ratio. Number of nurse per bed is determined at the hospitals and it is high (1:25).[23] The same applies to medical/surgical wards where this survey is carried out. It can be conceivable that this number is much better according to Turkish hospital standards but not better than developed countries standards.[24] There are no nursing aides in Turkey and also any distinction based on their educational levels.[23] Although the rate of patient/nurse is affected by provision of safe care, such as: workload, working environment, patient complexity, level of the nursing skill, and mix of nursing staff, the study from Rothberg and colleagues[25] has shown that 4 to 1 patient/nurse ratio is reasonable for safe and appropriate patient care. They have also concluded that in terms of a patient safety, patient to nurse ratio of 4:1 is a reasonable cost. This ratio is reasonable for surgical/medical wards which the research performed but not for other departments.[23]

2.2 Participants

A simple randomization strategy (based on table of random numbers) was used in assigning participants after informed consent was obtained. A total number of 460 male and female family caregivers whose ill relatives admitted to the hospital were invited to participate in this study. Out of 460 family caregivers, 8 refused to participate and 10 were accepted as non-completers. The major reasons for refusal to take part in the study were (1) no time to complete and (2) already having too much stress to complete the questionnaire. Percentage of the family caregivers reached and included in this study was 96.1%.

The participants were at least 18 years old and had been

in hospital for at least 48 hours during the period of the study. All patients and family caregivers could speak Turkish, and they did not have any other co-morbidity. As the study design required, the family caregivers completed the questionnaire by themselves during face-to-face interviews after the introduction, explanation and written permission for this study. However, the questionnaire for the illiterate family caregivers (4.5%) was filled by the researcher. There was no missing information. The participants were interviewed by the researchers in the medical and surgical units during their hospitalization between February 1, 2007 and September 15, 2007. Medical and surgical wards show similar characteristics in terms of accepting family caregivers and nurse rates.

2.3 Data collection and instruments

Data were obtained using a planned and self-administered questionnaire, which had been prepared for this study by the researchers and completed an extensive review of the literature.[14, 17–19, 26, 27] The comments from nurses responsible for the clinics used in this research were taken into account for the correction of the questionnaire. Both clinic medical and surgical nurses completed their corrections on the questionnaire separately, and then all corrections were collected on the questionnaire. 6 expert opinions were received for content validity of the questionnaire and tested by Kendall's Coefficient of Concordance (W: 0.267 and p = .001).[28] Pre-test applications on 10 family caregivers in the clinic were conducted to examine whether the questions in the questionnaire were understood or not. In the pre-test, the subjects and items that had not been understood were reevaluated.

It is aimed to investigate the role of family caregivers in meeting the patient's needs asked by himself/herself and also their patients, nurses, doctors. The questionnaire consists of two sections: (1) general characteristics of care and family caregivers, (2) patient's needs met by family caregivers and health professionals who asked for help. First section is general characteristics of care and family caregivers containing 11 questions about socio-demographic characteristics (age, gender, marital status, education, employment, relationship with patient), duration of care, reasons of caregiver's care and how much help patients do need for their own self-care.

Second section consists of three sub-sections containing 28 questions and is regarding how patients' needs are operated depending on how and by whom they are requested. The sub-section of psychological, emotional and social needs includes 6 questions; the sub-section of physical and hygienic needs includes 9 questions, and lastly, the sub-section of medical procedures related practices includes 13 questions. This section is likert type. The questions are in the form of yes, no, and no need. In the section where patients were asked "who asked to meet the needs" the choices were family caregiver, patient, nurse and doctor. When a patient is accepted to a hospital unit in Turkey, nurses and/or doctors ask the family members whether anyone would stay with patient during hospital period or not. If the patient needs and the family member wishes the permit for 24-hour stay in hospital would be given.

2.4 Ethical considerations

The approval needed to complete such questionnaire was obtained from the Director of the Hospital. Before completing the questionnaire, the written informed consent was signed by the subjects participating voluntarily. They were informed about the purpose and the length of the research. The research was approved by academic staff of Antalya Faculty of Health however not by the ethical committee of the hospital which did not exist that year. They were explained that the participation would be voluntary and they could withdraw from the study at any time. They were assured about the confidentiality, protection and anonymity of data.

