The Development of Islamic Based Caring Model for Critically Ill Patients in the Intensive Care Unit

Suhartini Ismail

A Thesis Submitted in Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Nursing (International Program)
Prince of Songkla University
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This is to certify that the work here submitted is the result of the candidate's own investigations. Due acknowledgement has been made of any assistance received.

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I hereby certify that this work has not been accepted in substance for any degree, and is not being currently submitted in candidature for any degree.

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ABSTRACT

It is common for the nurses in ICU to deal with critical health problems and with patients at risk of dying by providing them with immediate skillful nursing care and critical care technology. There is a growing concern that holistic caring is not adequately emphasized and practiced in ICU. This study aimed to develop Islamic based caring model for critically ill patients in the Intensive Care Unit (IBC-ICU) in order to promote harmony of life. The action research approach was used to develop the model. The Islamic caring theory according to Barolia and Karmaliani's theory was used to guide this study. There were 24 nurses as the key participants, 14 patients and their family caregivers as associate participants recruited to the study. Data were gathered using focus group discussions, interviews, field notes, observations, and questionnaires. The data were analyzed by using inductive content analysis.

There were two cycles of the model development; the capability building to increase awareness, knowledge and improving the caring practice; and the strengthening caring practice for sustaining the Islamic based caring model. The IBC-ICU composed of four core values: healing presence, caring relationship, caring environment, and faith in God. These core values and the five dimensions of Islamic concepts were integrated into the caring healing process using action research approach in assisting the critically ill patients to achieve harmony of life. In enhancing harmony of critically ill patients based on IBC-ICU, the nurses were required to promptly help respond to the patients' health care problems and needs, and maintain connectedness in four main aspects: the connection with self; others (nurses, families, and significant others); God, and environment. The findings revealed that the expected outcomes of the IBC-ICU were achieved through nurses' caring actions incorporating power of faith in God into their practice. The IBC-ICU was beneficial not only to the patients and their families in obtaining better nursing care but also to the nurses in uplifting them as well as nursing profession as a result of satisfactory nursing practice. Implications of the study can be made to other Muslim critically ill patients in similar sociocultural context.

Key words: action research; Islamic based caring model; critically ill patients; Muslim.

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CHAPTER 1

INTRODUCTION

Background and Significance of the Problem

The nature of the critical care environment is known as a closed unit with strict visiting hours, which uses equipment of a high technological standard and brings an abundance of unique patient physiological and psychological challenges. For example, the common difficulty in deciding whether to discontinue mechanical ventilation may encompass uncertainties about the probability of recovery, the quality of life of intubated patients, and ethical aspects of terminating life support. The nurses who work in a critical care setting, like the ICU, usually deal with people who are in crisis and at risk of dying. The critical care environment can be dehumanizing for the patients and their families, for example in patient care delivery and decision making treatment, personal and professional value conflicts, and the physical design of the environment (Brett, 2002; Pryzby, 2005). Duldt-Battey (2004) explained that the dehumanizing of patients and their families in the critical care unit include psychological isolation, uncertainty, loss of direction, emotional distress, hopelessness, and barriers to communication. It is implied that the ICU environment is stressful for patients and families including physical, psychological and social, and spiritual problems.

Patients in a condition of critical illness can experience physical, psychological, social, and spiritual problems. The patients may suffer from morbidity and co-morbidity which has an influence on their bodies, and they may experience psychological suffering, including social and spiritual problems. During a condition of

critical illness, the patient needs to undergo a lot of treatment in the intensive care unit. Moreover, the severity of an illness is a common issue among critically ill patients. The severity of an illness impacts on the processes and outcomes of health care such as the length of stay in hospital and high costs (Caine, 2003; Kynoch, Paxton, & Chang, 2011) as well as disharmony of life (Hofhuis, et al., 2008). The complexity of patient problems and care needs require the nurses who are capable in advanced clinical care and humanized nursing practice (Duldt-Battey, 2004).

Many patients also end their life in the ICU. Approximately 20% of all deaths occur in ICU's in Indonesia (Association of Indonesian Hospital, 2010). Although optimal care of out-patients may prevent many ICU admissions, the ICU will always remain an important setting because of the rigorousness of disease of the patients in the ICU (Indonesian Society of Intensive Care Medicine, 2011). In the ICU, the nurses perform nursing services focusing on the personal and human character of nursing practice while they are managing the technological environment. Kongsuwan and Locsin (2011) discussed the experience of caring as valuing competency to care in the use of technology. Technology provides valuable means of monitoring and treatment, but can also be dehumanizing (Almerud, Alapack, Fridlund, & Ekebergh, 2007). Furthermore, patients' physical needs are often perceived by the nurses as having greater priority than their psychological needs (Raines & Keller, 2007).

In a critical illness situation, health care providers should have a sense of caring for critically ill patients in order to avoid dehumanizing practice. For example, a study (Wilkin & Slevin, 2004) on the meaning of caring to nurses in an intensive care unit demonstrated that the nurses were delivering both holistic and human care to the patients and their families. In addition, Duldt-Battey (2004) suggested a solution to the

dehumanizing process was through effective interpersonal communication because it was the key to humanizing relationships between people, and to recognizing the individual's human characteristics with dignity and respect. This implies that caring is as essence of nursing (Watson, 2005), and critical care nurses use their caring emotions, knowledge, and actions to meet the needs of critically ill patients and their families.

The interventions related to humanizing patients using a holistic approach in the ICU have been implemented. For example, the effect of music on anxiety reduction in patients with ventilator support reported that music effectively reduced anxiety in patients with ventilator support (Suhartini, Kritpracha, & Taniwattananon, 2010). Music provided a calm environment for the patients under treatment by ventilator. Suhartini and Rahmahwati (2011) surveyed the holistic knowledge and skills of critical care nurses in the ICU in Indonesia. They found that all critical care nurses had adequate holistic knowledge to care for critically ill patients. However, they perceived themselves to have inadequate competency on healing modalities such as music intervention, spiritual intervention, and so on. This was probably because they were oriented to the patient's physical needs and healing modalities may not yet be included in nursing activities in Indonesia (Mardiyono, Angraeni, & Sulistyowati, 2007).

In 2012, the researcher conducted a study to explore caring in terms of the spiritual needs of the patients in the ICU in Indonesia (Suhartini & Fransisca, 2010). The nurses as well as other health care providers usually prioritized physical interference and the patient's disease. They also discussed that caring problems for critically ill patients in the ICU of their hospital included: lack of communication, neglect of respect to patients, and insufficiency in meeting the spiritual needs of the

patients and their families. These findings were congruent with Brett's study (2002) that reported aggregated factors of caring problems for critically ill patients were 1) communication, 2) respect for patients, 3) expectations, 4) uncertainty, 5) inappropriate care, and 6) external factors such as financial constraints. Therefore, both of the studies also agreed that Islamic based caring would be beneficial for our clients and the nursing profession.

Indonesia is a country with a large Muslim population. In 2010, the estimated Muslim population in Indonesia was 205 million (Pew Research Center's Religion & Public Life Project, 2011). Over the next few years, it is anticipated that Islam will be congruent with care (Rafii, Hajinezhad, & Haghani, 2008). So far, there has been little discussion about caring science and practice in Indonesia. Setiawan (2010) developed a professional caring model in Indonesia by recruiting 17 nurse participants and 70 other associate participants at a hospital in Medan Indonesia. The findings of his study demonstrated that there were significant improvements in families' satisfaction, nurses' satisfaction, nurses' knowledge on critical stroke care, and nurses' caring behaviors. In Setiawan's study, he used the Donabedian theory to comprehend the quality of care in the stroke unit and developed the professional caring model for enhancing the quality of care by using a holistic approach (physical, psychological, social, and spiritual dimensions). He found that a caring relationship and a caring environment were core values in the professional caring model. However, his study did not use Islamic based caring to guide the caring model. He addressed the importance of the spiritual needs of the patients; however, he did not investigate the issue in depth.

Currently, caring has been investigated by many studies using both qualitative and quantitative methodologies, and mainly in the context of western

culture. Those studies have indicated positive relationships between caring nurse-patient relationships and specific patient outcomes, such as caring behavior, quality of care, and technology as a caring (Kimberly, 2002; Kinoshita & Miyashita, 2011; Locsin, 1999). Moreover, qualitative studies have largely employed phenomenological or grounded theory approaches, which can obtain the view of caring as experienced by those involved in the process. The results of some studies highlighted themes which provided an overview of caring, themes which were indicative of good caring (Kongsuwan, 2011; Kynoch, et al., 2011; McGrath, 2008) and noncaring (Frieswick, 1990). In summary, the studies indicated that caring improved the well-being of patients and nurses. For the patients' well-being, they reported a sense of decreased stress, improvements in self-esteem, and a positive mental attitude. For a nurses' well-being, caring results in feelings of satisfaction and personal growth.

Caring has been identified as a holistic approach. The holistic approach connects the body, mind, and spirit leading to harmony of life. A concept analysis of harmony has been conducted by Easley (2007), and it was reported that the concept of harmony composed of the nurse-patient relationship, environment, personal self-concept, and effective nursing intervention programs. Lowe (2002) described that harmony was a result of a connection between the nurse and client, that was enhanced by a healing environment and affected the nurse's trust and empowerment (France, 2011). Those studies indicated that harmony plays a part in caring because it promotes balance of the body, mind, and spirit. However, the concept of harmony is unclear in nursing literature, and the meaning of harmony is rather diverse with a population and a study context. This present study provides examples and explores harmony as an ultimate health outcome of critical patients in the ICU of a hospital in Indonesia.

A search of literature related to Islam and nursing was undertaken in various databases. For example in CINAHL there were 241 studies found between 1986 and 2015. A concept analysis of nursing based on Islamic sources by Hoseini, Alhani, Khosro-panah, and Behjatpour (2013) found the remediation of physical or spiritual problems that should be informative based on *Al Quran*, because the human mind is preferred over body. Moreover, in the Islamic scholars' view, humans have biological, cognitive/perceptual, emotional, social, and spiritual dimensions. However, indicators of holistic health in Islam, such as harmony, spiritual well-being, and psychological well-being in contextual situations have not been widely discussed. It is because the view of nursing in Islam concentrates on perfection and remediation of the human being. Humans have superior capabilities and a nurse is responsible for promoting them in all aspects (Hoseini, et al., 2013) and this may include harmony. For that reason, the study will make nursing congruent to the beliefs of Muslim patients.

The Islamic faith is a strong influential factor contributing to the holistic direction for a way of life to promote health and harmony of life for Muslims (Ohm, 2003). When a Muslim is sick, he or she would not only seek medical treatment, but also enhance his or her spirituality in order to get well, or to ask God to cure the sickness. Muslims perceive illness as a way of *Allah* removing sin (Ibrahim & Dykeman, 2011). Therefore, for critically ill patients, it is important that nursing care should address not only physiological care but also care in the psychosocial (care of mind) and spiritual (care of the spirit) domains (Smith, 2006).

The present study develops an Islamic based caring model for critically ill patients in the ICU guided by the Islamic based caring concept introduced by Barolia & Karmaliani (2008). This Islamic based caring model aimed to promote harmony of

critically ill patients in the ICU. The researcher learned from a review of the nursing literature that there was an abundance of information regarding how nurses assess and implement nursing interventions to promote holistic care. However, there was little information related to an Islamic based caring model to promote harmony of critically ill Muslim patients. Thus, this model is specific and congruent with the Indonesian cultural context that beneficially promotes a harmonious life for patients and their families.

Research Objective

The objective of this study was to develop an Islamic based caring model for critically ill patients in an intensive care unit of a Central Hospital in Semarang, Indonesia.

Research Questions

Research questions for the study were as follows:

1. What are the components of an Islamic based caring model for critically ill patients in the ICU?
2. How can nurses provide Islamic based caring to promote harmony in critically ill patients in the ICU?

Theoretical Framework of the Study

The theoretical framework for this study embraced the theory of caring from an Islamic perspective (Barolia & Karmaliani, 2008). Theory of caring from an Islamic perspective is composed of physical, ethical, ideological, spiritual, and intellectual dimensions.

Theory of caring from an Islamic perspective.

The theory of caring from an Islamic perspective, according to Barolia and Karmaliani's theory (2008), was used as a conceptual framework of this study. This theory guided the researcher in the development of the Islamic caring model and caring practice in the ICU. According to this theory, a nurse succeeds in caring behaviors and caring actions if she or he sustains a balance among all the five dimensions of the human personality. Failure to maintain the balance results in disequilibrium or uncaring gestures. The theory justified that balancing the five dimensions of the human personality is essential for providing nursing care from an Islamic perspective.

The five dimensions are physical, ethical, moral and ethical, spiritual, and intellectual dimensions. These are as follows:

1. Physical dimension**.** For the physical dimension, in attempting to attain, maintain, and sustain health and wellness of patients, the nurses need to understand how to relieve the patient's pain physically and mentally, maintain cleanliness (piety), and prevent disease. The patients need patience and reassurance through prayer (*shalat*) equally.
2. Ethical dimension. Caring in nursing from an Islamic perspective focuses on Islamic ethics and reflects the ethical principles, including honesty, justice, non-maleficence, and equity. Rights should be offered equally and the ethical dimension is respecting the rights provided in Islam.
3. Ideological dimension. The ideological dimension of caring from the Islamic perspective is balance of three main duties, namely the

duties toward Allah (*huququllah*), the duties toward humankind *(huququnafs*), and duties toward self *(huququllabad).*

4. Spiritual dimension. The spiritual dimension in the Islamic perspective refers to the human personality. Inner happiness in the spiritual dimension is gained from service, human bounding, compassion, empathy, and hope
5. Intellectual dimension. Muslims believe that the intellectual dimension is sourced from *Al Quran* and *Hadith*. There are many priceless gems of knowledge in *Al Quran* and *Hadith*, and there is a lot more to discover and study.

The five concepts of the caring theory in nursing from an Islamic perspective have been identified as antecedent categories that require the nurse to maintain harmony among the five dimensions of the patients while taking care of them in practice settings. The state of maintaining a balance among various aspects of human life is the central theme of the caring process. The balance was maintained through the process of response, reflections, relationship, relatedness and role modeling (5 Rs), which in turn results in an action termed “caring action” (Barolia and Karmaliani, 2008).

Accordingly, the five Rs are as antecedents to act as caring in an Islamic perspective. Response refers to the nurse’s actions in caring continually to family members as well as patients. Caring is expressed through reflections of physical and mental well-being for both the patients and nurses. Caring includes the development of a close relationship between the nurse and patient or family. Caring is related to professional maturity and requires nursing competence in the field of knowledge and

skills (Finfgeld-Connet, 2008). Moreover, role modeling is the process by which the nurse facilitates and nurtures the individual in attaining, maintaining, and promoting health (Erickson, Tomlin, & Swain, 1983). In summary, the five Rs are behaviours that should be added when the nurse provides caring for a patient.

