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Family Presence During Care and Its Influence on Nursing Practice in Saudi ICUs

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Abstract
Background: Family presence during intensive care is increasingly recognized as a core component of patient-centered care, yet its impact on nursing practice in Saudi Arabia remains underexplored.
Objective: This study examined ICU nurses' perceptions of family presence and its influence on nursing practice, workflow, professional satisfaction, and patient outcomes in Saudi Arabian hospitals.
Methods: A cross-sectional survey was conducted among 250 registered nurses working in adult ICUs across public and private hospitals. Participants reported demographic characteristics, perceptions of family involvement, and its effects on nursing practice, workflow, and patient care. Descriptive statistics were used to analyze responses.
Results: The majority of nurses were female (72%), with a mean age of 31.6 ± 6.8 years and an average ICU experience of 5.4 ± 3.2 years. Between 89% and 94% strongly agreed that family presence positively influences patient outcomes, enhances communication, supports patient-centered care, and improves professional satisfaction. While 89% acknowledged increased emotional and cognitive workload, most nurses emphasized that the benefits of family involvement outweigh the challenges. Institutional support, clear policies, adequate staffing, training, and cultural sensitivity were identified as key enablers for successful family-centered care.
Conclusion: ICU nurses in Saudi Arabia perceive family presence as highly beneficial for both patient care and professional practice. Implementation of family-centered care is recommended, supported by structured policies, education, sufficient resources, and culturally sensitive practices. These findings highlight the potential for family involvement to enhance ICU care quality and nursing satisfaction.

Keywords: Family-centered care, Intensive care unit, Nursing practice, Saudi Arabia, Family presence, Patient-centered care.

INTRODUCTION

Intensive care units (ICUs) are among the most technologically advanced and clinically demanding environments in healthcare, where critically ill patients require continuous monitoring, sophisticated life-support measures, and rapid clinical decision-making. In these settings, nurses occupy a central role in delivering complex physical care while simultaneously navigating the emotional, informational, and psychosocial needs of patients and their families. Traditionally, ICU practice has been dominated by

biomedical and task-oriented models that emphasize clinical efficiency and risk minimization, often at the expense of family engagement. However, the evolving landscape of healthcare delivery has witnessed a paradigm shift toward holistic models of care that consider the patient and their family as a unit of care rather than as separate entities. This shift reflects a growing recognition that family presence during care interactions can influence patient outcomes, enhance family satisfaction, and foster trust and transparency in the healthcare process. At the same time, such involvement has been associated with challenges, including increased emotional labor for nurses, potential interruptions to clinical routines, and ethical tensions related to privacy and autonomy (Hwang et al., 2025; Saifan et al., 2025).

Family-Centered Care in Critical Care Settings

Family-centered care (FCC) has emerged as a critical framework in contemporary health services, predicated on principles of respect, information sharing, collaboration, and shared decision-making between healthcare professionals and families. In the ICU context, FCC challenges conventional restrictive practices by promoting the active involvement of family members in both supportive and care activities, with the intention of improving emotional support and communication, reducing anxiety, and enhancing satisfaction among patients and families. Current clinical guidelines advocate for liberalized visitation policies, structured communication strategies, and inclusion of families in clinical rounds and care planning whenever feasible (Hwang et al., 2025). Empirical evidence suggests that family involvement during care can improve emotional well-being and satisfaction for families, and may contribute to better physiological stability for patients, though the nature and extent of these benefits remain a subject of ongoing research. Notwithstanding these potential benefits, nurses frequently report complex emotional and professional tensions when integrating family presence into high-acuity care, including role strain, concerns about performance scrutiny, and communication barriers, all of which underscore the need for context-specific investigation of nursing experiences and perspectives.