2.5 Data analysis

All the data were recorded, checked for missing values, and the data were analyzed by SPSS Version 11.0 (Chicago, IL USA) for Windows using descriptive statistics. Descriptive statistics, such as the mean and standard deviation were used to describe the main variables. The chi-square (χ^2) significance test was employed for the comparison between the education level of family caregivers and procedures completed.

3. RESULTS

Table 1 summarizes the general characteristics of the care and the caregivers. The care given by family caregivers; psychological, emotional and social needs; physical and hygienic needs; and medical procedures related practices are summarized in Table 2. It can be seen from Table 2 that psychological, emotional and social needs, emotional support and making the patient feel safe (95.2%) and spending time with the patient and talking to them (94.1%) have the highest percentage providing the kind of family caregivers needs.

In physical and hygienic needs, changing nightdress/pyjamas (88.0%) giving a bed bath (74.0%) mobilizing (68.6%) taking the patient to the restroom and changing the position of the patient (63.6%) have the highest percentage. From medical procedures the most employed operations are giving oral medications (74.2%), collecting laboratory results and other test results (66.1%) and taking patients to other units

for tests (64.7%).

Table 1. General characteristics of the care and family members as a informal caregivers (n = 442)

	n	%
Wards		
Medical Wards	165	37.3
Surgical Wards	277	62.7
Age		
Mean ± SD	41.7 ± 13.7	
Range	18-85	
Gender		
Female	302	68.3
Male	140	31.7
Marital status		
Married	353	79.9
Single	65	14.7
Widow/Widower, divorced	24	5.4
Education		
Illiterate	20	4.5
Literate	18	4.1
Primary school	203	45.9
High school	128	29.0
University	73	16.5
Employment		
Employed	138	31.2
Unemployed	304	68.8
Relationship with patients		
Spouse	145	32.8
Children	145	32.8
Parents	61	13.6
Other relatives (sister, daughter-in-law)	91	20.8
Duration of care		
2-3 days	94	
4-5 days	88	21.3
6-7 days	61	19.9
8-14 days	67	13.8
15-21 days	62	15.2
22 days or over	70	14.0
Mean ± SD	14.6 ± 23.9	15.8
Range	2-180	
Reasons of caregiving (n = 498)*		
Voluntary Informal caregivers themselves	254	51.0
Upon the patient's request	114	22.9
Upon the doctor's request	105	21.1
Upon the nurse's request	13	2.6
Obligation	9	1.8
No response	3	0.6
How much help patients need for their self-care		
A little	273	61.8
Completely dependent	135	30.5
Completely independent	34	7.7

***Percentages are based on the number of given responses.

Table 3 explains who requested the family caregivers to complete such procedures. Although it is not shown in Tables, there is no correlation between the education level of family caregivers and procedures completed ($p > .05$).

4. Discussion

This study may raise a question like "can hospitals benefit from family caregivers to reduce the workload of health system in societies where patients are traditionally taken care of by family members?" Within the framework of the results derived through this study, possible effects of the procedures carried out might be discussed in terms of patient, family members and the hospital. In the societies where patient's basic care is provided by family members, both the patient and the family caregiver are happy and peaceful as care is provided that way.[7] At this point, the question of "what care activities/actions could be realized by family caregivers in the hospital?" gains importance.

People in some cultures may prefer to accompany and support and provide of the care their ill family members.[1–3, 5, 7, 17, 29] According to this study, family members as a informal caregivers provide a substantial amount of the direct care. However, this care should not jeopardize the patients' health and safety. We believe that the publication of the results will provide health professionals an opportunity to develop a better understanding about the families' contribution to the in-hospital care of hospitalized patients. There are very few studies about the performance by family caregivers at the hospital.