Methodological Framework for the Research

The methodological framework of the research is action research (Figure 1.1). Action research is growing in popularity with nurse researchers, where it is often seen as a way of bridging the theory-practice gap. The action research design based on the social science approach is found in the majority of studies conducted in nursing (Bergdahl, Benzein, Ternestedt, & Andershed, 2011; Duffy, 2009; Musanti, O'Keefe, & Silverstein, 2012). Action research is a social process of collaborative learning realized by groups of people who join in changing practices. Groups of people interact in a shared social world in which, for better or worse, they live with the consequences of one another's actions (Kemmis & Taggart, 2008). Thus, the researcher used an action research approach concerned with changing practice in the setting.

Kemmis and Taggart (2008) stated that action research is a learning process that produces real and material changes of what people do; how people interact with the world and with others; what people mean and what they value; and the discourse in which people understand and interpret their world. By understanding their practices as the product of particular circumstances, the researcher becomes alert to clues about how it may be possible to transform the practice through current ways of working. Similarly, Kim and Holter (1995) also stated that action research adopts four features and specifies them to be congruent with the premises of a critical theory,

consisting of collaboration, problem identification, institution of change in practice, and the development of new knowledge.

In action research, the researcher collaborates with participant(s). Collaboration can occur in the forms of mutual criticism and self-reflection: involving understanding, analyzing, and learning. Problem identification in critical action research involves systematic difficulties in practice. The researcher should develop an interpretative understanding of the context in the situation. When the comprehensive understanding of the situation occurs, the researcher and practitioner(s) can identify and come to an agreement regarding the problems/difficulties that require change. The strategies for change in practice will depend on the outcome of the problem identification phase. The last feature, the development of new knowledge from critical action research then can be used to gain a generalized understanding about social condition and praxis (Kim & Holter, 1995).

Action research provides opportunities for understanding the true interests of participants. According to Kemmis and Taggart (2008), in reality, the process might not be as neat as this spiral of self-contained cycles of planning, acting and observing, and reflecting suggests. Participants in the action research process undertake each of the stages outlined in the spiral of self-reflection collaboratively. The stages overlap and initial plans become obsolete in the light of learning from experience. In reality, the process is likely to be more fluid, open, and responsive. The criterion of success is not whether participants have followed the steps faithfully but rather whether they have a strong and authentic sense of development and evolution understanding, and the situations in their practices.

Definition of Terms

The Islamic based caring model was a model developed using action research methodology and guided by Islamic caring theory according to Barolia and Karmaliani (2008). Its' development also involved the participation of the researcher, the critical care nurses, family members, and patients in the ICU of a hospital in Indonesia.

Significance of the Study

There have been recent calls for a nursing model based on an Islamic perspective and Islamic based caring applicable to Muslim nurses and patients in Indonesia and Islamic societies. This model influenced the nursing care and the evaluation of care in the critical care setting in Indonesia. This research provides the missing link between Western nursing and Indonesian Muslim nurses' caring models and contributes to the development of a nursing model that is relevant to, and reflective of Islamic religious values. The development of the model can provide direction for nursing practice and the provision of care to Muslim patients and their family in the area of critical care nursing, because the study uses both a holistic care and spiritual care approach, which encourages caring engagement and a healing environment.

In addition, the development of the model can provide the basis for a nursing identity in Indonesia and a starting point for improving the moral status and image of nursing in Indonesia to the world. This study also adds to transcultural nursing knowledge and contributes to the emerging knowledge that there are culturally distinct forms of nurses' caring.

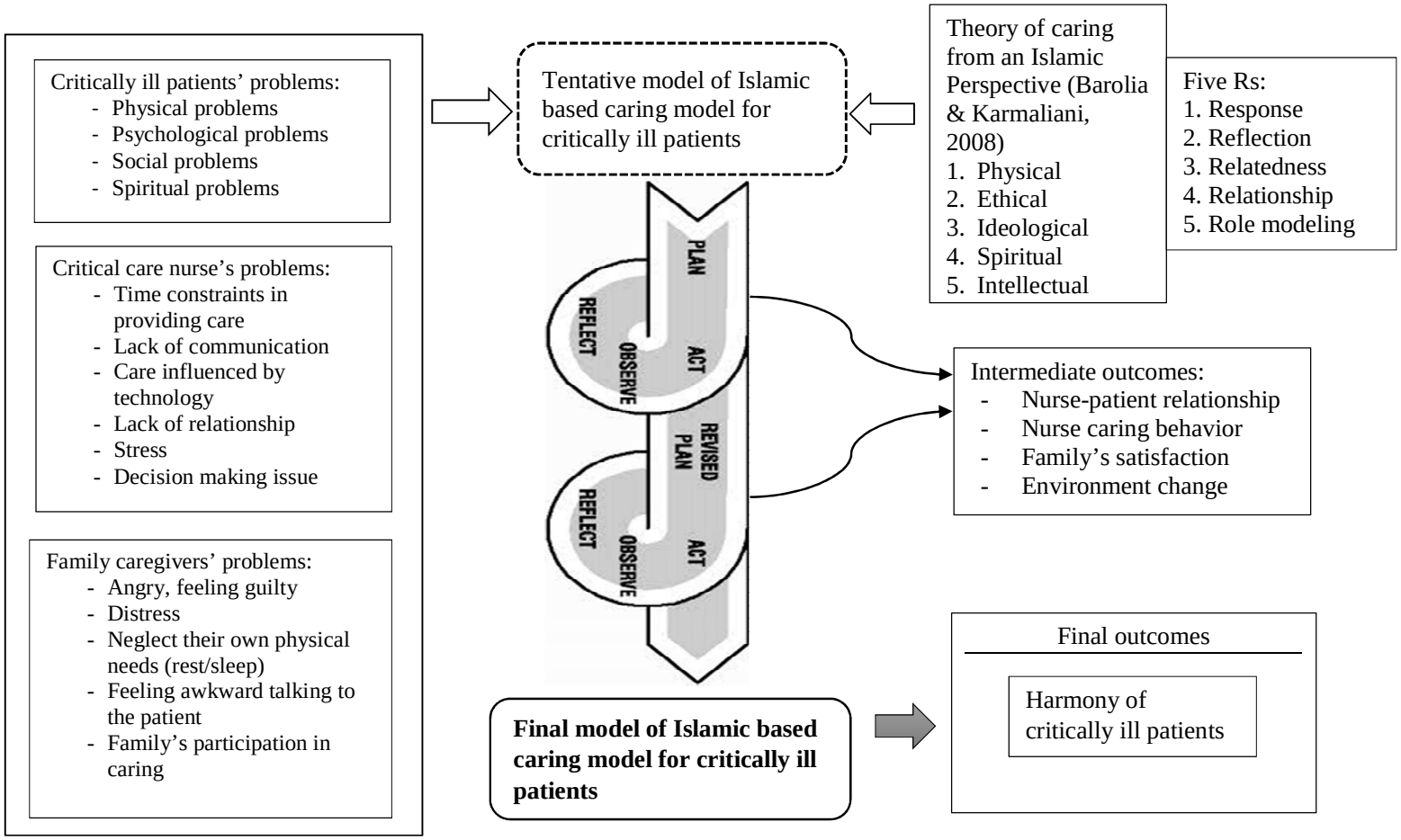


Figure 1.1 Theoretical and Methodological Framework of the Study

CHAPTER 2

LITERATURE REVIEW

This chapter explains the literature of caring within an Islamic context, critical care nursing and caring in the intensive care unit, and critical social theory and action research. The following substances were discussed as follows.

1. Caring in nursing practice
    - 1.1 Theories of caring
    - 1.2 Comparison of caring theories
    - 1.3 Integration of Islam into caring practice
    - 1.4 Caring outcomes
        - 1.4.1 Caring outcomes: the nurses, patients, and families outcomes
        - 1.4.2 Harmony as a caring outcome
        - 1.4.3 Harmony in Islamic perspectives for Muslim nurses and patients in the ICU
    - 1.5 Measurements of caring outcomes
2. Critical care nursing and caring in the Intensive Care Unit (ICU)
    - 2.1 Patients, setting, and technology in the ICU
    - 2.2 Nursing standards in caring for critically ill patients in the ICU
    - 2.3 Critical care nurse caring behavior for critically ill patients in the ICU
    - 2.4 Family participation in caring for critically ill patients in the ICU
    - 2.5 Influencing factors of caring for critically ill patients
3. Critical Social Theory and Action Research
    - 3.1 Critical Social Theory

1. Caring in Nursing Practice

Caring in nursing validates the nurses, the patients, and their families as human. Caring focuses on the physical, psychological, social, and spiritual dimensions of a human being and it makes sense of well-being. Caring takes place every time as a result of nurse-patient relationships. Interestingly, caring may occur without curing but curing cannot occur without caring (Watson 2003). A number of caring theories and several studies have been reported in caring science and are widely used to guide nursing research in caring. These following discussions explain the concept of caring theories focusing on five existing caring theories: 1) Theory of Cultural Care (Leininger's theory), 2) Theory of Human Care (Watson's theory), 3) Conceptualization of Caring; the five/six Cs of caring (Roach's concepts), 4) Theory of Nursing as Caring (Boykin and Schoenhofer's theory), and 5) Theory of Caring from Islamic perspectives (Barolia and Karmaliani's theory).

1.1 Theories of caring.

In nursing science, caring is an art, a science, and a philosophy. Caring is often described as the essence of nursing (Watson, 2008) and is recommended to complement the metaparadigm concepts of nursing. Caring is a way of being (ontology), a body of knowledge and way of knowing (epistemology), a moral idea (ethic), art of practice (aesthetic) and social cultural phenomena (Ray, 2010). Caring

could be a way to define the nurse's practice as caring has ingredients (Mayeroff, 1971). The essential ingredients of caring are knowing a patient, alternating rhythm, patience, honesty, trust, humility, hope and courage. These attributes are as a cornerstone for a nurse to apply caring for a patient (Mayerof, 1971). Caring should be a moral responsibility (Schaefer, 2002). Locsin (2005) viewed caring in nursing technology competencies.

Caring science is developing more nowadays. From a knowledge development standpoint, theories of caring and caring knowledge are located within nursing science. Caring science is emerging as a distinct field of nursing study (Cossette, Pepin, Cote, & de Courval, 2008). As a result, caring knowledge and practices affect on human health (patients and families) and health care practitioners (nurses). Scotto (2003) conducted a literature review for a new definition of caring. Scotto wrote that caring should be defined as the offering of the self. This means offering is the intellectual, psychological, spiritual, and physical aspects one possesses as a human being to achieve a goal. In nursing, this goal is to facilitate and enhance a patient's ability to do and decide for his or herself. However, caring is not always agreeable; it is sometimes frustrating and rarely easy (Mayeroff, 1971).

In summary, over the decade since literature on caring science has been published, the practical meaning of it has been extended to large numbers of research papers. Nurse scholars also have increasingly recognized the caring science as a discipline that requires specific methods of inquiry. The following explanation were examples of the fabulous caring theories in nursing science.

1.1.1 Theory of cultural care (Leininger's theory).

Theory of cultural care was developed by Leininger (1988). The theory viewed caring as universal phenomena, but it differs through culture in the expression and pattern of cultural care. Caring should be located within the cultural context to benefit for the patient (Beeby, 2000a). In providing a therapeutic nursing care, nurses should have knowledge of caring values, beliefs, and practices that reflect to the patients (Leininger, 1988). Leininger's theory believes that by ascertaining the cultural influences on caring, the nurse begin to provide meaningful care for the patients (Leininger, 1988). She also agreed that nurses might rely on psychophysiological and technological approach in order to support their patients. Thus, by acknowledging culture and social differences, the nurses give the meanings of caring into a cultural situation (Beeby, 2000).

1.1.2 Theory of human care (Watson's theory).

Theory of human care was developed by Jean Watson (2008), which centers on caring in the interpersonal relationship between nurse and patient. Watson views nursing as the science of caring, involving true concern, and the desire to assist the other individual to health. Watson (2008) believes that the nurse's caring offers caring environment and allows the patient to choose the best nursing intervention for him or herself. According to Watson (2008), the nurse and patient emphasis on subjective experience to promote personal growth and self-actualization. However, in promoting personal growth and self actualization in patients with critically ill is demanding, because the patient in ICU is somehow unable to speak and have difficult in making choice of treatment. Thus, the health care providers often decide the treatment choice in the best interest of the patient or families (Beeby, 2000a).

1.1.3 The six attributes of caring (Roach's concept).

In 1984, Roach conceptualizes caring as the human mode of being. She claims that the essential characteristics of nursing are as a helping discipline (Roach 1984). In 1992, the concepts of Roach's theory were added the five Cs as attributes of caring including compassion, competence, confidence, conscience, and commitment. First, compassion is a method for living conceived out a familiarity with one's relationship to all people. Second, competence is the condition of having learning, judgment, expertise, vitality, experience, and inspiration to react enough to the requests of one's expert capacity. Third, confidence is the quality that encourages trusting connections. Fourth, conscience is a state of moral awareness or good mindfulness. Fifth, commitment is full of feeling portrayed by merging between one's desires and one's responsibilities, and by a planned decision to act in accordance with them. In 2002, she added 'comportment' to her concept and namely the 6 Cs. Comportment is the nurses should look, sound, act as the professional expert, respect to, and be honest to oneself, patients and their families (Roach, 2013). However, an example of study using Roach's concepts could not be found. Thus, the development of a new model using Roach's concepts would be necessary in the future.

1.1.4 Theory of nursing as caring (Boykin & Schoenhofers's theory).

Theory of nursing as caring illustrates caring as an necessary feature and expresses human beings (Boykin & Schoenhofer, 2001). The theory viewed nursing as the response to human needs (McCance, et al., 1999). Boykin and Schoenhofers's theory takes a similar perspective to Roach's idea, in that they contend that caring is uniquely expressed in nursing (McCance, et al., 1999). As indicated by Boykin and Schoenhofers (2001), nursing as caring develops when persons present themselves to

offer and receive professional nursing provision. Thus, caring is the central focus of nursing, and the nurse help other people to grow with expectation, compassion, and presence, as value and attitude in the caring practice.

1.1.5 Theory of caring from Islamic perspectives (Barolia and Karmaliani's theory).

Barolia and Karmaliani (2008) developed a theory of caring in nursing from an Islamic perspective: an interactive model. There are five dimensions in this theory composed of physical, ideological, ethical, spiritual, and intellectual dimensions of the human being (Figure 2.2). Based on the theory, the balancing of 5 dimensions was necessary in order to deliver nursing care from an Islamic perspective.