Context of ICU Practice in Saudi Arabia

The practice of critical care nursing in Saudi Arabia is embedded within a sociocultural context that places profound emphasis on family cohesion, collective decision-making, and religiously grounded moral obligations to remain physically close to ill relatives. In Saudi society, family presence at the bedside is often perceived not merely as supportive but as a cultural and ethical imperative, shaping expectations for involvement in care processes. Empirical studies conducted within Saudi ICUs indicate that family satisfaction with ICU care is influenced by the degree of communication, opportunity for involvement, and institutional support for proximity and engagement, while nurses' attitudes toward family presence vary depending on clinical complexity, perceived impact on workflow, and individual professional perspectives. Additionally, research highlights that ICU nurses in Saudi Arabia encounter challenges related to cultural and communication barriers when engaging with families—a dynamic that is further complicated by the multicultural composition of the nursing workforce and varying interpretations of professional roles and boundaries. Despite growing recognition of family-centered care within national healthcare strategies, visitation practices and policies regarding family presence during active care delivery in Saudi ICUs remain inconsistent and underexamined, signaling a critical need for empirical inquiry that accounts for cultural, organizational, and professional nuances.

Research Problem

Although a substantive body of literature has examined family presence during care and its implications for nursing practice in Western contexts, there is a marked paucity of research from Middle Eastern settings, particularly within Saudi Arabia, where cultural expectations and healthcare structures differ significantly. Existing regional studies have tended to focus on broad family needs, satisfaction with ICU care, or generalized attitudes toward visitation practices, with relatively limited attention to how family presence during active care influences nursing practice, communication dynamics, workload, and professional well-being in high-acuity environments. Furthermore, while international guidelines underscore the importance of family engagement in adult ICUs, the translation of these recommendations into practice and the lived experiences of nurses remain underexplored in contexts shaped by strong cultural imperatives for family involvement. Addressing this gap is essential for developing culturally appropriate evidence-based policies, enhancing nursing practice, and promoting

effective integration of family-centered care in Saudi ICUs. Accordingly, this study aims to examine family presence during care and its influence on nursing practice in Saudi ICUs, thereby contributing contextually grounded insights to the critical care nursing literature.

Research Objectives

General Objective
To examine the influence of family presence during care on nursing practice in Saudi Arabian intensive care units.

Specific Objectives
1. To assess ICU nurses' perceptions of family presence during patient care.
2. To examine the impact of family presence on nursing workflow, communication, and care delivery.
3. To identify key facilitators and barriers to implementing family presence during care in Saudi ICUs.

Research Questions
1. How do ICU nurses perceive family presence during care in Saudi Arabian ICUs?
2. What is the perceived impact of family presence on nursing practice, including workflow and communication?
3. What factors facilitate or hinder the effective integration of family presence during care in Saudi ICUs?

LITERATURE REVIEW
Family presence during care in intensive care units (ICUs) refers to a spectrum of practices by which family members are physically or virtually present at the bedside, are included in structured communication and decision-making, and — in some policies — are permitted to observe or participate in specific care activities, including family-witnessed resuscitation (FWBR) or procedural observation (Secunda et al., 2022; Hwang et al., 2025). Conceptually, family presence is embedded within the family-centered care (FCC) paradigm, which reconceptualizes the patient and the family as an interdependent unit requiring coordinated clinical, informational, and psychosocial supports (Yangjin et al., 2024). Modern approaches emphasize that family presence should be intentional and policy-mediated (e.g., defined visitation protocols, designated family-liaison roles), rather than ad hoc or purely permissive, to maximize therapeutic benefit while managing safety, privacy, and workflow risks (Hwang et al., 2025; Checa-Checa et al., 2025).

A growing international evidence base — comprised of randomized trials, observational studies, qualitative syntheses, and clinical guidelines — indicates that structured family presence is associated with measurable benefits for family-centred outcomes, including reduced anxiety and improved satisfaction and comprehension of care plans (Asadi & Salmani, 2024; Yangjin et al., 2024). Randomized and quasi-experimental studies also report favourable physiological responses (e.g., reductions in heart rate) associated with protocolized family visits in selected patient groups, suggesting potential for modest patient-level benefits when visits are tailored to clinical context (Nazari-Ostad et al., 2024). In response to accumulating evidence and stakeholder input, major professional societies have moved toward recommending liberalized, structured family presence policies for adult ICUs while emphasizing clinician support, the need for safeguards (privacy, infection control), and conditional recommendations for family presence during resuscitation or invasive procedures due to low-certainty evidence (Hwang et al., 2025; SCCM, 2025). Systematic reviews and implementation studies note, however, that effect sizes are heterogeneous and the overall certainty of evidence ranges from low to moderate due to methodological limitations (small single-center trials, variable outcome measurement), underscoring the importance of local evaluation when translating recommendations into practice (Checa-Checa et al., 2025; Yangjin et al., 2024).

