Assessment of Family Satisfaction with Patient Care and Associated factors in Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital

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Abstract

Background: Family satisfaction is an important indicator of quality of care in intensive care units (ICUs), reflecting both clinical performance and communication with relatives. In low-resource settings such as Ethiopia, evidence on family satisfaction remains limited despite increasing recognition of family-centered care.

Objective: To assess family satisfaction with patient care and identify associated factors in the Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital from November, 2025 to March, 2026 GC.

Methods: An institution-based cross-sectional study was conducted among 141 family members of ICU patients using the standardized FS-ICU-24 questionnaire. Data were entered into EpiData and analyzed using SPSS version 27. Bivariable and multivariable logistic regression analyses were performed to identify factors associated with satisfaction. Statistical significance was declared at $p < 0.05$ with 95% confidence intervals.

Results: Overall, 66.7% of participants reported satisfaction, with a mean overall satisfaction score of 66.3 ± 14.9. Satisfaction with care (71.0 ± 13.3) was higher than satisfaction with decision-making (59.7 ± 20.1). The highest scores were observed for communication frequency and physician competence, while the lowest score was for the waiting area environment (40.6 ± 31.8). Marital status, monthly income, and previous ICU experience were significantly associated with satisfaction.

Conclusion: The overall family satisfaction was positive. While clinical care was relatively well perceived, significant gaps exist in communication quality, decision-making involvement, and waiting area environment. Strengthening family-centered care practices is recommended to improve overall satisfaction.

Key words: Family satisfaction, FS-ICU, Patient Care, Intensive Care Unit

Abbreviations and Acronyms

AAU- Addis Ababa University

AOR - Adjusted Odds Ratios

CI- Confidence Interval

COR- Crude Odds Ratios

FS-ICU -Family Satisfaction in the Intensive Care Unit

ICU- Intensive Care Unit

IRB - Institutional Review Board

TASH- Tikur Anbessa Specialized Hospital

MICU- Medical Intensive Care Unit

CICU- Cardiac Intensive Care Unit

SICU- Surgical Intensive Care Unit

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1. INTRODUCTION

1.1 Background

Satisfaction is usually defined as the result of the comparison between expectations and perceived outcome [1]. The intensive care unit (ICU) serves as a pivotal component of modern healthcare systems, delivering continuous monitoring and advanced medical support for critically ill patients. Yet, the ICU environment often introduces intense emotional and psychological strain not only for patients, but also for their families [2]. Family members frequently face uncertainty, delayed communication, and stress as they await updates and make decisions on behalf of incapacitated loved ones.

Globally, family satisfaction has emerged as a vital indicator of healthcare quality alongside traditional clinical outcomes like morbidity and mortality [3, 4]. Key determinants of family satisfaction in ICU settings include clear communication, emotional support, and inclusion in care decisions, cultural sensitivity, and perceived medical and nursing competence [5]. In high-income countries, numerous ICUs have adopted family centered models that emphasize transparency and shared decision-making [6].

However, in low and middle-income countries particularly in Sub-Saharan Africa evidence on family satisfaction in ICUs is limited. Such contexts often contend with strained infrastructures, shortages in staffing and equipment, and high patient volumes, all of which can hinder the delivery of compassionate care [7].

Critical care services in Ethiopia remain underdeveloped compared to global standards. In Addis Ababa, a 2021 citywide survey of public hospitals found that intensive care units (ICUs) were severely limited in both capacity and resources. The study reported that public ICUs had between 3 and 15 beds per unit, totaling only 103 beds across the city. While all units were able to provide basic life support, including mechanical ventilation and vasopressors, more advanced services were lacking. Only 53% of ICUs had intensivists on staff, and invasive arterial blood pressure monitoring was available in just 40% of facilities [8].

At the national level, a comprehensive review of ICU services conducted in 2020 highlighted similar limitations. The study documented 324 ICU beds across 51 public ICUs, representing a critically low density of 0.3 ICU beds per 100,000 people. Distribution of these services was highly unequal, with Addis Ababa hosting about 25% of ICU beds and more than 50% of the nation's critical care physicians. Access to advanced technologies was minimal, with invasive monitoring available in only 3% of units and renal replacement therapy in less than 10%. Outcomes for critically ill patients remain poor. Published data from Ethiopian ICUs report in-hospital mortality rates ranging from 39% to nearly 50%, underscoring the consequences of limited staffing, equipment shortages, and inadequate infrastructure [7]

1.2 Statement of the Problem

Family satisfaction with ICU care is recognized worldwide as a sensitive marker of healthcare quality, reflecting both clinical and psychosocial performance [2]. Yet, in resource-constrained environments such as Ethiopia, research has predominantly focused on patient survival metrics, leaving significant gaps in our understanding of family experiences [7].

At Tikur Anbesa Specialized Hospital (TASH), Ethiopia's largest referral and teaching hospital with over 700 beds, the ICU faces tremendous pressure due to high demand, limited staffing, and infrastructure constraints [8]. Studies at TASH have reported deficiencies in physician–patient and nurse–patient communication [9] and challenges in physician–family caregiver interactions, including restricted privacy and limited provision of detailed information [10]. Anecdotal evidence further suggests that family members of ICU patients experience delays in receiving updates and minimal involvement in treatment decisions. However, no systematic study has quantified family satisfaction or explored its determinants in the adult ICU at TASH. Without such data, tailored interventions to promote family-centered care cannot be effectively designed or implemented

1.3 Significance of the Study

1. Filling a Knowledge Gap: It will produce empirical data on family satisfaction with ICU care in Ethiopia
2. Informing Quality Improvement: By identifying areas like communication, decision-sharing, emotional support, and resource adequacy, findings can direct interventions aimed at enhancing family-centered ICU care.
3. Policy Relevance: Evidence may inform both hospital leadership and national policymakers in framing guidelines or protocols prioritizing family involvement in ICU settings.
4. Potential Impact on Outcomes: Studies show that engaging families and improving communication can reduce conflict, support better shared decision-making, and potentially improve patient outcomes.
5. Ethical and Social Significance: Recognizing and responding to families' needs reinforces their role in patient care, preserves dignity, and fosters trust in the healthcare system.

2. LITERATURE REVIEW

2.1 Family Satisfaction in the Intensive Care Unit (ICU)

Family satisfaction in the intensive care unit (ICU) is increasingly recognized as a key indicator of quality of care, reflecting not only patient outcomes but also the experiences of relatives. Globally, studies consistently highlight communication, involvement in decision-making, and environmental conditions as central determinants of family satisfaction.

A systematized literature review by Guerra-Martín and González-Fernández (2020) analyzed 15 studies published between 2013 and 2018 on patient and family caregiver satisfaction in adult ICUs. The review found that satisfaction was enhanced by good communication with healthcare professionals, high quality of care, and a clean, well-maintained ICU environment. Conversely, dissatisfaction was associated with poor communication, limited involvement in decision-making and inadequate infrastructure, particularly waiting areas. The authors recommended staff training, family inclusion in care processes, and improvements to ICU and waiting room environments as strategies to optimize family satisfaction [11].