1) Physical dimension.

According to Barolia and Karmaliani's theory (2008), three main themes emerged to form the category physical care from an Islamic perspective. The themes are pain relieving, piety, and prevention. In pain relieving, to encounter both physical and psychological pain, the patient and the nurse need to have patience. Patience also emerges in the category of the physical dimension of caring from an Islamic perspective. A sick person should remember that his/her illness is a test from Allah to clean the sin and to give mercy to His servant. Therefore, we should accept it with patience and ask Allah to cure and reduce the suffering.

Piety is the most admirable attribute: regular performance of ritual obligations, prayer, and *Al Quran* reading are therapeutic resources (Subaiyyil, 2002). Piety is related to cleanliness of body and purity of mind and is congruent to the physical dimension (Barolia & Karmaliani, 2008). The significance of purity of body and heart/mind have both a physical and spiritual dimension. The model of piety of

personal hygiene in Islam is of a high standard and follows the rules in *Al Quran* and *Sunnah* of Prophet Muhammad.

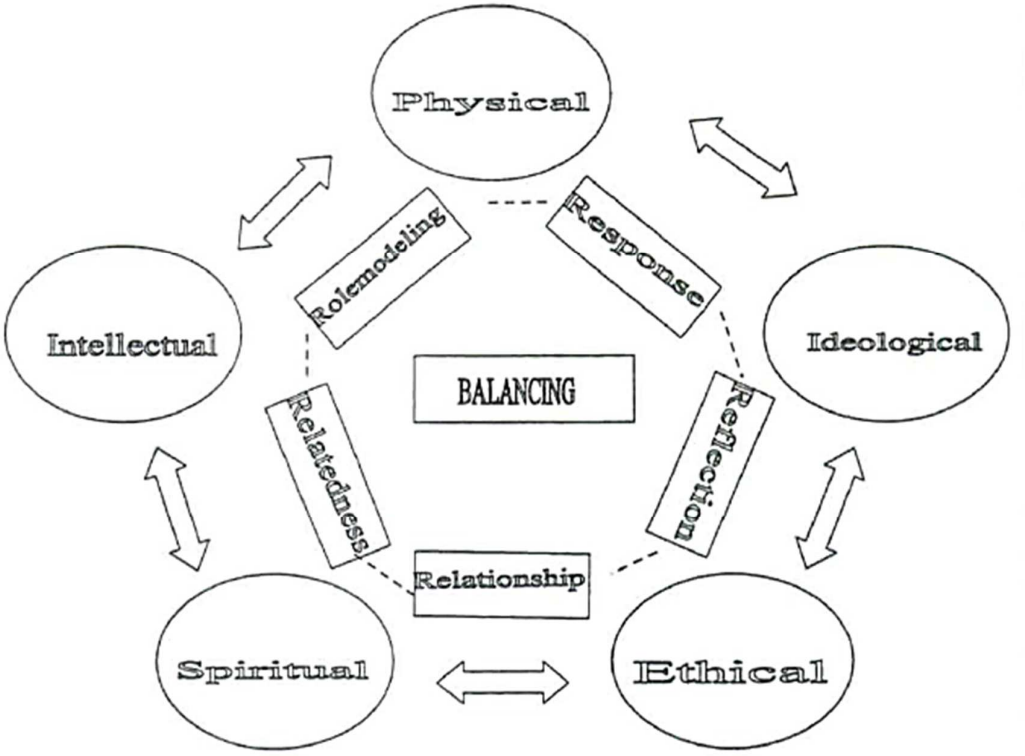


Figure 2.2 Theory of caring in nursing from an Islamic perspective: An interactive model. From "Caring in Nursing from an Islamic Perspective: A Grounded Theory Approach" by, R. Barolia and R. Karmalini, 2008. *International Journal for Human Caring, 13(1),* p. 58.

Furthermore, illness prevention is also discussed in the physical dimension of caring from an Islamic perspective. It is reflected that there is a linear relationship of pain and cleanliness with disease prevention within the theory. In *Al Quran, Allah* (God) says, *"When I am sick, Allah will cure me" (Al Quran, Ash Shura, 16:80)* (Abdul-Rahman, 2003). It is determined that the Islamic concept of cleanliness, relieving pain, patience, and prevention fit with the physical dimension of Barolia and Karmaliani's theory.

2) Ethical dimension.

Islam teaches Muslim people to serve others who need help, modesty, control of passions and desire, truthfulness, integrity, patience, steadfastness, justice, and fulfilling moral values and promises to self, others, and God. Islam also teaches Muslims to please God through helping other people (Carter & Anahita 2012). Islam seeks to firmly implant in one's heart the conviction that one's dealings are with God, who sees him at all times and in all places (Abdullah, 1999 was cited in Carter & Anahita 2012).

Islam teaches a Muslim the commitment to assist others as humankind. As humankind, a person has the connection of body, mind, and spirit (Ashy, 1999). The connection of these influence the health and illness of a person, such as the mental and emotional aspects, sleep, and wakefulness, diet and nutrition, physiological movement and rest, and retention and evacuation (Ashy, 1999).

Athar (1999) as cited in Rassool (2000) stated that the major roles of health care providers in patient care in an Islamic context are: 1) understanding the concerns of the patient and his or her family and transmitting them to health care professionals involved in the decision making process; 2) interpreting *Al Quran* as it applies to specific concerns of the patient; 3) consoling and comforting the patient and his or her family or significant others so that they can accept the present situation as a will of *Allah* and pray for better life in the hereafter; 4) taking care of the needs of the family (spiritual, psychosocial, and financial needs) after the death of the beloved one; and 5) preserving of faith, sanctity of life, alleviating of suffering, enjoining what is good and permitted, and forbidding what is wrong and prohibited. In doing so, the health care provider follows the Islamic principle of ethical consideration.

The principles of Islamic ethics are the preservation of faith, sanctity of life, alleviation of suffering, enjoining what is good and permitted, and forbidding what is wrong and prohibited. As mentioned in the ethical dimension, respecting the patient's autonomy while achieving social justice without harm is a necessary (Barolia & Karmaliani, 2008). The nurse must be honest and truthful in giving information. He or she should consult the patient or the family to ask for a second opinion before giving a final decision on treatment (Rassool, 2000). For these reasons, the ethical dimension is appropriate in Islamic based caring for critically ill patients as the ethical dimension is respecting the rights provided in Islam.

3) Ideological dimension.

The ideological dimension of caring from the Islamic perspective is composed of three themes, namely the duties toward Allah (*Huquq-u Allah*), the duties toward humankind *(Huquq-u Ibad*), and duties toward yourself *(Huquq-u Nafs)* (Barolia & Karmaliani, 2008). First, *Huquq-u Allah* refers to the obligation of humans to their God, for example prayers. Prayers for a Muslim is a duty toward Allah as His servant, because it protects a human from bad behaviors, and additional prayers are also performed in order to make a Muslim humble and thankful to *Allah* (Barolia and Karmaliani, 2008).

Second, *Huquq-u Ibad* refers to Islamic based caring as a commitment to assist others as humankind. Contained in the same word, *Huquq-u Ibad* is commitment. The nurse who commits to caring is following an obligation to *Allah* by helping others (Rassool, 2000). Commitment is fundamental in the nursing profession and it has good consequences for health care services. Highly committed nurses are

more accountable to deliver health care services for patients and families (Jafaragaee, Parvizy, Mehrdad, & Rafii, 2012).

Third, *Huquq-u Nafs* refers to how a nurse performs her or his duties to patients. In Islam, God will count each good deed of Muslims, when fulfilling their responsibilities. Allah says *"So, whoever does good work and is a believer, his effort will not be disregarded and God shall surely record it" (Al-Anbiya' 21:95)* (Ali, 2004).

4) Spiritual dimension.

Muslim patients believe that illness, suffering, and dying are a part of life and could be a test whereby *Allah* (God) checks the belief of the followers. Seeking help from *Allah* and praying during illness and difficulties are encouraged even after getting well. Barolia and Karmaliani (2008, p 60), stated that spiritual in the Islamic perspective refers to the human personality. Spirituality in an individual greatly affects a person's daily work and lifestyle. Developing compassion is a spiritual characteristic and is essential to the spiritual characteristic. She also argues that another inner feeling that relates to spirituality is empathy. Thus, spiritual strength is gained by developing feelings for others (commitment) and having a feeling of connection (empathy).

Moreover, Islam teaches the idea of caring for others as much as caring for one's self. However, in the case of Muslim patients, the spiritual dimension of an individual remains within the tradition of Oneness of *Allah* (*Tawheed*). It argues that nursing models and frameworks of care practiced within the framework of non-Islamic sources are inappropriate to meet the needs of Muslim patients in terms of this dimension (Rassool, 2000). Therefore, the spiritual dimension is one of the necessary dimensions for caring from an Islamic perspective.

5) Intellectual dimension.

Muslims believe that the intellectual dimension is sourced from *Al Quran* and *Hadith*. There are many priceless gems of knowledge in *Al Quran* and *Hadith*, and there are a lot more to be discovered and studied. *Allah* (interpretation of meaning) (Ali, 2004) says: *"And we send down of Al Quran that which is a healing and a mercy to those who believe (in Islamic Monotheism and act on it), and it increases the Zaalimoon (polytheists and wrongdoers) nothing but loss" (al-Isra' 17:82).*

Al Quran says a lot about health matters. The consumption of wholesome food and the leading of a healthy lifestyle are seen as religious obligations. The Prophet Muhammad taught, "Your body has rights over you" – *Hadiths* of Bukhari (Rassool, 2000). Prophet Muhammad said "Seek treatment, because Allah did not create a sickness but has created a treatment for it for old age" – *Hadiths* of Bukhari (Rassool, 2000). There are a number of verses of the Holy *Al Quran* concerning healing, as the whole *Al Quran* contains perfect guidance to give an intellectual dimension to the nurse in caring from an Islamic perspective. As Allah said, "It (*Al Quran*) is a guidance and healing for those who believe" (*Al Quran – Fussilat* 41:44).

Barolia and Karmaliani's theory was developed based on Muslim nursing scholars and Islamic scholars' perception and experience using grounded theory. Barolia and Karmaliani's theory is underpinned by Islamic concepts to guide caring actions. Islamic caring theory is based on the fundamental sources of Islam; *Al Quran* and *Hadiths* and is applicable to Muslim patients. The theory is used to guide the development of an Islamic practice model in the ICU.

1.2 Comparison of caring theories.

The comparison of five existing caring theories is presented on Table 2.1 and has been discussed above in the theories of caring and caring within an Islamic context. The caring theories of Leininger, Watson, Roach, and Boykin and Schoenfoer have been widely used to guide nursing practice and as fundamental theories in caring knowledge in recent years. Meanwhile, the Islamic caring theory (Barolia and Karmaliani, 2008) is a new theory. Comparison of the Islamic based caring theory with well known existing theories helps better understanding of the theory.

There are still differences among the theories. The differences of the theories are: First, for Leininger' theory, caring must be established in a cultural context since caring patterns can contrast transculturally. Second, Watson has concentrated on the philosophic (existential phenomenological) and spiritual premise of caring and considered caring to be the ethical and moral of nursing. This theory is known as the 10 caratives of caring. Third, Roach's caring theories emphasized caring as the important point of all attributes used to describe nursing. The attributes are compassion, conscience, competence, commitment, comportment, and confidence. Fourt, Boykin and Schoenfoer highlighted respect of persons as caring individuals. Meanwhile, caring theories have shown their uniqueness in their individual representations of caring and in their commitments to the advancement of nursing knowledge. Fifth, Barolia and Karmaliani's theory highlighted their theory with an Islamic concept. Islamic concepts, specific for Muslim culture, have not yet been utilized in the four existing caring theories.

Additionally, the similarities of these caring theories are also distinguished. The commonalities of these caring theories are caring as nursing that

facilitates the relationship between nurses and patients with compassion, connectedness, and respectedness. The caring theories are also concerned with all dimensions of a human being as well as the ethics and morals of nursing, and being embedded in the culture and religion.

Furthermore, the similarities of Barolia and Karmaliani Islamic caring and the other four caring theories are highlighted: 1) the cultural care in Leininger's theory allows the integration of other cultures, beliefs and religions. The Islamic religion exists in the culture of Muslims. Therefore, when nurses follow Barolia and Karmaliani's theory, they consider the culture of Muslims in caring practice; 2) the caring dimension identified in Barolia and Karmaliani's theory is similar to the one in the human sciences and the metaphysical dimension (philosophy of being and knowing) of Watson's theory. For example, the concepts of hope, relationship, positive and negative responses, transpersonal teaching/learning in the form of role modeling, and spiritual forces are alike in both the theories; 3) Roach's conceptualization of caring has emerged in Barolia and Karmaliani's theory. Compassion and conscience are reflected in the spiritual dimension. Competence and confidence also have been shown in the intellectual dimension; 4) the unique human focus, stated in Boykin & Schoenfoer's theory, is also signified in all dimension of caring in nursing from an Islamic perspective.

A western country may develop theory in terms of the Christian religion. However, caring from an Islamic perspective is like any other religious or non-religious perspective. It is because theories are based on the universal values of nursing. As Christianity, in Islam the body is respected and is considered important because it carries the soul (Barolia & Karmaliani, 2008).

Although, Barolia and Karmaliani's theory has some similarities with the four existing caring theories, it is noted that caring in nursing from an Islamic viewpoint has not been highlighted in any other nursing theories. It can be assumed that religion is embedded in the culture as transcultural nursing and cultural differences have not yet been identified as a major concern inBarolia and Karmaliani's theory.

The principle practices of caring from an Islamic perspective are based on the divine revelation that is permanent, and the one who practices caring receives many blessings. The Prophet showed how Allah expects human beings to practice by caring for other people (Rassool, 2000), for example visiting sick persons and supporting them with praying. In caring for patients in the ICU, nurses engage in all aspects of humans physical (Andrews & Nolan, 2006), psychological (Samuelson, Lundberg, & Fridlund, 2007), social (O'Connell & Landers, 2008), and spiritual aspects (Halligan, 2006; Tamura, Kikui, & Watanabe, 2006).

Evidence from Muslim scholars suggests that caring should be focused not only on the physical aspect of a human being, but should also be concerned with the interrelationship between the multiple dimensions of persons. A human being has a soul and an intellect that requires moral, ethical, and intellectual care in order to stay healthy (Rassool, 2000). Muslims believe that religious teachings bear on all aspects of life, and they strive to keep God at the center of their consciousness, intentions, and actions such as the five pillars of Islam (Power, 2007; Stefan, 2010).