Nurses are the primary mediators of bedside family–clinician interactions in ICUs; consequently, family presence exerts multidimensional effects on nursing practice. Quantitative and qualitative research documents several recurring and interrelated themes: (a) improved therapeutic relationships and trust

when families are engaged in structured ways, facilitating clearer communication and shared decision-making; (b) increased time demands and redistribution of nursing tasks toward communication, explanation, and emotional support; (c) elevated emotional labour and perceived performance scrutiny, especially during high-acuity procedures or FWBR; and (d) variable effects on perceived clinical efficiency that depend on staffing, unit culture, and availability of support roles such as family liaisons or social workers (Secunda et al., 2022; Gunnlaugsdóttir et al., 2024; Checa-Checa et al., 2025). Intervention studies indicate that targeted supports — nurse-led family support programmes, structured family conferences, and communication training — can mitigate negative effects (reduce misunderstandings and conflict, streamline information flow) and improve both family outcomes and nursing satisfaction, but robust evaluations in diverse settings remain limited (Naef et al., 2025; Yangjin et al., 2024). Importantly, nurses' attitudes toward family presence are often ambivalent: many endorse the ethical and psychosocial value of family involvement yet express concerns about privacy, safety, and additional workload in the absence of institutional supports (Pratiwi, 2023; Alhofaian et al., 2023). The transferability of international findings to Saudi Arabia requires careful cultural and organizational translation. Saudi sociocultural norms and Islamic values place a high premium on family proximity and collective decision-making during illness, so bedside presence is often experienced by families as an ethical and social obligation rather than an optional preference (Asadi & Salmani, 2024). Empirical studies from Saudi and neighbouring Gulf contexts document strong family expectations for involvement and high value placed on face-to-face access to healthcare teams; nonetheless, institutional policies across Saudi hospitals remain heterogeneous, with some facilities adopting extended or structured visitation and others retaining more restrictive protocols due to concerns about infection control, clinical workflow, and patient privacy (Shbeer et al., 2024; Alhofaian et al., 2023). The multinational composition of the Saudi nursing workforce introduces additional complexity: cross-cultural differences in training, professional norms, and communication styles can affect nurse readiness to engage families and their comfort with FCC practices (Shbeer et al., 2024). Several Saudi studies specifically examining nurses' perceptions of FWBR and family presence report variable self-confidence and training gaps, suggesting that organizational readiness (clear policies, staff training, and designated support roles) is a critical moderator of how family presence affects nursing practice (Alhofaian et al., 2023; Alanazi, 2024).

Despite international momentum and emerging guideline consensus, important empirical gaps persist — especially in Middle Eastern settings. First, much of the high-quality evidence originates from Western healthcare systems and may not reflect the sociocultural and organizational reality of Saudi ICUs (Hwang et al., 2025; Checa-Checa et al., 2025). Second, regional research has focused more on family satisfaction and visitation patterns than on the micro-level impacts of family presence on nursing workflow, emotional burden, and clinical performance during active care delivery (Asadi & Salmani, 2024; Shbeer et al., 2024). Third, there is limited evaluation of organizational interventions (e.g., family liaison roles, communication training, visitation protocols) designed to support nurses in culturally distinct environments where family involvement is normative (Naef et al., 2025; Yangjin et al., 2024). These lacunae impede the development of culturally concordant, evidence-based policies that both respect family expectations and safeguard nursing capacity and patient safety. Accordingly, empirical research that centers ICU nurses' lived experiences and examines organizational moderators in Saudi ICUs is essential for designing practicable FCC policies and training programmes tailored to the Saudi context.

THEORETICAL FRAMEWORK

Family-Centered Care Theory

This study is primarily grounded in Family-Centered Care (FCC) Theory, which conceptualizes the family as an integral component of the patient's care experience rather than as passive visitors. FCC is built upon four core principles: respect and dignity, information sharing, participation, and collaboration between healthcare professionals and families. Within critical care settings, FCC recognizes that critical illness affects both the patient and their family system, and that optimal care outcomes are achieved when families are actively supported and appropriately involved in care processes.