In Europe, a cross-sectional study in Norway (2015–2017) assessed family satisfaction in two ICUs using the FS-ICU 24 questionnaire. Fifty-seven family members reported high satisfaction with nursing and patient care but lower satisfaction with information provision and involvement in decision-making. Satisfaction was also influenced by demographic factors, including the relationship to the patient and patient survival, highlighting the importance of family-centered care and targeted communication interventions [12].

In the Middle East, studies in Bahrain and Saudi Arabia demonstrate similar trends. A study conducted at Bahrain Defence Force Military Hospital (2019–2022) assessed 100 relatives of ICU patients using the FS-ICU-24 questionnaire. Overall satisfaction was high (mean 5.04/6), with stronger ratings for quality of care compared to decision-making. Lower satisfaction was noted for physician communication, ICU and waiting room atmosphere, and opportunities to participate in decisions. Families recommended longer visiting hours, more frequent updates, and greater involvement in care [13].

Similarly, in Saudi Arabia, a cross-sectional survey of 248 family members using the Critical Care Family Satisfaction Survey (CCFSS) reported moderate to high overall satisfaction (mean 3.79 ± 1.26). The highest scores were for information and assurance, while lower scores were noted for proximity and support. Families valued staff honesty, shared decision-making and low noise levels but expressed dissatisfaction with limited visiting hours, transfer preparation, and responsiveness. Notably, male respondents reported higher satisfaction than females ($p = 0.007$), pointing to demographic influences on perceptions of care [14] .

In Ethiopia, family satisfaction studies reflect moderate levels and highlight persistent gaps. A 2015 study across five governmental hospitals in Addis Ababa, including adult, neonatal, and pediatric ICUs, found overall satisfaction of 62%. Families reported higher satisfaction in proximity (67.3%) and support (71.3%) but lower satisfaction in assurance (52%), information (41.6%), and comfort (41.6%). Younger relatives (<35 years) were less satisfied, whereas families with lower educational attainment reported higher satisfaction. Lack of awareness about the patient's condition and perception of deterioration were associated with lower satisfaction [15] .

More recently, a study in multiple Comprehensive Specialized Hospitals in the Amhara region (March–June 2023) enrolled 400 family members. The overall satisfaction rate was 58.6% (95% CI: 55.9–61.2). Satisfaction was higher for patient care (64.8%) and professional care (67.4%) but lower for care provided to families (52.2%), ICU environment (56.8%), and family involvement in decision-making (55.8%). Educational status was significantly associated with satisfaction, with lower-educated family members more likely to report satisfaction than those with higher education. The study highlighted gaps in communication, environment, and decision-making, recommending strategies to consistently engage families and enhance ICU care quality [4].

2.2 Factors Associated with Family Satisfaction in ICUs

Family satisfaction in ICUs is shaped by a variety of interrelated factors, spanning communication, decision-making, environment, and demographic characteristics.

Communication and Information Provision

Communication consistently emerges as the strongest predictor of family satisfaction. Clear, honest, and timely information provision enhances trust and reduces anxiety. Guerra-Martín and González-Fernández (2020) [11] and Al Ansari et al. (2023) [13] reported that completeness and ease of obtaining information significantly increased satisfaction, whereas lack of awareness about the patient's condition or inadequate updates decreased satisfaction [15].

Involvement in Decision-Making

Family participation in decision-making is another crucial determinant. Studies in Norway [12] and Ethiopia [4] found that limited involvement reduced satisfaction, while shared decision-making improved family experiences. Recommendations from Middle Eastern studies also emphasized the need for families to be more actively engaged in care planning [13, 14]

ICU Environment and Facilities

The physical environment plays a substantial role in shaping satisfaction. Cleanliness, quietness, and well-maintained ICUs improve perceptions of care, while poor infrastructure and uncomfortable waiting areas contribute to dissatisfaction. Studies in Bahrain and Saudi Arabia found that ICU and waiting room atmosphere were frequently rated lower compared to clinical care dimensions [13, 14]

Demographic and Social Factors

Satisfaction also varies by demographic characteristics. In Ethiopia, younger relatives (<35 years) were less satisfied, while those with lower educational attainment reported higher satisfaction [4, 15]. In Saudi Arabia, male family members expressed significantly higher satisfaction compared to female relatives. The relationship to the patient and survival outcomes also shaped satisfaction levels in Norway [12].

Cultural and Regional Contexts

Cultural norms and regional practices influence expectations of family involvement and communication. For instance, restricted visiting hours were repeatedly cited as a source of dissatisfaction in Middle Eastern studies, whereas communication gaps were more prominent in Ethiopian settings [4, 13, 15]

Taken together, the literature indicates that while family satisfaction in ICUs is generally moderate to high across regions, consistent gaps exist in communication, decision-making involvement, and environmental support. Demographic and cultural factors further shape perceptions of care. In Ethiopia, where satisfaction levels remain below global standards, these findings underscore the urgent need for improved communication strategies, greater family engagement in decision-making, and enhancement of ICU environments.

2.3 Conceptual Framework for Factors Associated with Family Satisfaction in ICUs

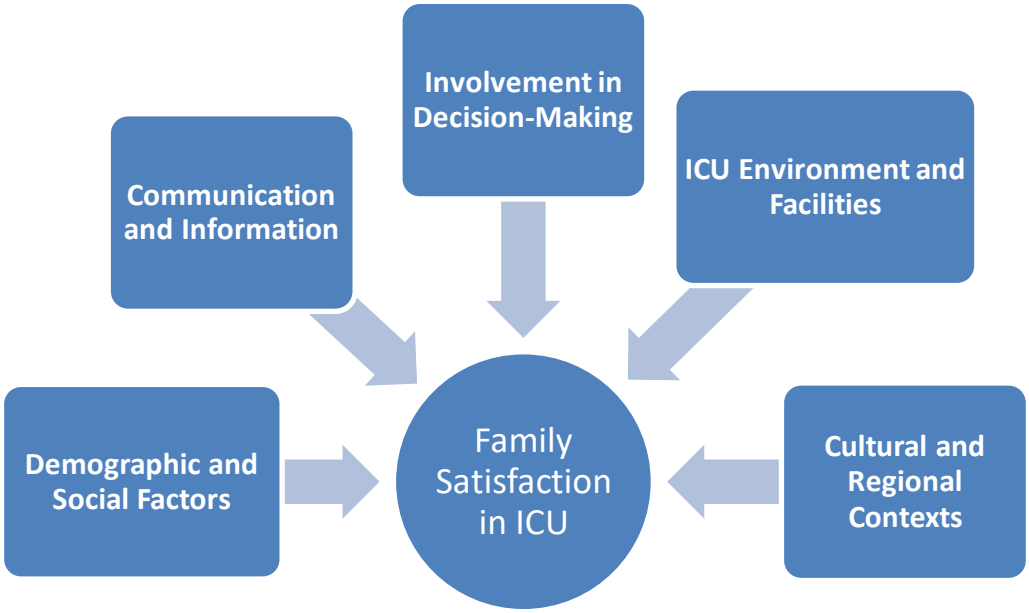


Figure 1. Conceptual Framework for Factors Associated with Family Satisfaction in ICUs[4, 11-15]

3. OBJECTIVES

General Objective

- ✓ To assess family satisfaction with Patient Care and its associated factors in Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital from November, 2025 to March, 2026 GC.