Table 2.1

The Comparison of Caring Theories

	Leininger	Watson	Roach	Boykin & Schoenfoer	Barolia & Karmaliani
Origin of theory	Anthropology	Human science and metaphysics	Philosophy and theology	Philosophy and human science	Philosophy and theology
Description of caring	Caring refers to action and activities coordinated toward helping and supporting individual or gathering with clear or expected needs to enhance human condition, lifeway, and to face demise.	A value and attitude that has to become a will, an expectation, or a commitment that expresses itself in solid acts.	Caring is the human mode of being.	Caring is the intentional and credible presence of nurses with another who is perceived as a person living and developing in caring.	Caring refers to the balancing of the human identity which is crucial for providing nursing care from an Islamic perspective.
Description of nursing	Nursing refers to a scholarly humanistic and scientific profession and discipline, concentrated on human consideration.	A human investigation of people and human health illness experiences that are interceded by expert, personal, scientific, aesthetic, and moral human consideration.	Nursing is the professionali-zation of human caring, through the confirmation that caring is the human mode of being and through the improvement of the ability to care through obtaining of skills, cognitive, affective, specialized, and administrative.	Nursing as caring involves the supporting of people living and developing in caring	Nursing refers to succeeding in caring practices and caring action by sustaining a balance of physical, ethical, ideological, spiritual, and intellectual dimensions.
Concepts	Caring: culture, cultural care diversity and universality	Transpersonal caring and the 10 carative factors.	The six Cs of caring: Compassion, Competence, Confidence, Conscience,	Personhood and the nursing situation	Caring, Islamic concepts.

	Leininger	Watson	Roach	Boykin & Schoenfoer	Barolia & Karmaliani
			Commitment, Compartment		
Goals/ outcomes	To enhance and provide care which is culturally acceptable and is beneficial, and useful to the patient and family.	To ensure, improve, and preserve humankind by helping a person discover a meaning in illness, suffering, pain, and presence.	This theory does not clearly state a goal or outcome	Enhancement of personhood	The act caring in the harmony of the human being
Scope of theory	Middle Range Theory	Middle Range Theory	Grand Theory	Grand Theory	Research-based Theory

1.3 Integration of Islam into caring practice.

The integration of Islam into a caring model, nowadays, is not yet widely developed. There were three studies related to Islamic based caring found in the literature review; the theory of caring from an Islamic perspective (Barolia & Karmaliani, 2008), professional caring model (Setiawan, 2010), and a model of spirituality for ageing Muslims (Ahmad & Khan, 2015).

Theory of caring from an Islamic perspective is used to guide Muslim nurses in caring practice. The theory provides five dimensions of a human being and the five Rs as the antecedents of caring based on Islamic perspectives. Barolia and Karmaliani (2008) integrated a process of caring based on *Al-Quran* and Islamic teaching, by reflecting the participants' experience in caring practice for patients and families refers to Islamic teachings and sourced from the Noble *Al-Qur'an*. Barolia and Karmaliani (2008) integrated a process of caring into their theory.

The professional caring model, which was developed by Setiawan (2010) as a model to enhance the quality of care for stroke patients. The development

of the model engaged the Muslim patients and their families and Muslim nurses in the stroke unit. Caring relationships and the caring environment were core values that needed to be strengthened and promoted in order to facilitate caring behavior (Setiawan, 2010). In the model, nurses assisted stroke patients to meet their physical, psychological, social, and spiritual needs. Even though concern was also placed on the congruency of care with the sociocultural context of the study, it did not systematically integrate Islam. Furthermore, Setiawan (2010) stated that the professional caring model directed the nurses to practice caring in their nursing practice. In Indonesian culture, spirituality is a high priority, so the nurse creatively expanded the spiritual aspect of caring for the patients and their families.

According to Ahmad and Khan (2015), spirituality influenced well-being. They developed a model of spirituality for ageing Muslims, and central to this perspective was the intertwining of the Islamic religion and spirituality. It helps the nurses to include appropriate spiritual care in taking care of Muslim patients. It is assumed that the framework for the spirituality model for ageing Muslims based on Islamic religious beliefs would help contextualize the relationship between spirituality and the patients. There were seven basic tasks or functions of spirituality for an ageing Muslim: translation, transaction, transformation, transition, transference, transcendence, and transposition. Thus, the nurse who is taking care of the ageing Muslim patients, should practice the seven basic tasks, and translate it into the goals in order to care for the patients and their families.

Caring practice involves a balance of the hand (skills) and the head (protocol and evidence) with the heart (ethical and human dimension) (Galvin, 2010). Nursing impacts on the health of individuals, families, groups, and populations through

caring action, because nurse and patient interaction incorporates a wide range of attitudes and behaviors in the humanistic, relational and clinical domains of nursing practice and constitutes the main vehicles for promoting the quality of nursing care (Cowling, 2000).

Caring practice in Islam is focused on assisting the patient's belief in God (Lovering, 2008). Several caring practices that may be provided by nurses for critically ill patients are as follows: 1) assist the patient's belief in God and articulate simple words in Islam: *Basmillah* (with the name of *Allah*), *Alhamdulillah* (acknowledge to Allah), *Astaghfirullah* (request forgiveness from *Allah*) which are always spoken by Muslim patients to tend the God in their soul (Lovering, 2008); 2) perform prayers while the patient is in a seated position or even in a lying position; 5 times a day. If a patient is unconscious, it is preferred that his or her face be turned to Mecca (Muslim prayer direction): roughly west-north-west (Hyder, 2003); 3) perform an accurate assessment and provide competent and sensitive care. The nurse must incorporate the patient's religious and spiritual beliefs, as well as cultural customs (Hyder, 2003); 4) communicate with the patients and the families constantly (Halligan, 2006); 5) use of specific prayers and verses from *Al Quran* and *Hadiths* for treating pain (Lovering, 2008); and 6) if possible, healthcare should be given by people of the same sex as the patient (Hyder, 2003).

In addition, Islamic spiritual intervention such as *Shalah* (prayer), supplications, *Al Quran* recitation, and *Zikir* (remembrance of Allah) play an important role in healing and recovery. Islamic spiritual intervention contains a mixture of spiritual and physical elements, including the use of natural substances and certain

Islamic supplications for healing and cures for both the body and the soul (Yousif, 2012).

1.4 Caring outcomes.

Caring has been studied for many years and the outcomes of caring are diverse. Several empirical indicators have been used to measure caring outcomes from multiple perspectives, such as patient and family perspectives including the nurses' perspective. Caring outcomes can be clinically measured through measurements. It may also be patient-based, such as information regarding patient satisfaction or health related to quality of life. Caring outcomes may have an economic perspective with measurements that may include length of hospital stay, and cost of testing and treatment.

1.4.1 Caring outcomes: nurses, patients, and families outcomes.

Caring outcomes of nurses and patients/families (Table 2.2) have been reviewed and analysed using meta-analysis with 130 empirical nursing studies (Swanson, 1999). The findings revealed that caring affects the relationship between the nurse and patient, structures change, and process interaction where caring occurred. When the practice of caring is enabled, nurses' and patients' satisfaction is enhanced (Watson, 2009).

Table 2.2

The Empirical Outcomes of Caring and Non-Caring for Nurses, Patients, and Families

Empirical outcomes of caring research: nurses		Empirical outcomes of caring research: patients and families	
Research outcomes of caring for nurses	Research outcomes of non-caring for nurses	Research outcomes of caring for patients and families	Research outcomes of non-caring for patients and families
- Develop a sense of accomplishment, satisfaction,	- Become hardened - Become oblivious	- Emotional-spiritual well-being (dignity,	- Feeling of humiliation, frightened, despair,

Empirical outcomes of caring research: nurses		Empirical outcomes of caring research: patients and families	
Research outcomes of caring for nurses	Research outcomes of non-caring for nurses	Research outcomes of caring for patients and families	Research outcomes of non-caring for patients and families
purpose, and gratitude - Preserved integrity, fulfilment, wholeness, self-esteem - Live own philosophy - Develop respect for life and death - Reflective - Develop love of nursing, increased knowledge	- Become depressed - Become frightened - Become worn down	self-control, personhood) - Enhanced physical healing, lives saved, safety, more energy, less cost, more comfort, less loss - Trust relationship, decrease in alienation, feeling closer family relations	helplessness, alienation, vulnerability, lingering bad memories, and that one is out of control - Decreased healing

Note. Adapted from "Assessing and Measuring caring in Nursing and Health Sciences," by J. Watson, 2009, p. 17.

The goal of caring in the context for holistic nursing is healing. Healing is as the emergence of a right relationship between a nurse and a patient (Lincoln & Johnson, 2009). The right relationship between a nurse and patient in caring will increase the coherence of the whole body-mind-spirit, decrease disorder, and maximize free energy in the whole body-mind-spirit, maximize freedom, autonomy, and increase the capacity for creative unfolding of the whole body-mind-spirit (Quinn, 2009).

1.4.2 Harmony as a caring outcome.

Caring has been discussed in several studies as beneficial to patients, families, and nurses. Caring also improves the relationship between the nurse and patient in the physical, psychological, social, and spiritual aspects. Harmony in life for patients and nurses is a condition that reflects the result of caring. Unfortunately, the discussion of harmony in research outcomes is limited. The researcher then tried to

enlighten an understanding of the concepts of harmony by reviewing some studies in which harmony was the main result.

As the final outcome of this study is harmony for critically ill patients and families, the following discussion will highlight the concept of harmony. Commonly, harmony has been typically associated with music (Easley, 2007). This term has become more popular recently in nursing research. The term is used in current literature in various contexts, including the environment, related to body, mind, and spirit. Easley (2007, p. 555) stated in her article “Harmony: A concept analysis”, that nurses should be able to ‘feel the air, sing the song, dance the dance, and play the part’ in their clinical setting to promote harmony for patients.

Nurses promote wholeness through caring using a holistic approach. Dossey, Keegan, and Guzetta (2005) have defined holistic as "concerned with the inter-relationship of body, mind, and spirit in an ever changing environment". While, The American Holistic Nurses Association (n. d.) defines wellness (health) as "a state of harmony between body, mind, and spirit". Therefore, if the nurse is helping a patient to attain wholeness well-being, the nurse needs to provide care in each of those areas. In providing care, caring is essential to nursing, and a nurse’s caring action will promote harmony of body, mind, and spirit for the patients.

Easley (2007) described harmony as a link between phenomena, such as nursing intervention, or spiritual dimensions in harmony with the universe. Harmony has been typically related to music, and is used in various senses including the environment, and connected to body, mind, and spirit. In addition, harmony is an integral part of effective communication and positive relationships. Thus, it is concluded that, harmony is a connection of body, mind, and spirit to the environment

that uses communication and relationships between healthcare members, and patients and families.

The attributes of harmony are balance, peace, and rhythm. Healing occurs when the client and the nurse both acknowledge their life processes and use them to move toward balance and harmony (Dossey et al., 2005). Nursing care is given to the patient with the intent of promoting his or her well-being through presence, respect, trust, and partnership. As a result this will maintain the balance and harmony of the patient (Lowe, 2002). In a study of Cumbie (2001), balance within one's self as well as with the world will result in harmony. Harmony with the environment, and balancing body, mind, and spirit was also present in adults with disabilities (Atkin, 2000). Furthermore, Islamic teachings and practice have enabled the production of a holistic framework in meeting the physical, spiritual, psychosocial, and environmental needs of individuals and communities (Ohm, 2003; Rassool, 2000).

Harmony in nursing caring manifests personal relationships, working relationships, and nurse-patient relationships as the major aspect of harmony (Easley, 2007). Personal relationship means a relation between persons. Working relationship refers to activities that are so intense that it is essential to have a united, harmonious, and committed team offering quality care, and there must be a solid base for constructive communication, friendship, and mutual respect (Martins & Robazzi, 2009). The nurse-patient relationship, which is essentially therapeutic in interaction, requires therapeutic communication to be of prime importance and is integral to holistic care (Wilkin & Slevin, 2004). Lastly, the harmonious relationship between individuals (patient, nurse) and environment will present a pleasant moment, nurse and patient

satisfaction, and effective nursing intervention. Thus, harmony is potentially relevant to caring as one of the nursing outcomes.

Harmony is routinely found in nursing research, for example, reconciling with harmony is one of the coping strategies employed by Chinese family caregivers of stroke-impaired older relatives (Lee & Mok, 2011), getting in harmony with oneself is the mode to accept a chronic illness (Delmar, et al., 2005) and open visiting hours in critical care will increase harmony of body, mind, spirit of the patients (Whitton & Pittiglio, 2011). All of these studies found that harmony of body, mind, and spirit help patients and their families in adjusting to the illness and environment. Thus, to achieve harmony, the nurse must maintain a pleasant environment, feelings of satisfaction, positive self-concepts, and effective nursing intervention programs for the patients. It is suggested that nurses should be able to promote harmony in nursing care to benefit the patients.

Until now, one study about the integrative harmony model has been developed by Haley and Ratliffe (2006). The model proposed a philosophy that can be universally applied to human beings to promote well-being. Based on the model, harmony presents when there is interconnectedness through energy that influences present experiences and sense of harmony. Tapping into the interconnectedness results in harmony. Thus, according to Haley and Ratliffe p 58, “harmony is the central core equilibrium that is reached when there is a connectedness between strengths and stressors”. What this harmony state looks like to an individual is influenced by the culture or worldview of the individual, which colors the lens through which the strengths and stressors are perceived. In the study of Haley and Ratliffe (2006), the stressors that emerged were pre-existing stressors, financial burden, role conflict, care

burden, and isolation. The stressor was dependant on each person's perception of a situation, whilst, the strengths were comprised of a free flow of energy, connectedness, openness to what is, and meeting a challenge.

Based on the model, Haley and Ratliffe highlight that the worldview in the model is culture. The culture of the individual consists of the beliefs, values, and attitudes. The beliefs and values of an individual about the situation will influence his or her attitude. The nurse can assess a patient's worldview to get information on the strengths and stressors. Strengths are a state of being arising from the sources of energy into attaining harmony. The undergoing of strengths, free flow of energy, connectedness, openness to what is, and meeting a challenge exist in the integrative harmony model. The following discussion will explain the components of the strengths of the integrative harmony model.

Free flow energy or presence. Presence is caring, and if the nurse would like to provide caring, she/he should have presence for the patient. Presence is as a way of being interpersonal, transpersonal, and spiritual within a caring relationship (Covington, 2005). Presence consists of a process that is enacted in moments or over days, weeks and years (Finfgeld-Connett, 2006). This results in a positive attitude characterized by the ability to act appropriately. Therefore, in presence, the specific aspect is a positive attitude focusing on the present situation.