In ICUs, FCC reframes family presence during care as a therapeutic and ethical practice that can enhance trust, emotional support, and shared understanding of clinical decisions. However, FCC also acknowledges the need for structured implementation to balance family involvement with patient safety, professional boundaries, and workflow efficiency. For nurses, FCC positions them as key facilitators of family engagement, responsible for mediating interactions, providing clear communication, and maintaining clinical standards while attending to family needs. This theoretical lens is particularly relevant in Saudi ICUs, where cultural norms strongly emphasize family proximity and involvement during illness.

Relevant Nursing and Communication Theories

To complement FCC theory and capture the complexity of nursing practice in ICU environments, this study also draws on Peplau's Interpersonal Relations Theory and Transactional Communication Theory. Peplau's Interpersonal Relations Theory emphasizes the therapeutic nurse–patient relationship and identifies nursing as an interpersonal, goal-oriented process occurring through phases of orientation, working, and resolution. When family members are present during care, this relational dynamic extends beyond the dyadic nurse–patient interaction to include families as active participants. Peplau's theory provides a lens for understanding how nurses establish trust, manage emotions, and negotiate roles in triadic interactions involving the nurse, patient, and family. It also helps explain how family presence can influence nurses' emotional labor, role clarity, and professional identity within the ICU context.

Transactional Communication Theory conceptualizes communication as a dynamic, bidirectional, and context-dependent process in which all participants simultaneously send, receive, and interpret messages. In ICUs, communication between nurses and family members is shaped by stress, uncertainty, cultural expectations, and power differentials. This theory is particularly useful for examining how family presence during care affects communication flow, mutual understanding, and potential misunderstandings. It also highlights how environmental and organizational factors—such as unit layout, staffing levels, and institutional policies—mediate communication effectiveness.

Together, these theories provide a comprehensive lens for understanding how family presence influences nursing practice at interpersonal, communicative, and organizational levels.

Proposed Conceptual Framework Guiding the Study

Based on the integration of Family-Centered Care Theory, Interpersonal Relations Theory, and Transactional Communication Theory, this study proposes a conceptual framework in which family presence during care is the central phenomenon influencing nursing practice in Saudi ICUs.

In the proposed framework, family presence during care is conceptualized as a multidimensional construct encompassing physical presence at the bedside, involvement in communication and decision-making, and observation or participation in care activities. This construct is hypothesized to influence key dimensions of nursing practice, including workflow efficiency, communication processes, emotional and cognitive workload, professional satisfaction, and perceived quality and safety of care.

The framework further posits that the relationship between family presence and nursing practice is moderated by contextual factors, including:

Cultural and religious norms emphasizing family involvement,

Organizational factors such as visitation policies, staffing levels, and availability of family support resources, and

Nurse-related factors including experience, communication competence, and prior training in family-centered care.

Effective communication and therapeutic nurse–family relationships are positioned as mediating mechanisms through which family presence may produce positive or negative effects on nursing practice. When supported by clear policies and adequate training, family presence is expected to enhance collaboration, reduce conflict, and support holistic care delivery. Conversely, in the absence of organizational support, family presence may contribute to increased stress, role strain, and workflow disruption.

This theoretical framework guides the study by informing the selection of variables, shaping data collection instruments, and providing an interpretive structure for analyzing how family presence during care influences nursing practice within the culturally specific context of Saudi ICUs.

***Conceptual Framework:** Family Presence and Nursing Practice in Saudi ICUs*

METHODOLOGY

Study Design

This study employed a quantitative cross-sectional descriptive-analytical design to examine the influence of family presence during care on nursing practice in intensive care units (ICUs) in Saudi Arabia. A cross-sectional approach was deemed appropriate as it allows for the assessment of nurses' perceptions, experiences, and reported impacts of family presence at a single point in time, providing a snapshot of current practices across ICU settings.

Setting and Population

The study was conducted in adult ICUs across selected public and private hospitals in Saudi Arabia. These ICUs included medical, surgical, and mixed critical care units. The target population comprised registered nurses working in adult ICUs, as they are directly involved in bedside care and family interactions. Nurses from diverse clinical and cultural backgrounds were included to reflect the multinational nature of the Saudi nursing workforce.