Specific objectives

- ✓ To assess family satisfaction with Patient Care in Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital from November, 2025 to March, 2026 GC. .
- ✓ To determine factors associated with family satisfaction with Patient Care in Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital from November, 2025 to March, 2026 GC. .

4. METHODS

4.1 Study Design

An institution based cross-sectional study design was conducted.

4.2 Study Period and Area

The study was conducted at the Adult Intensive Care Unit (ICU) of Tikur Anbesa Specialized Hospital, Addis Ababa, the largest referral and teaching hospital in Ethiopia. The hospital provides intensive care services through different specialized units. The Surgical Intensive Care Unit (SICU) has 10 beds, the Medical Intensive Care Unit (MICU) also has 10 beds, the Pediatric Intensive Care Unit (PICU) contains 8 beds, and the Cardiac Intensive Care Unit (CICU) has 8 beds. The Neonatal Intensive Care Unit (NICU) is the largest, with 15 beds. Together, these units deliver critical care to a wide range of patient groups, making the hospital a central facility for intensive care services in the country.

The study was conducted from November, 2025 to March, 2026 GC. Data collection was done from December to February, 2026 G.C.

4.3 Study and Source population

Source Population: The source population consisted of family members of patients admitted to the Adult Intensive Care Unit at Tikur Anbesa Comprehensive Specialized Hospital.

Study Population: The study population included family members who fulfill the predefined inclusion criteria.

Inclusion Criteria:

1. Family members (aged 18 years and above) of patients admitted to the Adult Intensive Care Unit.
2. Those who were willing to participate and provide informed consent.
3. Family members who were directly involved in the care or decision-making process of the patient.

Exclusion Criteria:

1. Family members who were unwilling or unable to provide consent.
2. Individuals with communication or cognitive impairments that prevent them from completing the questionnaire.
3. Family members of patients who have been admitted for less than 24 hours.

4.4Sample size determination

The sample size was calculated using the Single population proportion formula

$$n = \frac{\left(z\frac{\alpha}{2}\right)^2 \times p(1-p)}{d^2}$$

Where: n= the sample size

Z= standardized normal distribution curve value for the 95% CI which is 1.96

p= proportion of family satisfaction from previous study done in Addis Ababa, Ethiopia =62% = 0.62 is used

d=Marginal error = 5% = 0.05 Using this formula, the sample size was 363.

Since the source population was less than 10,000, a finite population correction formula was applied:

$$Nf = \frac{n}{1 + \frac{n}{N}}$$

Where:

- *Nf* = final sample size
- *n* = initial sample size (363)
- *N* = total number of patients admitted to the adult ICU in the previous three months (198)

Finally, by adding a 10% non-response rate, the final sample size for the study was **141 participants**.

4.5 Sampling technique

Due to the small and finite population of eligible family members of patients admitted to the Adult Intensive Care Unit (ICU) during the study period who meet the inclusion criteria, probability sampling was not feasible; therefore, a convenience sampling technique was used to include participants during the study period until the sample size was achieved.

4.6 Study Variables

Dependent Variable:

Family Satisfaction: Measured using the FS-ICU questionnaire, including overall satisfaction, satisfaction with care, and satisfaction with decision-making. Scores were quantified on a Likert scale, with higher scores indicating higher satisfaction.

Independent Variables:

1. **Socio-demographic characteristics of family members:** Age, Sex, Relationship to the patient (partner, parent, child, sibling, other), Educational level, Residence (urban/rural), monthly income

2. **Patient-related factors:** Length of ICU stay, Severity of illness, Side of ICU (Medical, Surgical, Cardiac)

3. Family Members related Factors: previous ICU experience

4.7 Data collection procedures

Data were collected using a structured and pretested questionnaire adapted from the FS-ICU 24 questionnaire, along with additional items assessing socio-demographic and clinical characteristics. The questionnaire consisted of three parts: Socio-demographic characteristics of respondents, family members and patient related factors and the standardized FS-ICU 24 questionnaire, which contains 24 items divided into two domains: Satisfaction with care (14 items) and Satisfaction with decision-making (10 items).

The questionnaire was initially prepared in English and translated into Amharic. A pretest was conducted on 5% of the sample size in a similar setting outside the study area, and necessary modifications were made accordingly. Data were collected through face-to-face interviews with family members of ICU patients using the structured questionnaire. Data collectors were trained health professionals, who were not directly involved in the care of the patient, and supervision was carried out throughout the data collection period to ensure data quality. Training was provided to data collectors and supervisors on the objectives of the study, confidentiality, and interview techniques. Completed questionnaires were reviewed daily for completeness and consistency by supervisors and the principal investigator.

The FS-ICU 24 questionnaire uses a 5-point Likert scale ranging from 1 (Not at all Satisfied) to 5 (Completely satisfied). For analysis, responses were transformed to a 0–100 scale, where higher scores indicate greater satisfaction. Domain scores (care and decision-making) and the overall satisfaction score were computed by taking the mean of the respective items. Satisfaction levels were categorized into satisfied and not satisfied using a predefined cut-off point (≥60).

4.8 Operational definitions

The intensive care unit (ICU): is a specialized hospital setting designed to provide close monitoring and advanced medical support for critically ill patients.

Family Member: Any person identified by the patient or medical record as a primary relative (spouse, parent, sibling, child, or close guardian) who is directly involved in the patient's care, decision-making, or support during ICU admission.

Family Satisfaction: The degree to which family members perceive that their expectations, needs, and preferences regarding patient care, communication, emotional support, and involvement in decision-making have been met.

This will be measured using the Family Satisfaction in the ICU (FS-ICU) questionnaire, with responses rated on a Likert scale. Higher scores indicate higher satisfaction. Each item is rated on a **5-point scale** (1 = Not at all Satisfied, 5 = completely satisfied). For analysis, responses were transformed to a 0–100 scale.

Family members with **a mean satisfaction score ≥60** were classified **as "satisfied,**" while those with **scores <60** were classified as **"not satisfied."**

Satisfaction with Care: Refers to the family's evaluation of the quality of medical and nursing care provided to the patient in the ICU. This includes perceptions of competence, responsiveness, and availability of healthcare providers.

Satisfaction with Decision-Making: Refers to the family's perception of their involvement in decisions about the patient's treatment, adequacy of information provided, and the degree to which their opinions were respected.

Adult ICU: The Intensive Care Unit at Tikur Anbesa Comprehensive Specialized Hospital that admits patients aged 18 years and above requiring critical care support.