The family members who participate in care are women. There are also other international findings that support this.[2, 11, 14, 30] The most frequent services performed to meet the physical and hygienic needs of the patients were changing nightdress/pajamas patients, giving a bed bath, mobilizing and taking the patients to the restroom, washing face and hands, and feeding (see Table 2). Most of the family caregivers performed these actions voluntarily (see Table 3). The least frequent practices were aspiration, changing IV fluid bottles and change dressings (see Table 2). Although health staff should have provided these services, it was surprising that these are completed by family caregivers. Because these procedures requiring professional knowledge and skill are in job description of nurses in Turkey.[31] Tzeng and Yin[32] have shown that family caregivers also completed the procedure of taking the patients out of the bed and intravenous monitoring. In western societies, such procedures are in job description of nurses and any kind of procedures requiring professional knowledge and skill is completed by professionals and nurses and not allowed to be done by family caregivers.[2, 3, 15]

Table 2. Patient needs met by family members as a informal caregivers (n = 442)

Needs	Yes		No (Patients with no needs/patients with unmet needs)	
	n	%	n	%
Psychological, Emotional and social Needs				
Emotional support	421	95.2	21	4.8
Making the patients feel safe	421	95.2	21	4.8
Spending time with patients and talk to them	416	94.1	26	5.9
Informing nurses about patient needs	414	93.7	28	6.3
Informing patients about their home and family	398	90.0	44	10.0
Going shopping for patients	390	88.2	52	11.8
Physical and hygienic needs				
Changing nightdress/pyjamas	389	88.0	53	12.0
Giving a bed bath	327	74.0	115	26.0
Mobilizing and helping them to walk	303	68.6	139	31.4
Taking the patient to the restroom	281	63.6	161	36.4
Changing the position of the patient	281	63.6	161	36.4
Washing face and hands	274	62.0	168	38.0
Feeding	259	58.6	183	41.4
Helping the patient to use a bedpan	202	45.7	240	54.3
Changing bedclothes	183	41.4	259	58.6
Medical procedures related practices				
Giving oral medications	328	74.2	114	25.8
Collecting laboratory results and other test results	292	66.1	150	33.9
Taking patients to other units for tests	286	64.7	156	35.3
Massaging	237	53.6	205	46.4
Checking IV fluid administration	231	52.3	211	47.7
Measuring body temperature	200	45.2	242	54.8
Cold therapy	190	43.0	252	57.0
Emptying the urinary bag	158	35.7	284	64.3
Changing the urinary bag	127	28.7	315	71.3
Helping the patient to use respiratory devices such as spirometry, balloon, triflow	117	26.5	325	73.5
Change dressing	86	19.5	356	80.5
Changing IV fluid bottles	63	14.3	379	85.7
Aspiration	34	7.7	408	92.3

The goal of nursing care is to help the person maintaining or recovering his/her independence by completing needs, such as breathing, eating and sleeping and resting, maintaining body temperature, acting in accordance with one's beliefs and values, attending to one's self-realization, recreating and learning.[27] In Özcan and colleagues,[10] 77.3% of the informal caregivers stayed in hospital to meet patient needs, 20.1% gave the patients their medications, 27.4% changed the patients' positions, helped them walking and provided massage, 13.7% checked IV fluid administration, which are consistent with the results of the present study. In fact, in this study, 14.3% changed IV fluid bottles and 7.7% performed aspiration. The family caregivers were asked by doctors to change sheets most frequently and by nurses to change IV fluid bottles most frequently (see Table 3). It seems that the family caregivers covered the responsibilities of nurses and doctors. The caregivers mentioned that they fulfilled these responsibilities because doctors and nurses asked them to

do so. Given also none of family caregivers were trained in this subject the situation may cause harm in treatment of patients. The services that family caregivers provide during hospitalization of their ill relatives should be limited to practices that never threaten patient's care and health. It is thought that such care is given by family caregivers due to cultural reasons and insufficient number of nurses. Safe care is professional care. Nursing shortages increases workload of nurses, mistakes on medication of patients, patients falling off the bed.[20] Moreover Nursing shortages affect the mortality at the hospitals.[21, 22]

Table 3. Patient needs met by family caregivers and the person asking for patient needs? (n = 442)