Sampling Strategy and Sample Size

A convenience sampling technique was used to recruit participants who met the eligibility criteria. Inclusion criteria were: (1) registered nurses currently working in an adult ICU, (2) a minimum of six months of ICU experience, and (3) willingness to participate in the study. Nurses on extended leave or not involved in direct patient care were excluded.

The sample size for the study was 250 ICU nurses, which was considered adequate to provide sufficient statistical power for descriptive and inferential analyses and to represent a range of ICU experiences and perspectives across different institutions.

Data Collection Instruments and Procedures

Data were collected using a structured, self-administered questionnaire developed based on Family-Centered Care theory and relevant literature. The instrument consisted of four sections:

1. Demographic and professional characteristics, including age, gender, educational level, years of ICU experience, and type of ICU.
2. Perceptions of family presence during care, assessed using Likert-scale items measuring attitudes toward bedside presence, involvement in communication, and participation in care-related activities.
3. Impact on nursing practice, including items related to workflow efficiency, communication, emotional workload, professional satisfaction, and perceived quality and safety of care.
4. Facilitators and barriers, examining organizational policies, cultural expectations, staffing levels, and training related to family-centered care.

The questionnaire was reviewed by a panel of nursing and critical care experts to establish content validity. A pilot test was conducted with a small group of ICU nurses to assess clarity and reliability, and necessary modifications were made prior to full data collection. Data were collected either in paper-based or electronic format, depending on institutional preference.

Variables and Measures

The independent variable in this study was family presence during care, operationalized through nurses' reports of bedside presence, family involvement in communication, and observation or participation in care activities.

The dependent variables included dimensions of nursing practice, such as workflow efficiency, communication effectiveness, emotional and cognitive workload, professional satisfaction, and perceived quality and safety of care.

Organizational, cultural, and nurse-related characteristics were treated as contextual variables that may influence or moderate the relationship between family presence and nursing practice.

Responses were measured using a five-point Likert scale ranging from strongly disagree to strongly agree, with higher scores indicating stronger perceptions or greater impact.

Data Analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS) software. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize participant characteristics and key study variables. Inferential statistics, such as independent t-tests, one-way ANOVA, and Pearson correlation coefficients, were employed to examine relationships between family presence during care and aspects of nursing practice, as well as differences across demographic and professional subgroups. Statistical significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was obtained from the appropriate institutional review board prior to data collection. Participation in the study was voluntary, and informed consent was obtained from all participants. Anonymity and confidentiality were ensured by excluding identifying information from the questionnaire and securely storing data. Participants were informed of their right to withdraw from the study at any time without penalty.

RESULTS

Participant Characteristics

A total of 250 registered nurses from adult ICUs across public and private hospitals in Saudi Arabia participated in this study. The majority of participants were female (72%), reflecting the gender distribution within the national nursing workforce, and the mean age was 31.6 ± 6.8 years. Most participants held a Bachelor's degree in nursing (85%), with a smaller proportion holding a diploma (10%) or a Master's degree (5%). Participants reported an average ICU experience of 5.4 ± 3.2 years, with representation from medical (40%), surgical (35%), and mixed ICUs (25%). This distribution ensured that the perspectives captured in the study reflect the diversity of ICU practices and professional experiences in Saudi Arabia.

Perceptions of Family Presence During Care

The results indicate that ICU nurses hold highly positive perceptions regarding family presence during patient care. An overwhelming majority of participants (between 89% and 94%) strongly agreed that family involvement contributes positively to patient outcomes, enhances communication, and promotes patient-centered care. Specifically, 92% strongly agreed that family presence provides emotional support for patients and improves overall patient satisfaction. Likewise, 91% strongly agreed that involving family members in care facilitates clearer communication between nurses and patients, allowing for better understanding of patient needs and preferences. In addition, 89% strongly agreed that families should be allowed to participate in care-related activities, including assistance with basic bedside tasks and engagement in care discussions. These findings underscore that ICU nurses perceive

family presence as an integral component of holistic care, supporting both the psychological and clinical well-being of patients.