Connectedness. The specific aspects of connectedness are 1) spirituality, 2) family support, 3) social or community support, 4) taking care of self, and 5)

interaction with nature. Connectedness in each aspect of patients in the ICU is detailed as follows.

Spirituality for patients has been reported in many studies as giving mental support for patients in the ICU (Lundberg & Kerdonfag, 2010), ICU nurses being in a better position regarding their perception levels of spiritual care (Turan & Yavuz Karamanoğlu, 2013), and spiritual well-being being substantially correlated with psychological well-being and personality (Unterrainer, Ladenhauf, Moazedi, Wallner-Liebmann, & Fink, 2010). Spirituality is gaining the patients' faith to connect with God resulting in well-being both mentally and spiritually.

In family support, most nurses are willing to invite family members to support patient care (Azoulay, et al., 2003). A significant positive correlation was found between spirituality and family support during invasive procedure and resuscitation in adult patients (Baumhover & Hughes, 2009). Maintaining connections with the family is beneficial for the emotional and social aspects of the patients (Haley & Ratliffe, 2006).

Social or community support is a source of strength in many studies. For patients in the intensive care unit, social support probably came from the visitation of friends, neighbors, and other community members. Their visitation increased the emotional well-being and mental well-being of patients, because the patient felt happy when friends came to give support (Finfgeld-Connett, 2007).

Taking care of yourself refers to the nurse who should take care of himself or herself before taking care of a patient. The nurses were required to be healthy physically, mentally, and spiritually in order to mediate the patients to connect with God, society or community, and environment or nature. Taking care of self is

imperative to personal health, sustenance to continue to care for others, and professional growth (Blum, 2014). Then, interaction with nature is reflecting strength and providing a positive energy to care for the patients (Haley & Harrigan, 2004). Similarly, Ratliffe and Haley (2002) stated that the linking with energy fields in the interaction with nature was as a means of reloading one's own energy and strength.

Openness to what is. Openness to what is refers to handling emotions, finding meaning and not being overwhelmed (Halley & Ratliffe, 2006). According to Halley and Ratliffe, handling emotions to face critical situations is a comfortable feeling to gain emotional well-being. The search for meaning to what is represents a new level of understanding or a new perspective. The search for meaning leads toward an increased "meaningfulness in life" (p. 64). Thus, the harmony reflects and finds the meaning in the fulfillment of each moment.

*Meeting a challenge***.** Problem solving, resourcefulness, dedication, and love are themes in meeting a challenge in the integrative harmony model (Halley & Ratliffe, 2006). Problem solving is accepted to be an intellectual process requiring reflecting and creative thinking (Cinar, Sozeri, Sahin, Cevahir, & Say, 2010). Therefore, resourcefulness is the searching for data to provide a response to the problems or potential problems, to improve knowledge for better decision making for the patients (Halley & Ratliffe, 2006). Resourcefulness is the ability to perform independently daily tasks (personal resourcefulness) and to seek help from others when unable to function independently (social resourcefulness) (Zauszniewski, Lai, & Tithiphontumrong, 2006). Personal resourcefulness is a nurse, and social

resourcefulness is family or community support. Moreover, dedication and love are portrayed in the integrative harmony model. Dedication and love give the nurse a confidence to meet challenge in caring for a patient. By having dedication and love, the nurse and the patient will immediately improve their harmony of body, mind, and spirit.

1.4.3 Harmony in Islamic perspectives for Muslim nurses and patients in the ICU.

Muslims live in a way that reflects unity of body, mind, and spirit with *Allah*. This unity view of harmony in life focuses on the relationship with *Allah* (Lovering, 2008). Thus, Muslim nurses put their attention to the body, mind, and spirit in caring for patients. Based on the literature review, harmony in an Islamic perspective for Muslim nurses in the ICU probably includes spirituality, and nurse-patient relationship.

Spirituality in Islam is how Muslim nurses have a connection with God (*Allah*), how they increase their faith, and what things Muslims need to do to get closer to *Allah*. For Muslim patients, spirituality is important, because spirituality gives an inner piece, energy, and sincerity to what *Allah* gives to them (Halligan, 2006) Likewise, Henry (2013) found that providing spirituality in Islam can produce spiritual energy that may yield physical, psychological, and spiritual well-being. Thus, the nurse can invest this intervention in the transforming and healing effects for the patient. Therefore, spirituality in Islamic faith for patients is an antecedent to provide harmony for the patients in the context of caring.

Meanwhile, the nurse-patient relationship in Islam refers to how the nurse considers the needs among the basic needs of hospitalized patients. The nurse

should emphasize kindness, compassion, and the showing of good behavior in the interactions and relations with the patient and their families. A good relationship will enhance patients' satisfaction. Patient's satisfaction is as an indicator that reflects the quality of care and caring behaviors of nurses (Rafii, et al., 2008). The nurse-patient relationship is an intervention that should be provided by the nurse to gain harmony in the life of their patients and for their profession.

1.5 Measurements of caring outcomes.

Caring outcomes were assessed both quantitatively and qualitatively. However, the present study employed qualitative method to assess the caring outcomes of the study in order to provide in-depth details for better understanding the nurses', patients', and families' subjective caring outcome. The interview guides developed by the researcher were used to guide the assessments of the patients', families', and nurses' satisfaction and the harmony of life (Appendix B, C, D, and E).

For quantitative measurement, there were many existing tools measuring the outcomes from different perspectives; the nurse, patients, and family outcomes. In this section, the researcher highlighted 4 measurements of caring, including 1) Nurse-Patient Relationship Questionnaire, 2) Nurse Caring Behaviour Checklist, 3) Professional Caring Behavior, and 4) Body-Mind-Spirit Well-Being Inventory (BMSWBI).The following table is summary of examples of tools of caring outcomes (Table 2.3).

Table 2.3

Examples of Measurements of Caring Outcomes

No	Tools	Description
1	Nurse Caring Behaviours Checklist (Setiawan, 2010)	This instrument is in the Indonesian language, to measure caring behaviour of nurses in caring for critically ill stroke patients in Indonesia. To date, there is no information of validity and reliability of this instrument.
2	Nurse-Patient Relationship Questionnaire (Quinn et al., 2003)	This questionnaire was developed to measure caring quality of the nurse-patient relationship. To date there has been no reliability, validity, or development effort to refine this scale.
3	The Professional Caring Behaviors (Watson & Lea, 1997)	This instrument is to measure the caring of aspects of caring nursing practice. This instrument is not widely used to measure caring practice among nurses, patients, and families.
4	Body-Mind-Spirit Well-Being Inventory (BMSWBI) (Ng, Yau, Chan, Chan, & Ho, 2005).	BMSWBI is to measure the holistic health of a person in Chinese adults. The validity of all of the relationships between the BMSWBI scales range from 0.40 to 0.72. However, this tool is not relevant to measure harmony in this study, as the tool is a general measurement to measure well-being of body, mind, and spirit for a healthy person. Moreover, harmony as a caring outcome in this recent study is in regard to Islamic concepts.

2. Critical Care Nursing and Caring in the Intensive Care Unit (ICU)

The following concepts will be discussed: patient, setting and technology in the ICU; nursing standards on caring for critically ill patients in the ICU; nurse caring behaviors for critically ill patients in the ICU; family participation in caring for critically ill patients in the ICU, and factors influencing caring for critically ill patients.

2.1 Patient, setting, and technology in the ICU.

Critically ill patients are defined as those patients who are at high risk of actual or potential life-threatening health problems. The more critically ill the patient is, the more likely he or she is to be highly vulnerable, unstable and complicated,

thereby requiring intense and vigilant nursing care (AACN, n.d). In the ICU, patients may recover or die. Therefore, the management of the patients involves the prediction of at risk patients, proactive observation and timely interventions to prevent deterioration. An appropriate treatment can improve the outcomes of the patients.

The intensive care unit (ICU) is an area of specialty within nursing that deals specifically with human responses to life-threatening problems (American Association of Critical-Care Nurse [AACN], n.d). The ICU has higher levels of staffing, specialist monitoring and treatment equipment that are only available in this area and the staff are highly trained in caring for the most severely ill patients (The Intensive Care Society, n.d). AACN differentiates three factors that cause intensive care units to differ from other units in the hospital: (a) a very high nurse-to-patient ratio, (b) the availability of invasive monitoring, (c) the use of mechanical and pharmacological life sustaining therapies (mechanical ventilation, vasopressors, continuous dialysis).

The environment of the intensive care unit is not like a general ward. The environment should be designed to offer efficient patient care as well as a healing and comfortable environment for both the patients and their families (Williams, 2001). The ICU environment, ideally, is divided into three zones: a patient area, a family area, and a caregiver area. The patient area includes the bed, bedside table, and bedside chair. The family area could have a reclining or sleeper chair, as well as storage space for personal belongings. The caregiver area consists of supply storage, monitors, computer terminal, and charting stand (Williams, 2001). However, the areas depend on the space allocation of the ICU, and each hospital may have different zones.

Monitors, intravenous (IV) tubes, feeding tubes, catheters, ventilators and other equipment are common in critical care units. Modern intensive care nursing

involves an environment in which a heavy reliance is placed on technology to carry out a range of functions concerned with both monitoring patients' physiological status and delivering treatments in the form of drugs and various types of respiratory support (Andrews & Nolan, 2006). The demand and complexity of technology makes it necessary to have a clear understanding of the ways in which the health care provider in the intensive care unit interacts with technology (Browne & Cook, 2011). For example, syringe pumps are widely used in ICU to deliver a range of medication at a controlled rate. Brown and Cook also claimed that a mechanical device is susceptible to malfunction as well as being affected by a number of outside influences that might affect its operation. Manufacturers have included an alarm system to alert nurses to the conditions that might need possible troubleshooting, such as the occlusion of a line, or the administering drug being finished.

In assessing the physiological data presented by equipment, a nurse then is faced with three possibilities. The first is the monitor display representing the patient's condition accurately; the second is the monitor display showing the patient's state inaccurately because of the presence of external factors, such as an occlusion or calibration errors; and the third is there are no external factors but the display is inaccurate because the device is faulty (Browne & Cook, 2011). The above statements are oriented to the machine and technology utilization to understand the physiological condition. Ozbolt (1996) as cited in Purnell (1998) discussed that technology appearances are designed to free the nurse from caring. Critical care nurses, definitely, should realize other factors that contribute to the patient's condition when the data display from the monitor does not match the patient's present condition.

Barnard (2000) conducted a phenomenography study to identify the nurse's experience of technology, by using a semi-structured interview with open-ended questions and pictures to describe experiences. The 20 nurses who participated, had 1 to 30 years of professional experience. The finding was that technology could be a form of medical dominance. According to the nurses' opinion, machines are usually purchased and controlled by the medical professionals and meet the needs of medical practice rather nursing. Kiekkas, et al. (2006) discovered that the majority of nurses recognized the positive effects of equipment regarding patient care and clinical practice. They agreed that the use of equipment possibly leads to increased risk due to human errors or mechanical error, increased stress and the restricted autonomy of nursing personnel.

2.2 Nursing standards on caring for critically ill patients in ICU.

A critical care nurse is a licensed professional nurse who is responsible for ensuring that acutely and critically ill patients and their families receive optimal care. Critical care nurses are educated in working with critically ill patients. Their education is extensive and covers physical, psychosocial, and spiritual aspects of care. Terry and Weaver (2011) mentioned that the critical care nurse needs to: 1) be well versed in advanced pathophysiology; 2) be adaptable and calm while treating patients in an environment that requires quick decision-making skills in regards to underlying threatening conditions; 3) stay abreast of changing advanced technology to preserve organ function; 4) coordinate the care with multiple influencing factors; 5) provide leadership in the management of care; and 6) coordinate the multiple disciplinary team.

Critical care nurses also have standards of care and standards of professional practice. These standards provide a framework for the quality of care delivered by the nurse (American Association of Critical-Care Nurse, 2008). The standards composed of 6 items include assessment, diagnosis, outcome identification, planning, implementation, and evaluation. The standards are related to the nursing process for the patients (Table 2.4).

Table 2.4

Nurses Caring for Critically Ill Patients Based on AACN Standards of Care

No	Standard	Description
I	Assessment	The nurses collected relevant patients' health data.
II	Diagnosis	The nurses analysed assessment data in determining diagnosis.
III	Outcome identification	The nurses developed plan of care that identify individualized, expected outcomes for patients.
IV	Planning	The nurses developed plan of care that prescribed interventions to attain expected outcomes.
V	Implementation	The nurses implemented interventions identified in the plans of care.
VI	Evaluation	The nurses evaluated patients' progress toward attaining expected outcome.

Adapted from AACN web site at http://www.aacn.org. Accessed January 13, 2013.

Furthermore, in AACN the most common role for the critical care nurse is administering care to the patient at the bedside. The AACN has then clearly defined eight critical care competencies that enclose the nurse's roles (Table 2.5). The critical care nursing competencies include clinical judgment, advocacy and moral agency, caring practice, collaboration, system thinking, response to diversity, facilitator of learning, and clinical inquiry. Caring practice is an important competency in critical care nursing. In caring practice, nurses should create a compassionate, supportive, and therapeutic environment for patients, families, and others, with the aim of promoting comfort and healing and preventing unnecessary suffering (AACN, n.d).

Table 2.5

Eight Critical Care Nursing Competencies

No	Competencies	Description
1	Clinical judgment	Clinical reasoning, which includes clinical decision-making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating formal and informal experiential knowledge and evidence-based guidelines.
2	Advocacy and moral agency	Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.
3	Caring practice	Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. Not limited to, vigilance, engagement and responsiveness of caregivers, including family and healthcare personnel.
4	Collaboration	Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals; involves intra- and inter-disciplinary work with colleagues and community.
5	Systems Thinking	Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources exist for the patient/family and staff, within or across healthcare and non-healthcare systems.
6	Response to Diversity	The sensitivity to recognize, appreciate and incorporate differences into the provision of care; differences may include, but are not limited to, cultural differences, spiritual beliefs, gender, race, ethnicity, lifestyle, socioeconomic status, age and values.
7	Facilitator of learning	The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community; includes both formal and informal facilitation of learning.
8	Clinical inquiry (Innovator/ Evaluator)	The ongoing process of questioning and evaluating practice and providing informed practice; creating practice changes through research utilization and experiential learning.

Note: From AACN website at www.acacn.org, last accessed January 13, 2013.