Needs	Family Caregivers who met patient needs	Who asked to meet patient needs			
		Nurses	Doctors	Family Caregivers	Patients
	n*	n (%)**	n (%)**	n (%)**	n (%)**
Psychological, Emotional and Social Needs					
Emotional support	440	8 (1.8)	14 (3.2)	368 (83.6)	50 (11.4)
Making the patient feel safe	427	6 (1.4)	23 (5.4)	368 (86.2)	30 (7.0)
Spending time with the patient and talk to them	447	4 (0.9)	7 (1.6)	324 (72.5)	112 (25.0)
Informing the nurse about the patient's needs	434	26 (5.9)	7 (1.7)	295 (67.9)	106 (24.5)
Informing the patient about his home and family	435	1 (0.2)	3 (0.7)	315 (72.4)	116 (26.7)
Doing shopping for the patient	414	6 (1.4)	6 (1.5)	316 (76.4)	86 (20.8)
Physical and Hygienic Needs					
Changing nightdress/pyjamas	409	2 (0.5)	2 (0.5)	271 (66.2)	134 (32.8)
Giving a bed bath	363	16 (4.4)	4 (1.2)	245 (67.5)	98 (26.9)
Mobilizing the patient and helping them to walk	322	13 (4.0)	58 (18.0)	146 (45.3)	105 (32.7)
Taking the patient to the restroom	303	5 (1.6)	11 (3.6)	127 (41.9)	160 (52.9)
Changing the position of the patient	307	22 (7.2)	37 (12.0)	145 (47.2)	103 (33.6)
Washing the patient's face and hands	303	5 (1.6)	1 (0.3)	186 (61.4)	111 (36.7)
Feeding	273	8 (2.9)	5 (1.8)	179 (65.6)	81 (29.7)
Helping the patient to use the bedpan	217	18 (8.3)	18 (8.3)	106 (48.8)	75 (34.6)
Changing bedclothes	185	24 (12.9)	1 (0.5)	131 (70.8)	29 (15.8)
Medical procedures related practices					
Giving oral medication	360	159 (44.2)	42 (11.7)	117 (32.5)	42 (11.6)
Collecting laboratory test results and other test results	304	29 (9.5)	153 (50.3)	114 (37.5)	8 (2.7)
Taking the patient to other units for tests	297	25 (8.4)	146 (49.1)	110 (37.0)	16 (5.4)
Massaging	254	22 (8.7)	27 (10.6)	115 (45.3)	90 (35.4)
Checking IV fluid administration	244	101 (41.4)	7 (2.9)	119 (48.8)	17 (6.9)
Measuring body temperature	228	139 (60.9)	11 (4.8)	62 (27.2)	16 (7.1)
Cold therapy	211	101 (47.9)	16 (7.6)	78 (36.9)	16 (7.6)
Emptying the urinary bag	169	66 (39.0)	17 (10.1)	65 (38.5)	21 (12.4)
Changing the urinary bag	135	53 (39.2)	16 (11.8)	53 (39.2)	13 (9.6)
Helping the patient to use respiratory devices such as spirometry and triflow	136	54 (39.7)	36 (26.5)	33 (24.3)	13 (9.5)
Change dressing	93	22 (23.6)	42 (45.2)	26 (27.9)	3 (3.3)
Changing the IV fluid bottle	66	50 (75.7)	3 (4.5)	11 (16.8)	2 (3.0)
Aspiration	34	11 (32.4)	11 (32.4)	11 (32.4)	1 (2.8)

*the number of given responses. ** percentages are based on the number of given response

In consistent with the results of this study, Doğan and Elibol[9] found that 70.2% of nurses and 39.3% of doctors thought that family members as a informal caregivers provided their patients physical and emotional needs. In addition, Bayat and colleagues[14] reported that the most frequently fulfilled needs were psychological-emotional and social needs, followed by physical and hygienic needs and needs concerning medical procedures. In Özcan and colleagues[10] it was pointed out that nurses allowed family members as a informal caregivers to stay with their ill rela-