4.9 Data Analysis procedures

EpiData software was used for data entry and cleaning to minimize entry errors. After data entry, the dataset was analyzed using SPSS version 27.Descriptive statistics was used to summarize the data. Frequencies, percentages, means, and standard deviations were used to describe socio-demographic characteristics of participants, patient-related factors, and satisfaction scores. Bivariate analysis was conducted using the chi-square test (or independent t-test/ANOVA for continuous variables, as appropriate) to assess the association between independent variables and family satisfaction. Variables with a p-value of less than 0.20 in the bivariate analysis were considered candidates for multivariable analysis. Multivariable logistic regression was then be used to identify independent predictors of family satisfaction, while controlling for potential confounding variables. Adjusted Odds Ratios (AOR) with 95% Confidence Intervals (CI) was reported. Model fitness was assessed using the Hosmer–Lemeshow goodness-of-fit test, and multicollinearity was checked using Variance Inflation Factor (VIF). Statistical significance declared at a p-value < 0.05.

4.10 Ethical consideration

Ethical clearance obtained from the Institutional Review Board (IRB) of AAU. A formal letter of permission was also secured from the administration of Tikur Anbesa Specialized Hospital before starting data collection. Written informed consent was obtained from each participant after explaining the purpose and benefits of the study. To maintain confidentiality, no personal identifiers such as names were recorded on the questionnaire. Each participant was instead assigned a unique code number. The results were reported only in aggregate form, ensuring that no individual participant can be identified. The study was conducted in accordance with the principles of the Declaration of Helsinki for ethical conduct in research involving human subjects.

4.11 Dissemination of results

The result of this study is planned to be presented in front of Anesthesia and medical faculty staffs of AAU and guests. Copy of the paper will be given to AAU Anesthesia department. In addition, the paper will be put in AAU library and it will also be sent to Ethiopian journal of health science for possible publication.

5. Results

5.1 Socio-demographic characteristics

A total of 141 family members participated in the study, yielding a response rate of 100%. Among those, 74 (52.5%) were male. The mean age was 42.85 ± 14.38 years. The educational level of most family members was higher education 63 (44.7%). Most participants (74.5%) resided in urban areas and majority, (65.7%) of them was married.

Table 1; Socio-Demographic Characteristics of family members of patients admitted to adult ICU

Variables		Frequency(percent)
Sex	Male	74(52.5%)
	Female	67(47.5%)
Age	18-34	41 (29.1%)
	35-49	54 (38.3%)
	50-64	37 (26.2%)
	65-80	9 (6.4%)
Residence	Urban	105(74.5%)
	Rural	36(25.5%)
Educational level	Illiterate	11 (7.8%)
	Primary Education	21(14.9%)
	Secondary Education	46 (32.6%)
	Higher Education	63(44.7%)
Marital status	Married	92(65.7%)
	Single	26(18.4%)
	Divorced	17(12.1%)
	Widowed	5(3.5%)
	Total	141(100%)

5.2 Family members and Patient Related Factors

Most patients were admitted to the MICU (45.4%) followed by SICU (39.7%). The majority of cases were classified as severe illness (72.3%), with the remaining 27.7% being moderate and no mild cases reported. In addition, most respondents (70.9 %) had no previous ICU experience. The mean length of ICU stay was 6.34 ± 2.96 days.

Table 2 Family members and Patient Related Factors

Variables		Frequency(percent)
ICU Side	MICU	64(45.4%)
	SICU	56(39.7%)
	CICU	21(14,9%)
Relationship with the patient	Parent	28 (19.9%)
	Child	38 (27.0%)
	Partner	26 (18.4%)
	Sibling	30 (21.3%)
	Other	19(13.5%)
Severity of illness	Mild	0(0%)
	Moderate	39(27.7%)
	Severe	102(72.3%)
Previous ICU experience	Yes	41(29.1%)
	No	100(70.9 %)
	Total	141(100%)

5.2 Mean Scores of Family Satisfaction with ICU Care and Decision- making

Significant differences were observed across ICU care and decision-making domains, with the highest satisfaction in ICU care reported for **frequency of communication (83.16 ± 21.86), breathlessness assessment (82.45 ± 21.49), doctor competence (81.21 ± 17.97), and ICU atmosphere (79.79 ± 20.25**), while the lowest was for **waiting area atmosphere (40.60 ± 31.84)**, indicating a clear area of dissatisfaction.

In the decision-making domain, relatively higher scores were seen for **ease of obtaining information (71.63 ± 33.97) and time to address concerns (73.58 ± 21.08),** whereas lower scores were noted for **honesty (52.48 ± 29.02), completeness (53.72 ± 28.65), and consistency of information (54.61 ± 29.82)**, reflecting important communication gaps.

Overall, satisfaction with **ICU care (71.00 ± 13.26)** exceeded satisfaction with **decision-making (59.72 ± 20.10)**, resulting in **overall satisfaction level (66.30 ± 14.99).**

Table 3 : Mean scores of family satisfaction with ICU care and decision-making

Variables	**Mean ± SD**
Part 1. Satisfaction with ICU Care	
Respect, Courtesy, Compassion	74.47 ± 24.72
Pain assessment	74.65 ± 21.75
Breathlessness assessment	82.45 ± 21.49
Agitation assessment	62.23 ± 27.49
Interest in need	58.87 ± 28.68
Emotional support	67.20 ± 22.78
Teamwork	75.00 ± 24.46
Care for family	75.35 ± 26.72
Nurse Communication	70.04 ± 27.91
Doctor competence	81.21 ± 17.97
Doctor communication	68.62 ± 24.17
ICU Atmosphere	79.79 ± 20.25
Waiting area Atmosphere	40.60 ± 31.84
Frequency of communication	83.16 ± 21.86

Part 2. Satisfaction with decision-Making	
Understanding the Information	57.45 ± 27.83
Honesty of the Information	52.48 ± 29.02
Completeness of the Information	53.72 ± 28.65
Consistency the Information	54.61 ± 29.82
Ease of getting Information	71.63 ± 33.97
Inclusion in decision	62.23 ± 29.67
Participation in morning visit	57.80 ± 33.02
Time to address a concern	73.58 ± 21.08
Control over decision	57.27 ± 27.15
Support in decision	56.38 ± 31.25
Overall Satisfaction score	
Satisfaction with care	71.00 ± 13.26
Satisfaction with decision-making	59.72 ± 20.10
Overall Satisfaction	**66.30 ± 14.99**

5.3 Level of Family Satisfaction with the Care in Adult Intensive Care Unit at Tikur Anbesa Specialized Hospital

The analysis of satisfaction domains showed variation in reported levels of satisfaction among respondents. Regarding satisfaction with care, 107 participants (75.9%) reported being satisfied. Satisfaction with decision-making was lower, with 77 respondents (54.6%) indicating satisfaction. Overall, 94 participants (66.7%) reported satisfaction. This indicates that approximately two-third of the respondents were satisfied with the care provided.