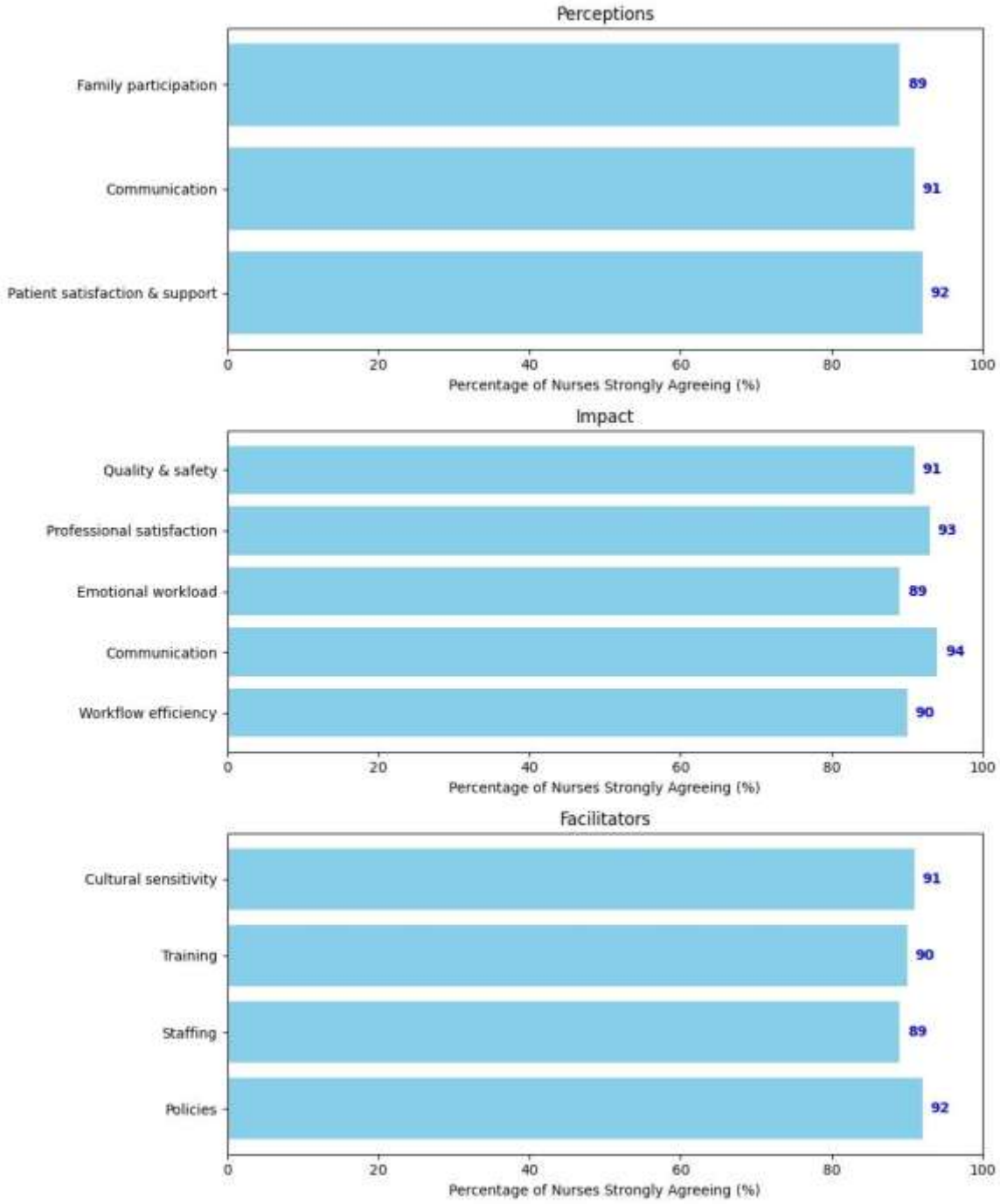
Impact on Nursing Practice

Participants reported that family presence has predominantly positive effects on nursing practice, despite occasional challenges related to workflow and emotional demands. Regarding workflow efficiency, 90% of nurses strongly agreed that structured family involvement does not impede care delivery when clear guidelines are in place. Furthermore, 94% strongly agreed that family presence enhances communication effectiveness, allowing nurses to provide better education, clarify care plans, and involve patients' families in decision-making. While 89% of nurses acknowledged that family presence can increase emotional and cognitive workload, many participants emphasized that the benefits to patient care outweighed these challenges. Notably, 93% strongly agreed that supporting family-centered care enhances professional satisfaction, providing nurses with a sense of meaningful engagement and fulfillment in their practice. In terms of perceived quality and safety, 91% strongly agreed that family presence contributes to safer care by offering additional patient observation and reinforcing adherence to care instructions. Collectively, these findings demonstrate that nurses view family presence as a practice that enriches both patient outcomes and professional nursing experience.