tives since family caregivers could fulfill patient care needs, provide support for patients and make patients feel safe. Appropriate guidance and education can help family caregivers to overcome psychological barriers and motivate them to help hospital professionals.[1–3,17] However, a high number of caregivers and a tendency to violate hospital rules may harm both patients and hospital staff.[2,18] The care and procedures were required to be provided by professionals and nurses. However, such duties supplied by family caregivers may cause some problems threatening the patient safety. While family members as a informal caregivers in no way replace nurses, anecdotal evidence suggests that family members might ease the demands on nurses.[16] The results of this study reveal that there is a gap in the provision of care to hospitalized patients, and that family caregivers are providing in-hospital informal care provision, reflecting specific nursing duties. Health professionals in developing countries (i.e. doctors and nurses) should directly focus on patients, and should not disregard the traditional elements of family life.[1,2,17] In this study, the majority of the family caregivers who volunteered to stay in the hospital with patients, performed most of the practices voluntarily (see Table 3). However, if caregivers are overloaded with work due to lack of staff, some problems may arise. It is recommended that the number of nursing staff should be increased, patient care procedures should be performed by nurses, admission and discharge procedures should be decreased. Family caregivers should be given appropriate responsibilities, and caregivers should provide psychological support. These may contribute to the recovery of patients. Appropriate guidance and education can help family caregivers to overcome psychological barriers and motivate them to help professionals.[1–3,17] Family caregivers provide many different services to patients, including transport, organization of medication, and assistance with basic activities of daily living such as bathing, dressing, and meal preparation.[2,18,27] Moreover, caregivers have to assume that the family roles and responsibilities are no longer able to be provided by patient. Also in some cases family caregivers may carry out those responsibilities by themselves.[17,18] Family caregivers in no way replace nurses but anecdotal evidence suggests that family involvement might ease the demands on nurses.[12,13,16] In a qualitative study done by Clissett and colleagues,[13] it has been found out that family caregivers are willing to support and give care to their hospitalized family members. In Turkey even the patient can meet some of his/her own needs, family caregiver would like meet them and this behavior is culturally accepted. This situation is clearly seen in data provided in Table 2 and Table 3. Family caregivers state that they care (see Table 3) more than patients' need (see Table 2). This situation is considered by the society as "looking after the patient perfectly" and supported.[7,11] Family caregivers are willing to cooperate with health staff. This valuable relation should be developed in favor of the patient.[13] It might be important to get help of the experienced family caregivers during safe transfer of the patient.[30] In this context examining difficulties of the family caregivers meet at the hospital and their need for support can be suggested.

5. Conclusion

There are many studies related to difficulties of experienced informal caregivers, but very few studies about the performance of family caregivers at the hospital. It is believed that the publication of the results will provide health professionals an opportunity to develop a better understanding about the family caregivers' contribution to the in-hospital care of patients. This article makes the care provided by family caregivers at the hospital visible. It is important to know the requirements met by family caregivers at the hospital in terms of defining boundaries of nursing which can be provided by family caregivers and evaluating its results. Furthermore, these findings may be of interest to health planners and policy makers, health authorities and nursing managers and they could have an influence on how future staffing plans are drawn up. This study may raise a question like "can hospitals benefit from family caregivers to perform some of caring activities in societies where patients are traditionally taken care of by family members?"

5.1 Limitations of the study

There are a number of limitations in the present study. First, the research carried out only in one center and it may be inappropriate to generalize our findings to other populations. Second, the study is based on a questionnaire study.

5.2 The needs for the future research

The needs and difficulties experienced of family members who care for their patients at the hospital can be studied. The study can be replicated in other setting and different cultures to provide cross-cultural comparisons.

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Conflicts of Interest Disclosure

The authors declare that there is no conflict of interest.