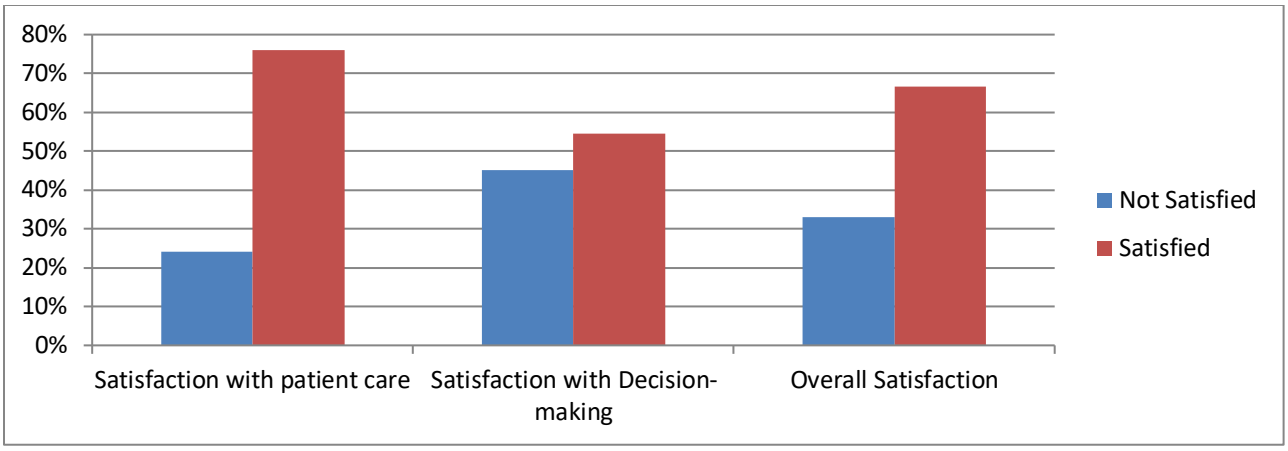


Figure 2 : Level of family satisfaction with care in Adult ICU

5.4 Factors associated with overall family satisfaction

In bivariable logistic regression analysis, sex, marital status, monthly income, relationship to the patient, and previous ICU experience were associated with overall family satisfaction at a p-value < 0.20. In the multivariable model, marital status (p = 0.002), monthly income (p = 0.003), and previous ICU experience (p = 0.002) remained significant predictors of overall satisfaction after adjustment.

Compared with married respondents, single (AOR = 0.028, 95% CI: 0.003–0.234), divorced (AOR = 0.065, 95% CI: 0.010–0.410), and widowed participants (AOR = 0.007, 95% CI: 0.000–0.167) had significantly lower odds of satisfaction. Higher monthly income was also associated with reduced odds of satisfaction compared with income <10,000 ETB (10,000–30,000 ETB: AOR = 0.044, 95% CI: 0.005–0.411; >30,000 ETB: AOR = 0.016, 95% CI: 0.001–0.174). Respondents without previous ICU experience were more likely to be satisfied than those with prior exposure (AOR = 9.43, 95% CI: 2.25–39.46).

Sex was not an independent predictor in the multivariable model (p = 0.431). The overall "relationship to the patient" variable remained significant (p = 0.038), although no individual category retained significance after adjustment.

Table 4: Bi-Variable & Multi-Variable Logistic Regression Analysis of Factors Associated with Overall Family Satisfaction

Variables		Overall Satisfaction		COR (95% CI)	AOR (95% CI)	P Value
		Not Satisfied	Satisfied			
Sex	**Female**	17(25.4%)	50(74.6%)			
	Male	30(40.5%)	44(59.5%)	0.49(0.24-1.02)	1.74 (0.44–6.84)	0.431
Marital Status	**Married**	22(23.9%)	70(76.1%)			
	Single	13(48.1%)	14(51.9%)	0.34(0.14-0.83)	0.028 (0.003–0.234)	**0.001**
	Divorced	8(47.1%)	9(52.9%)	0.35(0.12-1.03)	0.065 (0.010–0.410)	**0.004**
	Widowed	4(80.0%)	1(20.0%)	0.08(0.01-0.74)	0.007 (0.000–0.167)	**0.002**
Monthly Income	**<10000**	15(20.8%)	57(79.2 %%)			
	10000-30000	15(39.5%)	23(60.5%)	0.40(0.17-0.96)	0.044 (0.005–0.411)	**0.006**
	>30000	17(33.3%)	14(45.2%)	0.22(0.08-0.54)	0.016 (0.001–0.174)	**0.001**
Relationship to the patient	**Parent**	12(42.9%)	16(57.1%)			
	Partner	9(34.6%)	17(65.4%)	1.41(0.47-4.26)	1.11 (0.20–6.14)	0.907
	Sibling	5(16.7%)	25(83.3%)	3.74(1.11-12.66)	4.99 (0.61–40.89)	0.134
	Child	20(52.6%)	18(47.4%)	0.67(0.25-1.80)	0.52 (0.09–2.94)	0.457
	Other	1(5.3%)	18(94.7%)	13.5(1.57-115.69)	7.91 (0.56–111.25)	0.125
Previous ICU Experience	**Yes**	19(46.3%)	22 (53.7%)			
	No	28(28.0%)	72(72.0%)	2.22(1.04-4.71)	9.43 (2.25–39.46)	**0.002**

6. DISCUSSION

This study assessed family satisfaction with care and decision-making among relatives of patients admitted to the ICU. The overall level of satisfaction was **66.7%**. This finding is consistent with previous studies conducted in Ethiopia, which reported satisfaction levels ranging from **58% to 62%** [4, 15]. This similarity may be explained by shared challenges in low-resource settings, including high patient load, limited staffing, and constrained infrastructure, which can negatively affect communication and family engagement.

The mean score of overall satisfaction **(66.30 ± 14.99)** is higher than the study done in Amhara region **(58.6±17.04),** comparable with study done in Addis Ababa **(67.7±11.6)** but was lower than the study done in Norway **(70.4±16.1).** The relatively higher score compared to the Amhara region could reflect improvements in critical care services and patient–family communication in the study hospital. The similarity with Addis Ababa may be due to comparable urban settings and shared healthcare delivery systems. However, the lower score compared to Norway is likely attributable to differences in health system funding, nurse-to-patient ratio, structured family support programs, and ICU communication practices, which are more developed in high-income countries [4, 12, 15].

In this study, satisfaction with ICU care **(71.00 ± 13.26)** was higher than satisfaction with decision-making **(59.72 ± 20.10)**. This indicates that families generally perceived the clinical care provided as adequate but experienced limitations in their involvement in decision-making processes. Similar findings have been reported in studies from Norway and the Middle East, where families expressed high satisfaction with patient care but lower satisfaction with participation in decision-making [12-14]. This pattern reflects a gap in the implementation of family-centered care and suggests that decision-making remains largely clinician-driven.

Communication was identified as a critical determinant of satisfaction. Although the frequency of communication was rated highly (83.16 ± 21.86), lower scores were observed for honesty (52.48 ± 29.02), completeness (53.72 ± 28.65), and consistency (54.61 ± 29.82) of information. This indicates that while healthcare providers communicated frequently with families, the quality and clarity of the information provided were insufficient. These findings are consistent with previous studies, which emphasize that effective communication must be clear, transparent, and consistent to improve satisfaction and trust [11, 13, 15].