2.3 Critical care nurse caring behavior for critically ill patients in the ICU.

The focus of care in the ICU is not only on the patient but also on their families. Nurses caring behaviors are a factor that enables the nurse-patient relationship. A study about nurses caring behavior by O'Connell and Landers (2008) revealed the ten most important nurse caring behaviors as perceived by nurses and families (Table

2.6), whereas, the patients in the study considered the technological caring behaviors of the nurses. In addition, Omari, AbuAlRub, and Ayasreh (2013) also found that patients in critical care units perceived physical and technical behaviors as the most important caring behaviors for nurses, whereas nurses in critical care units perceived teaching behaviors as most important caring behaviors. It is concluded that the importance of the caring behaviors of critical care nurses were similar as perceived by nurses, patients, and patient's family in terms of treating the patient as an individual.

Table 2.6

The 10 Most Important Nurse Caring Behaviors as Perceived By Nurses and Patients' Families in Critical Care Unit based on O'Connell and Landers (2008)

No.	Nurse caring behaviours perceived by nurses	Nurse caring behaviours perceived by patients' families
1	Know what you are doing	Treat the patient as an individual
2	Treat the patient with respect	Know what you are doing
3	Treat the patient as an individual	Know how to give injections, IVs, etc.
4	Reassure the patient	Know how to handle equipment
5	Are kind and considerate	Give the patient medications and treatments on time
6	Know when the patient has had enough (visitors, etc.) and act accordingly	Treat the patient with respect
7	Maintain a calm manner	Make the patient feel someone is there when he/she needs it
8	Give the patient your full attention when with him/her	Are kind and considerate
9	Help the patient with his/her care until the patient is able to do so for himself/herself	Give the patient pain medication when he/she needs it
10	Know when it is necessary to call the doctor	Let the family visit as much as possible

2.4 Family participation on caring for critically ill patients in the ICU.

Family members of critically ill patients are integral to the recovery of their loved ones. When planning for the overall care of patients, nurses and other caregivers need to consider the informational and emotional support needs of this

group. Families of critically ill patients report their greatest need is for information. The informational requirements of families with a critically ill patient are as: 1) having questions answered honestly; 2) knowing the facts about the patient's prognosis; 3) knowing the results of procedures as soon as possible; 4) having staff inform family members of the patient's status; 5) knowing why things are being done; 6) knowing about possible complications; 7) receiving explanations that can be understood; 8) knowing exactly what is being done; 9) knowing about the staff providing care; 10) receive directions about what to do during a procedure (Leon & Knapp, 2008; Thacker & Long, 2010; Verhaeghe, Defloor, Van Zuuren, Duijnstee, & Grypdonck, 2005). Flexible visiting hours and informational booklets regarding the critical care experience are recommended to meet this (Urden, Stacy, & Laugh, 2008).

To help the family to participate in caring, the nurses should understand the needs of the family. Verhaeghe, et al. (2005) divided the family's needs into four categories of cognitive, emotional, social and practical needs.

1. The cognitive needs are the need for accurate and comprehensible information. Family members want to speak to a doctor every day about the condition of and the prognosis for the patient, and want a nurse to explain to them about the care, the unit, the equipment, and what they can do for the patient during visiting hours. Family members place great importance on being called at home if the condition of the patient changes.
2. The emotional needs include hope, reassurance and being able to remain in the vicinity of the patient. Family members always give

priority to the welfare of their loved one. In their confused state, they often do not get around to paying attention to themselves.

3. The social needs can be the relationship between the patient and his or her family members as well as the relationship between family members and friends.
4. The practical needs generally concern the family member's feeling of comfort, in which both material and non-material matters can play a role. In the category of the non-material needs, flexible visiting hours are at the top, followed by help with financial or family problems and explanations of what family members can do at the bedside of the patient, and how they can contribute to the patient care.

The families often focus on the fundamental aspects of physiological needs such as shaving, pain relief and communication (Ryan, 2004). The families' values and their perspectives often differ from the nurses (Endacott & Berry, 2007). In the ICU, the family are often afraid to touch their loved ones in case they interfere with some of the machines, relatives should be offered opportunities to be actively involved in care without being made to feel guilty or becoming physically exhausted (Woodrow, 2012).

The patient's family may be angry. They are usually angry at the disease, but it is difficult to take anger out on disease. Instead, anger, complaints or passive withdrawal may be directed at those nearby, who are usually the nurses (Asa & Siv, 2007). Most families display emotional reactions such as symptoms of anxiety or depression and so on (Hughes, Bryan, & Robbins, 2005; McAdam, Fontaine, White,

Dracup, & Puntillo, 2012). The families may blame themselves, have feelings of guilt and distress. They may neglect their own physical needs, such as rest and sleep (Bournes & Mitchell, 2002) in accompanying the patient in the hospital. Therefore, the facilities for the family should include a waiting room near the unit, somewhere to stay overnight and facilities to make refreshments (Thompson, et al., 2012).

Family members could be encouraged to be involved in the actual care delivery at a very basic level, for example assisting with basic hygiene needs, emptying urine bags, etc. However, not all family members have the ability or motivation to be involved, and therefore nurses should carefully assess their ability (Moore, 2004). Families need to feel that they are contributing positively in some way and this involvement should not be denied. Family members' interaction with and the support of the patient is a way of demonstrating their love and concern, and constitutes an aspect of care that only they can provide (Williams, 2005).

Families like to have a presence in the ICU (Bell, 2011; Thacker & Long, 2010). This presence is related to being with the patient, having emotional as well as a physical presence. It involves connectedness and bonding. Humanistic practitioners are personally involved (Leon & Knapp, 2008; Thacker & Long, 2010). Nurses should act as effective role models in talking to and touching the patients, as many families may feel awkward talking to a patient who is unconscious. Nurses must be aware of the family's participation in taking care of the patients while being hospitalized in the ICU and or after being discharged from the unit. That is the reason why family participation in caring will be beneficial for patients.

2.5 Factors influencing caring for critically ill patients.

The factors influencing caring for critically ill patients in the ICU are reported in the literature. The influencing factors consist of 1) the nurses' caring knowledge and skills, 2) the nurses' motivation on caring, 3) the nurses' work experience, and 4) gender issue.

2.5.1 The nurses' caring knowledge and skill.

Numerous conceptualizations of caring have been published over the years in order to give nurses caring knowledge. The conceptualization of caring given to the nurses, is that caring is valued in the nursing practice. Despite caring being regarded as a valuable attitude of nursing for decades, nurses' knowledge about caring is mainly on a philosophical level. That is why some nurses in a diverse world are limited on caring knowledge and skill. For example in Indonesia, the level of nurse's caring knowledge may be at the state of remembering and understanding, as they had learned from nursing school. It is the reason that the nurses neglect to practice caring in the setting.

Effective caring requires adequate knowledge in order to apply it in the nurses' caring practice (skill). According to Scotto (2003), the knowledge and skill of caring for patients consists of four aspects: 1) intellectual, 2) psychological, 3) spiritual, and 4) physical. The intellectual aspect of nurses consists of an acquired, specialized body of knowledge, analytical, thought, and clinical judgment, which are used to meet patient's needs. The psychological aspect of nurses compose of the feelings, emotions, and memories, which are part of the patient's experience. The spiritual aspect of nurses helps the patients to seek a supernatural power and to answer the question, "Why? What is the meaning of this?" The physical aspect of nurses is the ability of the nurses offer

the nursing service and skills to attain a goal. Therefore, the nurses must be accomplished in their knowledge. Nurses' caring knowledge for critically ill patients specifically is not limited to the nursing standard care, but also it should touch the all dimensions of a human being.

2.5.2 The nurses' motivation on caring.

The nurses' motivation on caring in the intensive care unit is important to influence good caring practice, as they should take care of the patients with their heart and love. The giving and receiving of love is something that is embedded within everyday nursing and caring practice (Stickley & Freshwater, 2002). A study on positive benefits of caring on nurses' motivation were revealed that the importance of considering the emotional aspect of the nurses correlated with their motivation and well-being (Donoso, Demerouti, Garrosa Hernandez, Moreno-Jimenez, & Carmona Cobo, 2015). Therefore, the nurses' motivation on caring consists of emotional and physical demands.

The emotional demand on the nurses' motivation refers to the emotional condition (such as stress, feelings, and satisfaction) in their job in taking care of the patients. Nurses, who are stressed in their job, may not take care of the patients sincerely. However, the positive emotions of nurses on caring ensure the nurses are a good in their profession. In other words, the positive emotional demand of the nurses is crucial in order to motivate the nurses to care for the patients. Meanwhile, the physical demands refers to the physical well-being of the nurses. The physical well-being of the nurses is important, as the nurses should keep healthy in taking care of the patients. Physical health influences the nurses' motivation in their job and taking care of the patients.

2.5.3 The nurses' work experience.

Work experience is a fantastic way to gain an insight into a career in nursing. It can also be a valuable way of getting some confidence and experience of caring for the patients and their families. However, most nurses in the ICU are young and novices. They have not had experience caring for critically ill patients. Thus, they lack experience on how to recognize the patients' crisis and their needs. They have no motive to assess and to observe patients more directly (Yue, Wang, Liu, & Wu, 2015). The young or novice nurses expressed confusion and stress as their impression about their first job experience. A study on novice nurses in Indonesia revealed that the opportunities to gain clinical experience were acknowledged as the factors that make nurses feel good about their job. However, lack of support from seniors, lack of clinical skill and knowledge, unfamiliarity with work environment and procedure, work schedule system, relationships with patients and doctors, and limited autonomy were reported as causes creating negative feelings about their job (Maftuhah & Tashiro, 2015).

2.5.4 Gender issue.

One of the influencing factors of caring in Islam is gender issue. Halligan (2006) described in his study that older male patients disliked female nurses taking care of them. Similarly, female patients did not want male nurses in the room, because for female patients there is an overriding objective of modesty and privacy. Modesty is an important issue and is held in high regard by males and females in Islamic culture. Unnecessary touching between non-related people of the opposite sex should be avoided (Hyder, 2003). Thus, it is suggested that caring for Muslim patients should be gender oriented.

A case study method related to gender and caring was also investigated by Pasic, Poeschla, Boynton, and Nejad (2010). They found that gender is a challenging area in Muslim culture, because Islam is more strictly ruled than other religions in interactions between male and female. However, due to the current shortage of nurses the possibility of achieving this gender mix seems unachievable.

3. Critical Social Theory and Action Research

In action research, the philosophy underpinning the study is critical social theory. The following description discusses the concept of the philosophy in collaborating with action research concepts.

3.1 Critical Social theory.

Critical social theory has contributed to action research since it suggests that researchers are attentive to how it operates in social, cultural, and economic contexts and throws light on the ways in which people act in everyday situations (Kemmis & McTaggart, 1988). Research methodology that adopts critical social theory as the basis of knowledge development has been specifically advanced by the researcher in social sciences (Holter & Kim, 1995).

Critical social theory in knowledge of human interest was proposed by Habermas in 1984. Habermas explicated a foundation for a methodology consistent with his metatheory. He claims that there is an interdependence between the basic concepts of action and the methodology of understanding social science. Habermas also addressed a question of communicative action in rational interpretation. Communicative action is oriented to reach an interpersonal understanding and as action where the participants are not primarily interested in attaining their own individual

successes, but in arriving at their individual goals through mutual understanding and harmonious interpretations (Habermas, 1984). Thus, the researcher has to understand the reasons with which persons would defend their validity (Kemmis, 2001; Kim & Holter, 1995).

Critical social theory has been shown by nursing scholars as addressing key issues in the development of nursing knowledge. Such interest has pointed out the need to rethink nursing practice not only as problem solving, but also as praxis in which nurses are human agents (Kim & Holter, 1995). In this research, critical social theory will highlight the empowerment and emancipation of the participants, as the research process creates the practical intent of the participants. Empowerment encourages people to undertake activities by which they work to improve their situation (Glasson, Chang, & Bidewell, 2008).

Action research relates to the humanistic approach. The humanistic approach encompasses the qualities of non-defensiveness, of openness, of authenticity, which are characteristics of the real self and are also concerned with the social field (Rowan, 2001). In being a virtual participant, the researcher brings his or her own understanding to the situation. Thus, there is no difference between understanding and interpretation as all understanding involves interpretation and all interpretation involves understanding (Habermas, 1984).

3.2 Action research.

Action research is now widely used as a way of categorising research that has moved beyond researching "on" to researching "with" participants (Cook, 2012). Authors such as Kemmis and McTaggart (1988), Adelman (1993) stated that

this mode of research originated with Kurt Lewin, an American psychologist in the late 1930s.

A primary purpose of action research is to produce practical knowledge that is useful to people in the everyday conduct of their lives. A broader purpose of action research is to contribute through this practical knowledge to the improved well-being, economic, political, psychological, spiritual dimensions of persons and communities, and to more equitable and sustainable relationships with the wider environmental science of the sphere of which we are an essential part (Reason & Bradbury, 2001). Thus, action research is about working towards practical outcomes, and also about creating new forms of understanding, since action without reflection and understanding is blind.

3.2.1 Types of action research.

There are three approaches of action research consisting of the technical collaborative approach, the practical/mutual collaborative approach, and the emancipatory approach (Grundy, 1982; Holter & Schwartz-Barcott, 1993). The characteristics of action research are summarized in Table 2.7.

1) Technical Collaborative Approach.

According to Inger Margarethe Holter and Schwartz-Barcott (1993), the main goal of the researcher in technical collaborative approach is to examine a particular intervention based on a pre-specified theoretical framework. The query is to know if the intervention can be applied in a practical setting. The aspects of collaboration between the researcher and the practitioners are technical and facilitatory. The researcher focuses on an identified problem and a specific intervention. The interaction between the researcher and the practitioner is aimed at gaining the

practitioner's interest in the research and agreement to facilitate and help with its implementation. The kind of knowledge that results from this approach is predictive knowledge and the major thrust is on validation and refinement of an existing theory and hence is essentially deductive.

2) Practical Collaborative Approach.

In the practical collaboration approach, the researcher and practitioners come together to identify potential problems, their underlying causes and possible interventions. The practitioners gain a new understanding of their practice, and the changes implemented tend to have a more lasting character. The type of knowledge generated is generally descriptive, and moves towards the development of new theory and also follows an overall inductive approach (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996).

3) Emancipatory Collaborative Approach.

In this approach, the researcher raises questions about the underlying assumptions and values, and involves the practitioners in critically reflecting on their practice. The emancipatory collaborative approach is bringing to light the difference between stated practices underlying assumptions and conventions that really manage that practice. The researcher facilitates the practitioners in the discussion of underlying problems and assumptions on a personal level, as well as discussing the level of the organization's culture and the possible conflicts they can generate. This approach focuses on the value system, norms, and conflicts, which are the probable causes of the problems. In this step the emerging patterns of new practice and new theoretical insight originate from a freshly shaped culture of practice (Holter & Schwartz-Barcott, 1993).