REFERENCES

[1] Reinhard SC, Given B, Petlick NH, et al. Supporting Family Caregivers in Providing Care. In: R.G. Hughes (Ed). Patient safety and quality: an evidence-based handbook for nurses, First ed. Rockville: AHRQ Pub. 2008. 1-23. http://www.ahrq.gov/qual/nurseshdbk/docs/ReinhardS_FCCA.pdf

[2] Sapountzi-Krepia D, Raftopoulos V, Psychogiou M, et al. Dimensions of informal care in Greece: the family's contribution to the care of patients hospitalized in an oncology hospital. J Clin Nurs. 2008; 17(10): 1287-1294. PMid:18328040 https://doi.org/10.1111/j.1365-2702.2007.02033.x

[3] Quattrin R, Artico C, Farneti F, et al. Study on the impact of caregivers in an Italian high specialization hospital: presence, costs and nurse's perception. Scand J Caring Sci. 2009; 23: 328-333. PMid:19302398 https://doi.org/10.1111/j.1471-6712.2008.00626.x

[4] Türker M, Erdost Ş, Aygün P, et al. "Hemşirelik Uygulamalarına Yönelik Hasta memnuniyetinin İncelenmesi". II. Uluslararası Sağlıkta Performans ve Kalite Kongresi Bildiriler Kitabı, II. Cilt. Antalya. 2010. 236-248.

[5] van den Brink Y. Diversity in Care Values and Expressions Among Turkish Family Caregivers and Dutch Community Nurses in the Netherlands. TCN. 2003; 14(2): 146-154. https://doi.org/10.1177/1043659602250641

[6] Tabar, E. Hasta Yakını Olmak. 1. Baskı. Istanbul: Pan Yayıncılık. 2006.

[7] Bektas H, Cebeci F, Karazeybek E, et al. Informal caregivers' experiences during hospitalization in Turkey. Health MED. 2012; 6(9): 3061-3069.

[8] Arıkan D, Güdücü-Tüfekçi F, Taştekin A. Çocuk Kliniklerindeki Refakatçilerin Hastanede Yaşadıkları Sorunlar, Beklentileri ve Problem Çözme Düzeyleri İle İlişkisi. Ata. Üni. Hemşirelik Y.O Dergisi. 2007; 10(2): 49-57.

[9] Doğan S, Elibol N. Hasta Refakatçi Uygulaması Konusunda Hekimlerin ve Hemşirelerin Görüşleri. Cumhuriyet Üni. Tıp Fak.Dergisi. 1997; 19(2): 81-86.

[10] Özcan A, Karataş B, Nural N, et al. Refakatçı olarak kalan hasta yakınlarının bakım ile ilgili konularda hemşire hasta ve refakatçılar tarafından nasıl algılandığının incelenmesi. III. Hemşirelik Kongresi Kitabı. 1992; 593-597.

[11] Duman ZÇ, İnan FŞ, Moursel G, et al. Psikiyatri Kliniğinde Refakatçi Uygulamasına Yönelik Hasta Yakınlarının ve Sağlık Profesyonellerinin Görüşleri. Psikiyatri Hemşireliği Dergisi. Journal of Psychiatric Nursing. 2015; 6(2): 79-84.

[12] Kumcağız H, Doyurgan TK, Malazgirt Z. Özel ve normal hasta odalarında yatan hastaların memnuniyet düzeylerinin karşılaştırılması. Deneysel ve Klinik Tıp Dergisi Journal of Experimental and Clinical Medicine. 2012; 1(29): 296-303. https://doi.org/10.5835/jecm.omu.29.04.009

[13] Clıssett P, Porock D, Harwood RH, et al. Experiences of family carers of older people with mental health problems in the acute general hospital: a qualitative study. J Adv Nurs. 2013; 69(12): 2707-2716. https://doi.org/10.1111/jan.12159

[14] Bayat M, Yaramış N, Kartal B, et al. Pediatri Servislerinde Refakatçi Olarak Kalan Annelerin Hastaneden Etkilenme Durumları ve Gereksinimlerinin Belirlenmesi. Hemşirelik Forumu. 2006; 1: 57-63.