The ICU environment also significantly influenced satisfaction levels. While the ICU atmosphere was rated positively (79.79 ± 20.25), the waiting area atmosphere received the lowest score (40.60 ± 31.84), indicating a major area of dissatisfaction. This may be attributed to limited space, overcrowding, and lack of basic amenities, which are common challenges in resource-constrained hospitals. Similar findings have been reported in studies conducted in Bahrain and Saudi Arabia, where poor waiting room conditions negatively impacted family experiences [13, 14]. Since family members often spend prolonged periods in waiting areas, poor environmental conditions can substantially affect their overall experience and perception of care. This highlights the importance of providing a supportive and comfortable environment for families.

Emotional support and responsiveness to family needs showed relatively lower scores compared with other domains, with mean values of 67.20 ± 22.78 and 58.87 ± 28.68, respectively. These findings suggest that although some level of support is provided, it may not be sufficient to meet the emotional and psychological needs of family members. Previous studies have shown that emotional support is a key component of family satisfaction and plays a crucial role in reducing stress and improving coping mechanisms [11]. This suggests that although healthcare providers focus on clinical care, less emphasis may be placed on addressing the emotional and psychological needs of families, which are essential components of holistic ICU care.

Regarding associated factors, marital status, income, and previous ICU experience were significant predictors of satisfaction. Higher income was associated with lower satisfaction, which may be explained by higher expectations regarding quality of care, communication, and hospital environment among wealthier individuals. Similarly, participants with previous ICU experience were less satisfied, possibly due to prior exposure shaping expectations and enabling comparison with past experiences.

Overall, the findings of this study are consistent with both local and international literature, demonstrating that while satisfaction with clinical care is relatively high, significant gaps remain in communication quality, family involvement in decision- making, and environmental support. Addressing these gaps is essential to improving the overall quality of ICU care and enhancing family experiences.

7. LIMITATIONS AND STRENGTH OF THE STUDY

The cross-sectional design limits the ability to establish causal relationships and captures family perceptions at a single point in time. The use of self-reported data may introduce social desirability bias, as respondents might provide favorable answers due to concerns about ongoing patient care. The emotional and psychological state of family members during ICU admission may have influenced their responses, potentially affecting the accuracy of satisfaction reporting. Using a convenience sampling technique may limit the representativeness of the study population. In addition, being conducted in a single institution reduces the generalizability of the findings to other settings with different resources and practices.

Strengths of the study include the use of a standardized and validated tool (FS-ICU-24 questionnaire), which improves the reliability of the findings and allows comparison with local and international studies. Data were collected through face-to-face interviews by trained data collectors, enhancing response completeness and overall data quality. In addition, inclusion of multiple domains of satisfaction, such as care and decision-making, provides a more comprehensive assessment of family experiences. Finally, the use of multivariable logistic regression enabled identification of independent predictors while controlling for potential confounders.

8. CONCLUSION

This study found that family satisfaction with ICU care at Tikur Anbesa Specialized Hospital was positive, with approximately two-thirds of participants reporting satisfaction. While satisfaction with clinical care was relatively high, satisfaction with decision-making and communication quality was comparatively lower. Key gaps were identified in information clarity, consistency, and family involvement in decision-making, as well as in the ICU waiting area environment, which was the lowest-rated domain. Factors such as marital status, income, and previous ICU experience were significantly associated with satisfaction.

These findings indicate that improving communication quality, strengthening family involvement in decision-making, and enhancing the ICU environment are critical areas for intervention. Addressing these issues will be essential to advancing family-centered care and overall quality of ICU services in this setting.

9. RECOMMENDATION

- For healthcare providers, to improve communication by ensuring information is clear, consistent, complete, and honest is essential, alongside promoting family involvement in decision-making, providing regular structured updates, and strengthening emotional and psychological support for families during ICU admission.
- For hospital administration, to give priority to improving waiting area conditions in terms of comfort, cleanliness, and accessibility, implementing family-centered care policies, training healthcare professionals in communication and interpersonal skills, and reviewing visiting policies to allow more flexible family access where appropriate.
- For policy makers, the development of national guidelines for family-centered ICU care is recommended, together with allocation of resources to improve ICU infrastructure particularly family support areas and support for programs that enhance communication and patient–family engagement within healthcare systems.
- For future researchers to conduct multicenter and qualitative studies to provide a deeper understanding of family experiences and to evaluate interventions aimed at improving communication, decision-making involvement, and overall satisfaction in ICU settings.

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ASSURANCE OF PRINCIPAL INVESTIGATORs

We the undersigned agree to accept all responsibilities for the scientific and ethical conduct of the research project. We will provide timely progress report to my advisor and seek the necessary advice and approval from my primary advisors in the course of the research. We will communicate timely to my advisors all stakeholders involved in the study including any source of funding for this research.

Name of the students: _____

Signature: _____

Date: _____

Approval of the Advisor

Name of the advisor:_____

Signature: _____

Date: _____

Approval of the Advisor

Name of the advisor:_____

Signature: _____

Date: _____

ANNEXES

Annex 1: Consent Form

I am Dr. Bereket Mengistu, conducting my research paper for my partial fulfillment of specialization on Anesthesiology from Addis Ababa University.

There is no risk involved in giving consent to this research to be conducted in your Institution. If some Ethical issues happened in the study period, the institution has full authority to reverse the decision of consent.

I would like to get permission to conduct this research in your institution and contribute to the field of ophthalmology. If you are willing mark yes if not mark No in the check box below.

YES ☐

NO ☐

Annex 2: Interviewer Administered Questionnaire English Version

Part 1 Socio-Demographic Characteristics

1. Sex a. female b. male

2. Age

3. Level of education

a. Illiterate b. Read and write c. High school d. Higher education

4. Marital status a. Married b. Single c. Divorced d. Widowed

5. Average monthly income:

6. Relationship to patient a. Parent b. Partner c. Brother/sister.

d. Son/daughter. e. other

7. How many days the patient spent in the ICU

8. Residency a. Urban b, Rural

9. Which side of the ICU is the patient admitted at?

a. MICU b. SICU c. CICU

10. Severity of illness a. Mild b. Moderate c. Severe

11. Previous ICU experience, a. yes b. no If not go to question

12. Satisfaction with previous ICU experience

a. Not at all satisfied b. Barely Satisfied c. Quite Satisfied

d. Very Satisfied e. Completely Satisfied

Part 2 Family Satisfaction with Care and Decision- making

No	Questions	Not at all satisfied	Barely Satisfied	Quite Satisfied	Very Satisfied	Completely Satisfied	N / A
	(Part 1): Satisfaction with Care						
1	Respect, Courtesy and Compassion you were given by ICU Staff?	1	2	3	4	5	
2	How well the ICU staff assessed and treated your family member's pain?	1	2	3	4	5	
3	How well the ICU staff assessed and treated your family member's breathlessness?	1	2	3	4	5	
4	How well the ICU staff assessed and treated your family member's agitation?	1	2	3	4	5	
5	How well the ICU staff showed an interest in your needs.	1	2	3	4	5	
6	How well the ICU staff provided emotional support to you.	1	2	3	4	5	
7	The teamwork of all the ICU staff that took care of your family member.	1	2	3	4	5	
8	How satisfied are you with the Level or amount of health care your family member received in the ICU?	1	2	3	4	5	
9	Skill and Competence and Communication of ICU Nurses						
10	Skill and Competence of ICU Doctors (All Doctors including Residents)?	1	2	3	4	5	
11	How often doctors communicated about your family member condition.	1	2	3	4	5	
12	How satisfied are you with the atmosphere (mood) of the ICU?	1	2	3	4	5	
13	How satisfied are you with the atmosphere in the ICU waiting room?	1	2	3	4	5	
14	How satisfied are you with frequency of communication n in the care of your critically ill family member?	1	2	3	4	5	
	(Part 2): Family Satisfaction with Decision-Making						