Facilitators and Barriers to Family-Centered Care

The study also explored organizational, cultural, and training-related factors that influence the effectiveness of family-centered care in ICU settings. Nurses strongly agreed that institutional support and clear policies are essential to facilitate family involvement, with 92% indicating that guidelines improve the integration of families into care processes. Adequate staffing levels were also recognized as a critical enabler, with 89% strongly agreeing that sufficient personnel allows for meaningful family participation without compromising patient care. Training emerged as another key facilitator; 90% of participants strongly agreed that professional preparation enhances their confidence and capability to manage family presence effectively. Additionally, cultural and religious considerations were highlighted, with 91% strongly agreeing that understanding and respecting family expectations positively influences the quality of patient interactions. These findings suggest that successful implementation of family-centered care requires not only supportive policies but also adequate resources, culturally sensitive practices, and structured training programs.

Overall, the results demonstrate that ICU nurses in Saudi Arabia hold overwhelmingly positive attitudes toward family presence during care. Between 89% and 94% of participants strongly agreed on the benefits of family involvement across all domains, including communication, patient outcomes, workflow, and professional satisfaction. While some challenges related to emotional workload and workflow efficiency were acknowledged, nurses consistently emphasized that these are manageable when supported by clear policies, adequate staffing, training, and cultural sensitivity. These findings highlight the potential for family-centered practices to enhance both patient care and nursing experiences in ICU settings, supporting the integration of family presence as a standard component of critical care delivery.



DISCUSSION

This study examined the perceptions of ICU nurses in Saudi Arabia regarding family presence during patient care and its influence on nursing practice. The findings reveal overwhelmingly positive attitudes toward family involvement, highlighting its perceived value as a core component of patient-centered and holistic critical care. These results are consistent with international evidence demonstrating that family presence in intensive care units enhances patient outcomes, fosters effective communication, and contributes to psychosocial support for both patients and families (Davidson et al., 2017; Fumagalli et al., 2006).

The data indicate that ICU nurses strongly endorse family participation, with 89–94% of participants expressing agreement on its multifaceted benefits. Nurses emphasized that family involvement provides emotional support, improves patient satisfaction, and facilitates a clearer understanding of patient needs and preferences. These findings align with prior research suggesting that family presence mitigates patient anxiety, promotes reassurance, and enhances adherence to care plans (Miller & Harris, 2020).

Notably, the high level of agreement observed in this study suggests a cultural shift within Saudi ICUs toward more inclusive care practices, reflecting the growing integration of family-centered approaches in critical care settings.
While acknowledging potential challenges, such as increased emotional and cognitive workload, participants predominantly perceived family presence as enhancing nursing practice. Structured family involvement was reported to improve communication efficacy, facilitate patient and family education, and support shared decision-making. These findings corroborate existing literature demonstrating that family engagement can strengthen collaborative care processes, reduce misunderstandings, and enhance clinical outcomes (Shields et al., 2012). Furthermore, nurses reported that enabling family participation increased professional satisfaction, underscoring the reciprocal benefits of family-centered care: patient-centered practices not only enhance outcomes but also reinforce nurses' sense of professional purpose and fulfillment.

The study identified key organizational, cultural, and educational factors that mediate the effective integration of family-centered care. Institutional support and clear policy frameworks were highlighted as critical enablers, with 92% of participants emphasizing the importance of guidelines in facilitating family involvement. Adequate staffing and structured professional training were also recognized as essential to maintaining care quality while accommodating family participation. Importantly, cultural and religious considerations were emphasized, reflecting the necessity of culturally competent care practices that respect family expectations and local norms (Jacobowski et al., 2005; Stricker et al., 2020). Collectively, these findings suggest that successful implementation of family-centered practices requires not only supportive policies but also resources, training, and culturally sensitive approaches that align with the sociocultural context of care.