[15] Tzeng HM, Yin CY. Inpatient falls: the impact of family and personal caregivers. Appl Nurs Res. 2009; 22: 159-165. PMid:19616163 https://doi.org/10.1016/j.apnr.2007.09.002

[16] Frampton S, Wahl C, Cappiello G. Putting Patients First: Partnering with Patients' Families. AJN. 2010; 110(7): 53-56. PMid:20574205 https://doi.org/10.1097/01.NAJ.0000383936.68462.1b

[17] Li H. Identifying family care process themes in caring for their hospitalized elders. Appl Nurs Res. 2005; 18: 97– 101. PMid:15991107 https://doi.org/10.1016/j.apnr.2004.06.015

[18] Andrén S, Elmståhl S. Family caregivers' subjective experiences of satisfaction in dementia care: aspects of burden, subjective health and sense of coherence. Scand J Caring Sci. 2005; 19(2): 157–168. PMid:15877641 https://doi.org/10.1111/j.1471-6712.2005.00328.x

[19] Astedt-Kurki P, Lehti K, Paunonen M, et al. Family member as a hospital patient: sentiments and functioning of the family. Int J Nurs Prac. 1999; 5: 155-163. https://doi.org/10.1046/j.1440-172x.1999.00167.x

[20] Duffield C, Diers D, O'Brien-Pallas L, et al. Nursing staffing, nursing workload, the work environment and patient outcomes. Appl Nurs Res. 2011; 24(4): 244-55. https://doi.org/10.1016/j.apnr.2009.12.004

[21] Aiken LH, Sloane DM, Bruyneel L, et al. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. The Lancet. 2014; 383(9931): 1824-30. https://doi.org/10.1016/S0140-6736(13)62631-8

[22] Cho E, Sloane DM, Kim EY. et al. Effects of nurse staffing, work environments, and education on patient mortality: an observational study. Int J Nurs Stud. 2015; 52(2): 535-42. https://doi.org/10.1016/j.ijnurstu.2014.08.006

[23] Türkmen E. Hemşire Istihdaminin Hasta ve Hemşire Sonuçlari ile Organizasyonel Çıktılara Etkisi: Yataklı Tedavi Kurumlarinda Hemşire Insan Gücünü Planlama. Hacettepe Üniversitesi Hemşirelik Fakültesi Dergisi. 2015; 2(3): 69-80.

[24] Gümrükçüoğlu OF, Tosun N, Yol S, et al. Health Manpower Status Report in Turkey. The Ministry of Health of Turkey & The education of Higher Education, Ankara: Uyum Ajans. 2008. 53-5.

[25] Rothberg MB, Abraham I, Lindenauer PK, et al. Improving nurse to patient staffing ratios as a cost effective safety intervention. Medical Care. 2005; 43(8): 785-791. PMid:16034292 https://doi.org/10.1097/01.mlr.0000170408.35854.fa

[26] Astedt-Kurki P, Paunonen M, Lehti K. Family members' experiences of their role in a hospital: a pilot study. JAN. 1997; 25: 908-914. https://doi.org/10.1046/j.1365-2648.1997.1997025908.x

[27] Lesneski L. The profession of Nursing. In Craven RF, Hırnle, CJ. (Eds). Fundamentals of Nursing. Human Health and Function, Philadelphia: Lippincott Williams and Wilkins; 2007: 36-52.

[28] Erdoğan S, Nahcivan N, Esin N. Hemşirelikte Araştırma, 2. Baskı. İstanbul: Nobel Tıp Kitabevi. 2015: 216-17, 223-226.

[29] Mayer GG. Families as Hospital Care Givers: A Self-service Approach to the Nursing Shortage. JONA. 2001; 31(10): 457-458. https://doi.org/10.1097/00005110-200110000-00002

[30] Toles M, Colón-Emeric C, Asafu-Adjei J, et al. Transitional care of older adults in skilled nursing facilities: A systematic review. Geriatric Nursing. 2016; 37: 296-301. http://dx.doi.org/10.1016/j.gerinurse.2016.04.012

[31] Hemşirelik Yönetmeliği. Available from: http://www.turkhemsirelerdernegi.org.tr/menu/yasa-ve-yonetmelik/hemsirelik-yonetmeligi-2010-2011.aspx%20eri%C5%9Fim%20tarihi%2026%20kas%C4%B1m%202016

[32] Tzeng HM, Yin CY. Using family visitors, sitters, or volunteers in preventing inpatient falls. JONA. 2007; 37(7-8): 329-334. https://doi.org/10.1097/01.NNA.0000285116.68313.c1