15	How well ICU staff provided you with explanations that you understood.	1	2	3	4	5	
16	The honesty of information provided to you about your family member's condition.	1	2	3	4	5	
17	How well ICU staff informed you what was happening and why things were being done (completeness).	1	2	3	4	5	
18	Did you get a similar story from the doctor, nurse, etc. about your family member's condition(Consistency)	1	2	3	4	5	
19	Ease of getting information?	1	2	3	4	5	
20	How included or excluded did you feel in the decision-making process?	1	2	3	4	5	
21	Did you participate in morning visit?	1	2	3	4	5	
22	Did you have adequate time to have your concerns addressed and questions answered?	1	2	3	4	5	
23	Did you feel you had control over the care of your family member?	1	2	3	4	5	
24	How supported did you feel during the decision-making process?	1	2	3	4	5	
	(Part 3): Open-Ended Feedback						
25	Do you have any suggestions on how to make care provided in the ICU better?						
26	Do you have any comments on things we did well?						
27	Do you have any suggestions on how we could improve the ICU experience for you and your family member?						

Annex 3 የመረጃ መስጫ ቅጽ እና የፍቃደኝነት መግለጫ (በአማርኛ)

አ/አ ጤና ሣይንስ ኮሌጅ የአንስቴዥዎሎጂ እና ፅኑ ህሙማን ትምህርት ክፍል
በጥቁር አንበሳ ሆስፒታል በፅኑ ህሙማን ክፍል ተኝተው የሚታከሙ የህሙማን ስለሚያገኙት እንክብካቤ የቤተሰቦች እርካታን የሚዳስስ መጠይቅ፣2018 ዓ.ም

ቤተሰቦች በጥናቱ ለመሳተፍ ፍቃደኛ ስለመሆናቸው የሚገልፁበት ፎርም

እንደምን ሰነበቱ የእኔ ስም ----------ይባላል። በጥቁር አንበሳ ሆስፒታል በፅኑ ህሙማን ክፍል በሚደረገው በዚህ ጥናት ውስጥ ተሳታፊ ስሆኑ እርስዎ በዚህ ሆስፒታል በፅኑ የታመሙ ህሙማን ክፍል ቤተሰብዎን ሲያስታምሙ ቤተሰብዎ በጤና ባለሙያዎች ስላገኙት እንክብካቤ እጠይቆታለሁ።የዚህ ጥናት አላማ ሕሙማን በቂና የተሟሉ አገልግሎት በጤና ባለሙያዎች እንዲያገኙ እንደሆነ ለማወቅ ነው። ዓላማውን ለማሳካት የእርስዎን ትብብር እንሻለን።የእርስዎ ስምም ሆነ አድራሻ በመጠይቅ ውስጥ አይካተትም እንዲሁም የእርስዎ ማንነትም ሆነ የሰጡት ምላሽ የእርስዎ ስለመሆኑ በምንም ሁኔታ አይገለፅም።በዚህ ጥናት ለመሳተፍ የእርስዎን ሙሉ ፍቃደኝነት ስንጠይቅ ያለምንም አስገዳጅነት ሲሆን ፍቃደኛ ካልሆኑ ከመጀመሪያውም ሆነ ቃለመጠይቁን ከጀመሩም በኃላ ከመሃላ ላይ ማቋረጥ ይችላሉ።
በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነዎት?
አዎ፡
አይደለሁም፡
ፍቃደኛ ከሆኑ መጠይቁን ይቀጥሉ
ፍቃደኛ ካላሆኑ መጠይቁን ወደ ሌላ የተመረጠ ቤተሰብ አሳላፍ/ፈ

ክፍል 2 የፍቃደኝነት መግለጫ
ከታች ፈርማዬን ያኖርኩት እኔ የጥናቱ አላማ የተነገረኝ ሲሆን ለምጠይው ጥያቄ የማውቀውን መመለስ እንደምችል፤ እኔ የምሰጠው መረጃ ለዚህ ጥናት አገልግሎት ብቻ የሚውል ሲሆን ስሜን እና የምሰጠው መረጃ በሚስጥር እንደሚጠበቅ
ተነግሮኛል። ፍላጎት ከሌለኝ በጥናቱ ያለመሳተፍ ፤ጥያቄ ያለመመለስ እና በጥያቄው ወቅት ምላሽ መስጠት ማቋረጥ እንደምችል ተነግሮኛል።
በዚህ መሰረት በጥናቱ ለመሳተፍ ፍቃደኛ መሆኔን በፈርማዬ አረጋግጣለሁ።
ፈርማ _____
ቀን _____

Annex 4 በቃለ መጠይቅ ሰጪ የሚሞላ የአማርኛ መጠይቅ

ክፍል አንድ፣ ማህበራዊ እና ስን- ህዝባዊ መረጃዎች

1. ፆታ ሀ. ሴት ለ. ወንድ
2. ዕድሜ፡
3. የትምህርት ደረጃ
   ሀ. ማንበብ እና መፃፍ የማይችሉ ለ.ማንበብ እና መፃፍ የሚችሉ
   ሐ. ሁለተኛ ደረጃ ያጠናቀቁ መ. ከፍተኛ ትምህርት

4. የጋብቻ ሁኔታ
   ሀ. ያግባ/ች ለ. ያላገባ/ች ሐ. የፈታ/ ች መ.የሞተበት/ባት

5. አማካይ የወር ገቢ፡
6. ከታካሚው ጋር ያሎት ዝምድና
   ሀ.ወላጅ ለ. የትዳር አጋር ሐ. ወንድም / እህት መ. ልጅ ሠ. ሌላ

7. ታካሚው በፅኑ ህሙማን መከታተያ ክፍል ውስጥ ስንት ቀናት ቆየ/ች
8. የመኖሪያ አካባቢ
   ሀ.ከተማ ለ.ገጠር
9. ታካሚው የትኛው ፅኑ ህሙማን መከታተያ ክፍል ውስጥ ነው የተኛው
   ሀ.የዉስጥ ደዌ ፅኑ ህሙማን መከታተያ ክፍል
   ለ. የቀዶ ጥገና ፅኑ ህሙማን መከታተያ ክፍል
   ሐ. የልብ ህክምና ፅኑ ህሙማን መከታተያ ክፍል