Table 2.7

The Characteristics of Three Modes of Action Research

Philosophical Base	Technical Collaborative approach	Practical/Mutual Collaborative approach	Emancipatory Collaborative approach
The nature of reality	Single, measurable, fragmental	Multiple, constructed, holistic	Social, economic. Exists with problems of equity and hegemony
Problem	Defined in advance	Defined in situation	Defined in the situation based on values clarification
Relationship between researcher and practitioners	Separate	Interrelated, dialogic	Interrelated, embedded in society
Focus of collaboration theory	Technical validation, refinement, deduction	Mutual understanding, new theory, inductive	Mutual emancipation, validation, refinement, new theory, inductive, deductive
Type of knowledge produced	Predictive	Descriptive	Predictive, descriptive
Change duration	Short lived	Longer lasting, dependent on individuals	Social change, emancipation
The nature of understanding	Events explained in terms of real causes and simultaneous effects	Events are understood through active mental work, interactions with external context, transactions between one's mental work and external context	Events are understood in terms of social and economic hindrances to true equity
The role of value in research	Value free	Value bounded	Related to values of equity
Purpose of research	Discovery of laws underlying reality	Understand what occurs and the meaning people make of phenomena	Uncover and understand what constrains equity and supports hegemony to free oneself of false consciousness and change practice toward more equity

Adapted from: Masters, J. (1995) 'The History of Action Research' in I. Hughes (ed). *Action Research Electronic Reader*. The University of Sydney. Retrieved from http://www.behs.cchs.usyd.edu.au/arow/Reader/rmasters.htm

Action research encourages people to convey change by producing knowledge through reflection on their personal experiences and situations. The action research process enables nurses who actually work with patients to bring innovation to their practice in clinical settings. So, nurses are encouraged and empowered to address their identified concerns with the care they provide, to engage step by step in the cyclical process to improve their practice and better meet the needs of their patients (Badger, 2000; Glasson, et al., 2008; Hall, 2006). In summary, mutual action research was applied in this study and nurses, patients, and families were invited to engage and collaborate to change the practice and develop a model of Islamic based caring.

3.2.2 The cycle of action research.

Kemmis and McTaggart (1998, 2008) discussed that there are four steps for the action research planner, which are: (1) reconnaissance, (2) planning a change; (3) acting and observing; the process and consequences of the change, (4) reflecting on these processes and consequences, and re-planning (Figure 2.3).

1) Reconnaissance.

Reconnaissance refers to initial reflection on one's own situation in the light of the thematic concern (Kemmis & McTaggart, 1988). Reflection identifies concerns that need addressing and reveal the ward nurses' perceptions of their nursing practice (Glasson, et al., 2008). Further, reconnaissance is similar to preliminary investigation. Several nurses should state their concerns about changing their unit practice, and express their enthusiasm to change the nursing care they provide. Reflection also involves the action researcher documenting what happens throughout the study. Nursing staff and reference group meetings record the exchange of

information, ideas, issues raised and reflections about the ways of improvement during the reconnaissance.

2) Planning.

The nurses worked with the researcher to plan when, where and how to address their concerns. The planning action step commenced when the researcher presented the information from a literature review for the nurses to select ideas from which to develop their new model of nursing (Glasson, et al., 2008; Kemmis & McTaggart, 1988; Street & Robinson, 1995). Following the planning presentation, the nurses devised a particular nursing model of caring to address their concerns. They also planned the instruments to evaluate the new model of caring.

3) Action and observation.

In the acting phase, the nurses implemented their plan on the ward. Meanwhile in the observing steps, the researcher observed the nurses caring practice for the patients. According to Kemmis and McTaggart (1988), the researcher's team simply have to go ahead and try to do what has been planned to do. The plan may not have visualized all of the circumstances in which it is enacted, but the researcher will get some instant feedback once the situation is underway.

4) Reflection and re-planning.

The reference group reflected on the outcomes to determine whether the model has improved the quality of care and whether the ward nurses are satisfied with the care they had agreed to provide. The researcher facilitated this process by encouraging and guiding the nurses to reflect on their ward practice (Glasson, et al., 2008). So, the nurses developed their own knowledge and gained confidence through reflecting on their everyday practice. Somehow, re-planning is needed to decide on how

next to proceed, retain, or change the model of caring. The researcher encouraged the reference group to continue meeting to reflect on previous steps and plan further enhancements for the next cycle (Kemmis & Taggart, 2008).

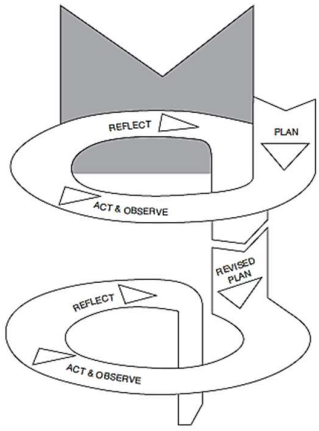


Figure 2.3 The Action research Spiral. Adapted from "Participatory Action Research: Communicative Action and the Public Sphere" by S. Kemmis and R. McTaggart. In Strategies of Qualitative Inquiry (2008), p 278. In *Strategies of qualitative inquiry* by N. K. Dezin and Y. Lincoln.

Undertaking action research is a disciplined inquiry that pursues a focused effort to gain the knowledge that is necessary for people to take action to improve the quality of their lives (Koch, Selim, & Kralik, 2002). Koch and colleagues also justified that action research is a collective, self-reflective inquiry that is undertaken to improve a situation. The spiral nature of action research, with the planning, action, and evaluation phase goes beyond the mere fact finding expedition that is the hallmark of much conventional research (Cook, 2012; Kemmis & McTaggart, 1988). The process of engaging in practices that are informed by reflection is called "praxis", which is achieved by critically identifying issues and collaborating to reflect politically upon practice to systematically deconstruct it (Koch, et al., 2002).

Action research is widely used in nursing studies since the inquiry stems from the methodology, which describes the development of the model and workings with the participants in the clinical setting. Methodologically, there is a continuing

dialectic as people strive to make meaning and collectively create knowledge. The principles adapted for the action research process are democratic, equitable, liberating, meaningful, useful, and ultimate. The research process within the cycles resulted in praxis for the researcher and reference group, as knowledge is achieved from the critical thinking beyond the cycle.

4. Summary

In most clinical theories and models, based on the consideration of human nature, nursing concepts present the fact that in an Islamic nursing context, humans are regarded as a comprehensive whole, and caring is defined in the holistic framework. According to Islamic scholars, caring focuses on the human being approach, and basis of holistic nursing in dealing with patients' crisis. Nurse caring is regarded not only as a responsibility and social commitment but also as a holy and altruistic job, benevolent, and among the highest forms of worship to God.

In addition, caring is based on well-being improvement and healing, and concentration on all domains of nursing care, and the relationship of nurses and patients. Humans are powerful and capable of reaching the highest levels of perfection in life. The nurse should pay attention to all dimensions of the human being: the physical, psychological, social, and spiritual dimensions. Islamic based caring to achieve harmony of critically ill patients distinguishes the nursing profession to be unique and contributes to capitalizing on a full range of ideas in order to advance the profession. Thus, a better understanding of caring in Islamic perspectives is needed to ensure optimal care.

CHAPTER 3
RESEARCH METHODOLOGY

This chapter describes the research methodology that was used in this study. The research can be divided into 11 parts: 1) research design, 2) researcher roles, 3) research setting, 4) participants of the study, 5) research instrument, 6) research processes, 7) data collection methods, 8) data analysis, 9) trustworthiness of the data, 10) translation issues, and 11) ethical consideration.

Research Design

This study was an action research performed to create a change in caring practice and to develop a model to achieve this goal. This area of interest was chosen due to nurses' ongoing concern with the gap between theory, research and practice, and with the over-emphasis on naturalistic forms of inquiry (Holter & Schwartz-Barcott, 1993). Action research emphasizes the importance of the researcher and participants working together in order to achieve an understanding of the participants' interests, meanings, and constraints within the context in which the research is conducted.

The final outcome of the study was to investigate the harmony of the critically ill patients who were participants in this study and the satisfaction of the participants in the implementation of the Islamic based caring model through participatory observations, in-depth interviews, focus group discussions, and group meetings. An outcome evaluation was conducted in order to comprehend the impacts of the model on the patients, primary family caregivers, and nurses, via both quantitative and qualitative methods. As the final desired outcome was the harmony of

critically ill patients, the findings from the final evaluation of the model became components of the Islamic based caring model.

Researcher Roles

In action research, the researcher participates in the action of the research. In this study, the researcher observed evidence of the ongoing dialectic process while group members were shifting their understanding to make sense of their situations or experiences (Koch, et al., 2002). Therefore, the role of the researcher was to participate actively in the action of the research process. The researcher acted as a facilitator and collaborator with the practitioners and documenters.

As an instrument, the researcher in the study was obliged to be a catalyst to help the participants define and think about problems and interventions, and functioned as a data-gathering instrument. The researcher asked questions, carried out observations, and reviewed artifacts. The researcher was also involved in the data analysis, the development and evaluation of the Islamic based caring model, and writing reports on the findings. The researcher shared the knowledge about the development of caring science and Islam. The researcher also organized a workshop and a guest lecturer was invited to share the knowledge and practices for the development of the caring practice.

The researcher has had two years of work experience in the ICU, and she has had almost fifteen years of teaching experience in the area of critical care nursing. In addition, she is a board member of the Association of Critical Care Nurses in Indonesia. The researcher holds various certificates in the area of critical care nursing in ICU. She has also worked for one year in an ICU in order to increase her capability

in critical care nursing. She also teaches the nursing students who practice there, in addition to her knowing the environment and the nurses who work in the setting. This background has enabled the researcher to conduct the study successfully.

Research Setting

This study was conducted at an Intensive Care Unit, in a hospital in Semarang, Indonesia, over a period of 8 months. The setting was a referral hospital in central Java. The ICU had 15 beds in total: six medical care beds, four surgical care beds, and five coronary care beds. There were 45 nurses, an administrative staff member, and a clerk who worked in this unit. Most of the nurses were diploma nurses (75.6%) while the rest were baccalaureate nurses (24.4%). The total number of patients admitted to this unit was 200 in 2014, at a 95% occupancy rate. The average length of stay during 2014 was 4.5 days.

The head of the unit (an anesthesia doctor) and a head nurse led the unit. Anesthesia doctors were assigned on a daily basis to assist patients in a critical condition. The nurses worked in three shifts. They obtained 11 days off per month after working for 150 hours. The nurse to patient ratio was usually one nurse per patient. However, when the beds were fully occupied, a nurse could also be assigned to take care of two patients in cases where patients are in a stable condition and waiting to be transferred to a ward. The typical patients' diagnoses varied, such as stroke, acute myocardial infarction, post-operative status, and gynecology cases. The patients in the ICU were in a serious condition, or end-of life phase, and often suffering from co-morbidity.

Participants of the Study

The participants of the study were nurses, patients, patients' families, and a physician using purposive and convenience sampling. Key participants consisted of critical care Muslim nurses. The inclusion criteria of the key participants were having Diploma III of Nursing or higher, working in the ICU, being able to share their experience, and having at least one year of experience of caring in a critical care unit.

Associated participants consisted of 14 patients, 14 family caregivers, and a physician. The patients were recruited based on their health condition, which was determined by the patient's condition and was decided upon by the nurse. The patients should be able to communicate, cooperate, and have no cognitive impairment. The inclusion criteria of family caregivers were being adults (18–50 years of age) who provided care for the patient.

Research Instruments

The fieldwork instruments used in this research were a tape recorder, camera, and camcorder. The data collection instruments consisted of a Demographic Data Form, interview guide, and observation guide.

Demographic Data Form.

The demographic data form (Appendix A-1, A-2, and A-3) was composed of a checklist of demographic questions regarding the characteristics of the participants. These questions included information about sex, age, religion, educational background and other information of each party. The demographic data form was filled out by each participant who participated in this study, which included nurses, patients, and family members.

Interview guides.

There were two types of interview guides used in this study: 1) interview guides for in-depth interviews and 2) interview guides for focus group discussions. All interviews guides for in-depth interviews and focus group discussions were developed by the researcher and conducted in Indonesian language.

Interview guides for in-depth- interviews.

The interview guide for in-depth interviews was composed of two parts. The first part was used to assess the nurse-patient relationship, and it consisted of four questions. The second part was used to assess the harmony of life for the critically ill patients. The interview guide for the nurses consisted of three questions, while the interview guide for the patients or families consisted of two questions. The interview guides were composed of semi-structured questions followed by probing questions (Appendix B, C)

Interview guides for focus group discussions.

Three interview guides were used in the focus group discussions (FGD). The first interview guide for FGD with the nurses consisted of seven questions. This interview guide was developed by the researcher in order to assess the nurses' understanding of the caring situation in the ICU and their experience relating to Islamic based caring for critically ill patients in the ICU. The second interview guide was for FGD with patients' families and consisted of seven questions. It was also developed by the researcher in order to assess families' experiences in obtaining Islamic based caring provided by the nurses in the ICU. The third interview guide was used for assessing the families' levels of satisfaction with the critical care nurses in the Islamic based caring practice. This interview guide was composed of three questions (Appendix D, E).

Observation guide.

The observation was conducted in two ways. The first stage involved using structured observations to observe the nurses' caring behavior in providing Islamic based caring to the patients and families directly (Appendix F). The observation guide was composed of seven verbal caring behaviors and seven non-verbal caring behaviors. The second stage employed unstructured observations to observe the ICU environment using field notes and a video camera to gather the real data of going occurrences. The unstructured observations covered 4 parts: structural and organizational features, such as what the actual buildings and environment look like; how people behave, interact, move and engage in dialogue; the daily process of nursing activities; and special events in the unit, such as nursing rounds/conferences or multidisciplinary team meetings.

Research Processes

In the research process, there were two phases: preparation phase and action research phase. The preparation phase encompassed the literature review and pilot study. The action research phase consisted of planning, acting and observing, reflecting, and re-planning.

1. Preparation phase.

The objective of the preparation phase was the development of the tentative Islamic based caring model. There were two steps in the preparation phase: the literature review and pilot study.

1.1 Literature review.

In order to develop a tentative Islamic based caring model, a review was conducted of the literature on Islam, Islamic principles, and caring. This involved reviewing books on caring and Islamic books sourced from libraries and databases. A tentative Islamic based caring model was developed based on the information gathered from the literature review and pilot study. The model development was guided by Barolia and Karmaliani (2008). The theory is composed of five dimensions (physical, ideological, ethical, spiritual, and intellectual) and five Rs (response, reflection, relationship, relatedness, and remodeling). From this, the tentative model was developed and is presented in Figure 3.4.