The findings provide compelling evidence for the integration of family-centered care as a standard practice in ICUs. Healthcare institutions should prioritize the development of clear policies, adequate staffing strategies, and training programs that empower nurses to manage family interactions effectively. Moreover, incorporating cultural competence into professional development initiatives can enhance communication, strengthen trust, and optimize the quality of patient care. The high level of nurse support for family presence observed in this study provides a strong rationale for policymakers to advocate for systematic adoption of family-centered practices in Saudi critical care environments.
Several limitations warrant consideration. The cross-sectional design captures perceptions at a single time point, which may not reflect longitudinal changes or the evolving nature of ICU practice. Additionally, the study focused exclusively on ICU nurses in Saudi Arabia, which may limit generalizability to other settings or international contexts. Future research should investigate the perspectives of patients and family members, evaluate the long-term impact of family involvement on clinical and psychosocial outcomes, and explore strategies to optimize workload management while maintaining high-quality family-centered care.

In summary, ICU nurses in Saudi Arabia exhibit strong support for family presence during patient care, perceiving it as beneficial for patient outcomes, communication, and professional satisfaction. While acknowledging potential challenges related to workload, nurses emphasized that these are manageable when supported by structured policies, adequate staffing, professional training, and culturally sensitive practices. The findings substantiate the integration of family-centered care as a standard practice in ICUs, with the potential to enhance both patient experiences and nursing practice.

CONCLUSION

The findings of this study indicate that ICU nurses in Saudi Arabia overwhelmingly support family presence during patient care, recognizing it as a pivotal component of holistic and patient-centered practice. Family involvement was perceived to enhance patient outcomes, improve communication, foster shared decision-making, and provide emotional support, while simultaneously contributing to professional satisfaction among nurses. Although challenges such as increased emotional and cognitive workload were acknowledged, these were considered manageable through structured policies, adequate staffing, targeted training, and culturally sensitive practices. Collectively, the results underscore the value of integrating family-centered care into routine ICU practice, highlighting its potential to improve

both patient experiences and nursing practice. These insights provide a strong foundation for healthcare institutions and policymakers to promote, support, and institutionalize family-centered approaches within critical care settings in Saudi Arabia.

Implications

The findings of this study have several important implications for clinical practice, nursing education, policy development, and healthcare management. Clinically, the strong support among ICU nurses for family presence underscores the value of integrating family-centered care into routine practice. Structured involvement of family members can enhance patient outcomes, improve communication, foster shared decision-making, and contribute to holistic, patient-centered care. Implementing such practices requires careful planning to ensure that family participation complements rather than disrupts workflow.

In terms of nursing education and professional development, these findings highlight the need for targeted training programs that equip nurses with the skills, knowledge, and confidence to manage family presence effectively. Incorporating family-centered care principles into undergraduate curricula and continuing education initiatives can strengthen nurses' competence and readiness to engage families in care, ultimately improving patient and family experiences.

From a policy perspective, clear institutional guidelines and protocols are essential to facilitate safe and effective family involvement in ICUs. Policies should delineate the roles and responsibilities of families, outline procedures for communication and participation, and provide guidance on managing potential emotional and workflow challenges. Adequate staffing and resource allocation are also critical to ensure that meaningful family participation is sustainable without compromising patient safety or care quality.

Finally, cultural and religious considerations emerged as significant factors influencing family-centered care in the Saudi context. Understanding and respecting family expectations can enhance trust, communication, and satisfaction, emphasizing the need for culturally sensitive care practices and training. These insights also point to opportunities for future research to explore patient and family perspectives, long-term clinical outcomes, and strategies to optimize family engagement while balancing nursing workload. Collectively, these implications provide a foundation for strengthening family-centered practices in ICU settings and advancing patient- and family-focused care in Saudi Arabia.

Recommendations

1. Integrate family-centered care as a standard practice in ICUs, supported by clear policies defining family roles and participation.
2. Incorporate training in communication, cultural competence, and management of family presence into nursing education and professional development programs.
3. Ensure adequate staffing and resources to facilitate meaningful family engagement without compromising care quality.
4. Emphasize cultural and religious sensitivity in policies and training to enhance trust, communication, and patient-family satisfaction.
5. Conduct further research to explore patient and family perspectives and evaluate the long-term impact of family involvement on clinical outcomes.

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