10. የህመሙ ደረጃ
    ሀ.ቀላል ለ. መካከለኛ ሐ. ፅኑ
11. ቀደም ሲል ፅኑ ህሙማን የመከታተያ ክፍል ሰው አስታመው ያውቃሉ
    ሀ. አዎ ለ. የለም (የለም ከሆነ ወደ ቀጣይ ጥያቄ ይለፉ)

12. በቀድሞው የፅኑ ህሙማን የመከታተያ ክፍል ቆይተዎ ምን ያህል ረክተው ነበር
    ሀ. በፍም አልረካሁም ለ. በትን ረክቻለሁ ሐ. በጥሩ ሁኔታ ረክቻለሁ
    መ. በጣም ረክቻለሁ ሠ. ሙሉ በሙሉ ረክቻለሁ

ክፍል 2 መጠይቅ በፅኑ ህክምና ክፍል ውስጥ ባለው እንክብካቤ የቤተሰብ እርካታ።

ቁጥር	ጥያቄዎች	በፍጹም አልረካሁም	በትንሹ ረክቻለሁ	በጥሩ ሁኔታ ረክቻለሁ	በጣም ረክቻለሁ	ሙሉ በሙሉ ረክቻለሁ	አይተገበርም
(ክፍል 1)፡ በህክምና አገልግሎት ላይ ያለዎት እርካታ							
1	የፅኑ ህክምና ክፍል ሰራተኞች አክብሮት ፣ ትህትና እና አዘኔታ?	1	2	3	4	5	
2	የፅኑ ህክምና ክፍል ሰራተኞች የቤተሰብዎን ህመም በመገምገም እና በማከም ረገድ የነበራቸው ብቃት?	1	2	3	4	5	
3	የፅኑ ህክምና ክፍል ሰራተኞች የቤተሰብዎን የመተንፈስ ችግር (የትንፋሽ እጥረት) በመገምገም እና በማከም ረገድ የነበራቸው ብቃት?	1	2	3	4	5	
4	የፅኑ ህክምና ክፍል ሰራተኞች የቤተሰብዎን መቅበዝበዝ ወይም መረበሽ በመገምገም እና በማከም ረገድ የነበራቸው ብቃት?	1	2	3	4	5	
5	የፅኑ ህክምና ክፍል ሰራተኞች ለእርሶ የሰጡት ትኩረት?	1	2	3	4	5	
6	የፅኑ ህክምና ክፍል ሰራተኞች ለእርሶ የሰጡት ስነ-ልቦናዊ (የሞራል) ድጋፍ?	1	2	3	4	5	
7	የቤተሰብዎን አባል ሲንከባከቡ የነበሩ የፅኑ ህክምና ክፍል ሰራተኞች በሙሉ የቡድን ስራ።	1	2	3	4	5	
8	ቤተሰብዎ በፅኑ ህክምና ክፍል ውስጥ ባገኘው የህክምና እንክብካቤ ደረጃ ወይም መጠን ምን ያህል ረክተዋል?	1	2	3	4	5	
9	የፅኑ ህክምና ክፍል ነርሶች ያላቸው ክህሎት፤ብቃት እና የመግባቢያ ችሎታ?	1	2	3	4	5	
10	የፅኑ ህክምና ክፍል ሀኪሞች (ሬዚደንት ሀኪሞችን ጨምሮ) ያላቸው ክህሎት እና ብቃት?	1	2	3	4	5	

11	ሀኪሞች ስለቤተሰብዎ የጤና ሁኔታ መረጃ የሚሰጡበት ድግግሞሽ(ብዛት)?	1	2	3	4	5	
12	በፅኑ ህክምና ክፍሉ ውስጥ ባለው አጠቃላይ ድባብ ምን ያህል ረክተዋል?	1	2	3	4	5	
13	በፅኑ ህክምና ክፍል የመጠባበቂያ ክፍል ባለው ድባብ ምን ያህል ረክተዋል?	1	2	3	4	5	
14	ስለ ታካሚዉ ሁኔታ የሚሰጥዎ የመረጃ ልውውጥ ድግግሞሽ ምን ያህል አርኪ ነበር?	1	2	3	4	5	
	(ክፍል 2)፡ ውሳኔዎችን የማድረግ ሂደት በውሳኔ አሰጣጥ ላይ የቤተሰብ እርካታ						
15	የፅኑ ህክምና ክፍል ሰራተኞች ለእርስዎ ግልጽ በሆነ መንገድ ማብራሪያ የመስጠት ብቃታቸው?	1	2	3	4	5	
16	ስለቤተሰብዎ ሁኔታ የሚሰጥዎት መረጃ ምን ያህል እዉነተኛ (ታማኝ) ነበር?	1	2	3	4	5	
17	የፅኑ ህክምና ክፍል ሰራተኞች ምን እየተደረገ እንደሆተ እና ለምን እንደተደረገ(የመረጃዉ ሙላት) የማሳወቅ ብቃታቸው?	1	2	3	4	5	
18	ስለ ቤተሰብዎ ሁኔታ ከዶክተር፣ ነርስ እና ሌሎች ሰራተኞች ተመሳሳይ መረጃ ያገኛሉ?(መረጃው ወጥ ነዉ?	1	2	3	4	5	
19	መረጃ የማግኘት ሂደት ምን ያህል ቀላል ነበር?	1	2	3	4	5	
20	በውሳኔ አሰጣጥ ሂደት ውስጥ ምን ያህል እንደተካተቱ ወይም እንደተገለሉ ይሰማዎታል?	1	2	3	4	5	
21	በተዋቱ የሃኪሞች ጉብኝት ላይ ተሳትፈዋል?						
22	ስጋቶችዎ እንዲፈቱ እና ለጥያቄዎችዎ መልስ እንዲያገኙ በቂ ጊዜ ተሰጥዎታል?	1	2	3	4	5	
23	በቤተሰብዎ የህክምና እንክብካቤ ሂደት ላይ ቁጥጥር ወይም ተፅዕኖ እንዳለዎት ይሰማዎታል?	1	2	3	4	5	
24	በውሳኔ አሰጣጡ ሂደት ወቅት ምን ያህል ድጋፍ እንደተደረገልዎት ይሰማዎታል?	1	2	3	4	5	

	(ክፍል 4)፡- አስተያየቶች	
25	በፅኑ ህክምና ክፍል ውስጥ የሚሰጠውን እንክብካቤ ይበልጥ ለማሻሻል የሚሰጡት አስተያየት አለዎት?	
26	በጥሩ ሁኔታ አከናዉነናል የሚሉአቸዉ ነገሮች አሉ?	
27	ለእርስዎ እና ለቤተሰብዎ በፅኑ ህክምና ክፍል ውስጥ የሚቆዩበትን ጊዜ የተሻለ ለማድረግ ምን ብናደርግ የጠቁማሉ?	

Assessment of Family Satisfaction with Patient Care and Associated factors in Adult Intensive Care Unit by Bereket Mengistu

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