1.2 Pilot study.

The pilot study was conducted for the purpose of building rapport, testing the data collection process, and developing and implementing the tentative model as well as training the researcher who was inexperienced in action research.

The pilot study was conducted with four nurse participants (2 females and 2 males), aged 30 years, and each with a bachelor degree in nursing. Their work experience was 5–10 years. There were also 2 male and 2 female patients who were recruited in this pilot project. They were patients with post ketoacidosis diabetes (participant 1, aged 58 years); pre-eclampsia (participant 2, aged 28 years); post-operative coronary artery bypass graft (participant 3, aged 45 years); and acute myocardial infarction (participant 4, aged 50 years). The family members who participated in this study were primary caregivers. The nurses and patients participated in investigating the caring situation and problems related to nursing practice for critical patients at the study context. They were also asked to provide comments and

suggestions to improve the caring action and the development of the Islamic based caring model.

The routine of nursing care in the unit included assessing the patients during the morning rounds, documenting the information, administering medications, feeding, and monitoring the patient every hour. The nurse-patient ratio in this ICU was 1:2, which was considered a good level for critically ill patients. However, this ratio only applied during the morning shift of working days (Monday to Saturday). There were 15 nurses working in the morning shift and 7 nurses in the afternoon shift and night shift. The average number of patients in the ICU was 10 to 13 patients each day. Thus, in the afternoon and night shift, there was a heavy workload of routine care in the unit.

There was also a lot of sophisticated equipment in the unit, such as mechanical ventilators, cardiac monitors including those with telemetry, external pacemakers, defibrillators, dialysis equipment for renal problems, equipment for the constant monitoring of bodily functions, feeding tubes, suction pumps and drains as well as a wide array of drugs to treat the primary condition(s) of the hospitalized patients.

A registered nurse served as the primary nurse in charge of nursing care for 24 hours a day, from entry to discharge from the ICU. The primary nurse assigned the nurses to take care of the patients, wrote nursing care plans, and coordinated with other health care providers. He or she was also responsible for writing the patients' reports in the documentation book, and teaching health education to patients and family caregivers.

From the observations, it was noted that the nurses mainly practiced routine care. The care was implemented using nursing processes. However, care was still disease oriented and mainly followed the physician's orders. In the daily work, an associate nurse was assigned to take care of one or two patients under the supervision of the primary nurses.

Handover was performed using SBAR (Situation, Background, Assessment, and Recommendation) and SOAP (Subjective, Objective, Analysis, and Planning) methods. The documentation system of the nursing process and medication order was still paper based. There was a form in which to write each patient's condition (such as vital signs, doctors' orders, intake, and output) that was always hung on each patient's bedside. All the health care providers, physicians, nurses, and others documented their services by hand in each patient's folder.

There were many suggestions from the nurses that the unit should change to a paper-less system for several reasons. The hand writing of documentation was time consuming; there was a high error rate due to unclear or unreadable statements; and physicians and nurses sometimes forgot to document the order and evaluation. However, the top manager and the head nurse did not support the idea due to budget constraints.

The ICU was not very well equipped with medical technology for intensive patients. There was no central monitoring system where any default problems could be notified for urgent assistance. As a result, two problems were identified: 1) delay of response to critical patients, especially in the emergency condition, and 2) time constraints for caring practice. From the observations, it was concluded that the

situations were seriously unsafe, and many patients were receiving delayed assistance that worsened their health.

The situations outlined above could be worse during the afternoon and nighttime shifts due to the lower number of nurses on duty. Nurses usually paid little attention to alarm systems, such as bedside monitors or ventilator monitors. From the researcher's observations on one night shift, it was found that the monitor alarm buttons were turned off for various reasons given by some nurses, such as the alarm was too sensitive and the noise from the alarm disturbed the other patients. The researcher clarified the problems with some of the nurses who had turned off the alarm, to which, they replied that they knew the risks and would check the alarms later on before handing over. Statements from the participants were as follows:

> This was because the alarm settings have probably not yet been changed by nurses. Normally the machine response is too sensitive. I will report it to the primary nurse and check it later. (Nurse I)

> When the alarm was ringing, then I switched it off in order to reduce the interference. I know the patients may feel anxious from the alarms. For this patient (patient X), if the alarm was ringing, he called the nurse and asked what had happened to him. (Nurse Y)

In accordance with maintaining the nursing care quality, the head nurse and coordinator of nursing services took this responsibility. If there was a special case, they evaluated and reported it to the head of the unit. In some instances, they might also invite some nurses to discuss the case and find a solution. Indicators were identified to ensure quality of care. The average length of time for artificial airway use was 4.5 days, while the average number of days for invasive procedure use was 5.3 days for IV line, ETT, and NGT. Accidents involving falling were not reported. The accidental removal of ETT, nasogastric tubes, and IV lines was 5/10 cases. ; Bedsores signs were positive in some patients.. The infection control measures were applied. The nurses tried to keep

changing the patients' positions every 2-3 hours for those who could not help themselves, particularly during the morning shift. The visiting time for patients' families was 11.00 a.m. to 13.00 p.m. and 4.00 p.m. to 5.30 p.m. The number of visitors was limited to two visitors per visit and they were to wear the shoes and gowns provided.

In 2014, the hospital received accreditation from the Joint Commission International (JCI). All wards, including ICU, should follow the international standards from the JCI. There are 6 goals in JCI programs: 1) identify patients correctly; 2) improve effective communication; 3) improve the safety of high-alert medications; 4) ensure correct site, correct procedure, and correct patient surgery; 5) reduce the risk of health care-associated infections; and 6) reduce the risk of patient harm resulting from falls.

Furthermore, the data collected from the pilot study revealed three main problematic situations, relating to systems, nurses, and families. The problematic situations regarding systems were medical/disease and technology oriented, closed and big unit, lack of institutional support, and no role model. The problematic situations regarding the nurses were workloads, stress, lack of communication with patients and families, and lack of spiritual care. The problematic situations regarding the families were dehumanized care, uncertainty, lack of information and communication from nurses and health care providers, and uncomfortable waiting room. Based on these findings, the tentative Islamic based caring model was developed and tested in the action research process (Figure 3.6).

1.2.1 Building rapport.

The study started with establishing relationships with the nurse participants and the health care team in the ICU. The researcher tried to embed herself as a team member in the setting. She and the nurse participants worked together to conduct the whole process of action research. Her primary role was a researcher who led and actively participated in the action research process. The researcher, therefore, was able to gain deeper understanding and insights into the participants' work situation, observe nursing practice, and interact on an interpersonal level with the nurse participants and other health personnel in the ICU.

1.2.2 Testing data collection process.

The researcher used the interview guides to collect the data and recorded the interviews on audio tape. While the interviews were being conducted, document field notes were taken with regard to non-verbal information and issues related to caring in the setting. Furthermore, other data collecting methods were also needed such as reviewing relevant documents collected from the field. All data collected from the various sources were analyzed using content analysis.

1.2.3 Development and implementation of the tentative caring model.

A tentative attempt at Islamic based caring had been conducted by the researcher and the nurse participants based on the concept of Islamic caring according to Barolia and Karmaliani (2008) and data collected from the field (Figure 3.6). Prior to the implementation of the tentative model, it was further modified based on the data collected from the pilot study.

After the changes and modifications had been made, the model was used on four patients, and all outcomes were recorded and monitored. During the process,

the head nurse followed the ongoing activities and interacted closely with the nurses, patients and their families. The researcher documented all relevant information about the nurse's caring practice, the patients and families responses, and the outcomes of the practice. In addition, the researcher inquired about the satisfaction of the participants after implementing the tentative model. The results ensured that the patients' and the families' satisfaction had increased. Furthermore, two themes of the family's satisfaction were raised in the interviews: satisfaction with the caring relationship and satisfaction with the caring action provided by the nurses.

The action research phase was then conducted to develop the actions guided by the five Rs of Barolia and Karmaliany's (2008) theory. The integration of the 5 Rs involved applying it into the nursing care plan. The action research process consisted of reconnaissance, planning, actions, observation, and evaluation.

Lessons learned from the preparation phase.

Modification of the tentative caring model was made based on the results from the data collection process. There were benefits that the researcher received from the preparation phase, which were building rapport, gaining understanding and insights, developing the tentative model, and developing the caring protocol. Furthermore, the researcher uncovered nursing/hospital policies that might affect the research process and the Islamic based caring model. The researcher also gained skill in performing the research process.

2. Action research phase.

In this research project, the researcher followed the action research process of Kemmis and McTaggart (1988). The cycles were continually and repeatedly implemented until the final model was obtained. As participants engaged in the research, they simultaneously addressed integral aspects of the research process (Potvin, Bisset, & Walz, 2010). The process of action research consisted of reconnaissance, planning, acting and observing, reflecting, and re-planning.

2.1 Reconnaissance.

In the reconnaissance phase, the relationship between the researcher and the participants was established by using informal conversation techniques, spending extended periods of time together, and friendly interactions. These methods were used to develop trust and decrease the gap between the participants and the researcher. The researcher also introduced the concept of Islamic based caring to the nurses. In addition, the researcher observed the environment of the setting and the participants. The researcher encouraged the participants to identify their problems in nursing practice and the caring situation in the setting.

2.2 Planning.

The first cycle started from the planning step. To achieve the objectives of the planning step, the tentative Islamic based caring model had been developed in the preparation phase in the pilot study. The planning included strategies, activities, and evaluations that were integrated into the tentative model for further implementation. The participation of the participants was encouraged in the setting of the plan. In this step, the researcher's role was a facilitator, collecting and analyzing the data.

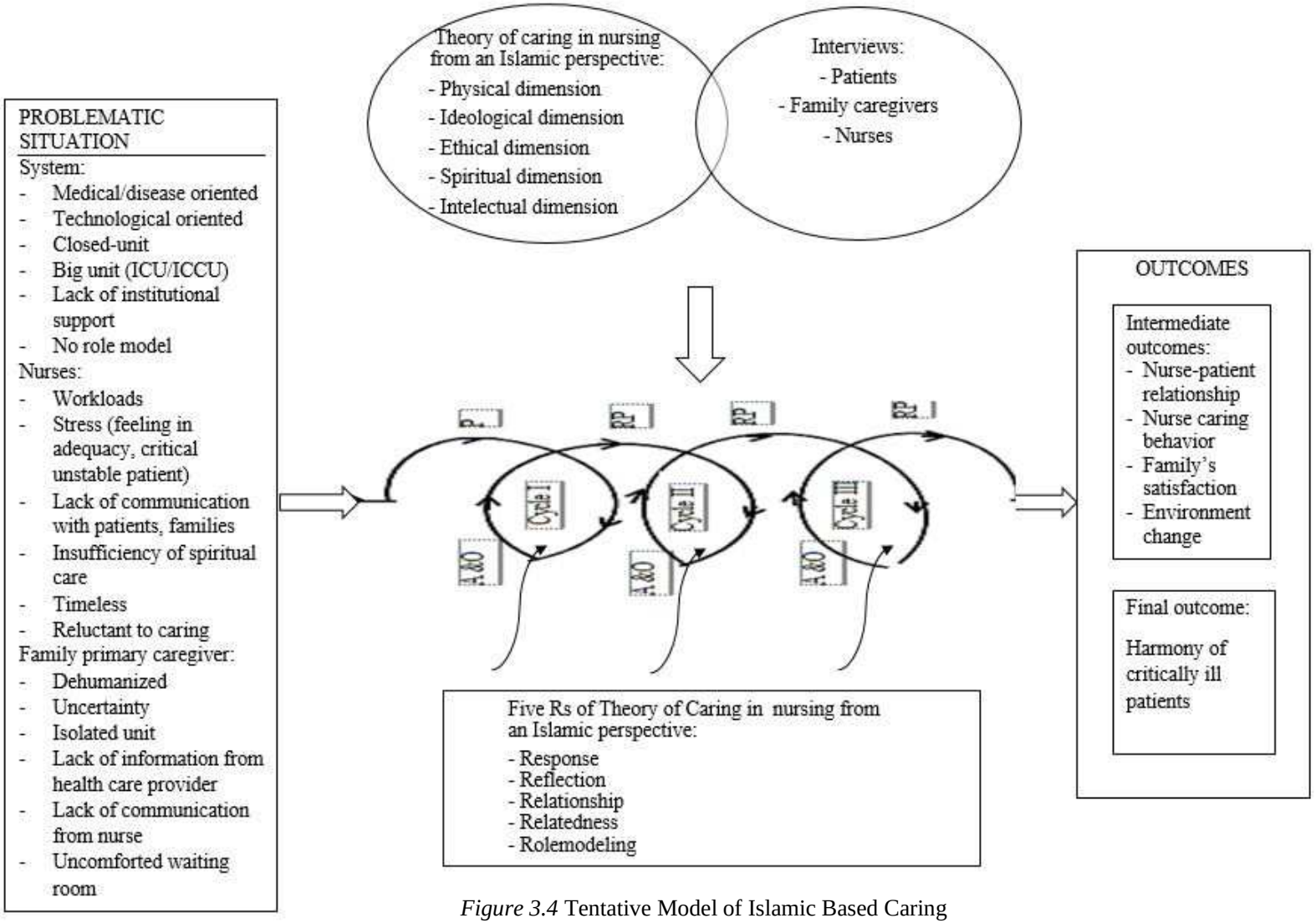


Figure 3.4 Tentative Model of Islamic Based Caring

The researcher concerned herself with being a facilitator for the action of the participants. She pondered the thematic concerns and the possibilities and limitations of the situation, and categorized aspects of the setting (neither improving nor diminishing), and formulated and defined the strategies of the work schedule. The participants opened their minds and critically reflected on their responsibilities. They ensured that they understood the study and could commit themselves to participate freely, honestly, and sincerely. In this step, the data collection process gathered data from written descriptions of the problems of concern to and the expectations of the participants. The researcher and the participants in this step developed action plans, describing in detail the actions to be taken together with a time frame and strategies for implementing the actions.

2.3 Action and observation.

The purpose of this step was the implementation and observation of the interactions, behaviors, feelings, and consequences of the participants in the implementation of the tentative Islamic based caring model. The researcher and nurses developed and applied the plan of action, and motivated the participants to put Islamic based caring into practice. Moreover, the researcher organized the participants to use the model in their routine nursing process. The taking of field notes was used to collect data.

2.4 Reflection.

In the reflection step, both the researcher and the participants examined what happened during the implementation, what factors were helpful and unhelpful, what had been learned, and how further improvement could be made. The researcher

then made recommendations and the revised plans were implemented into the next cycle of action research.

2.5 Re-planning.

After the action, observation, and reflection phases, the development plan was revised for use in the next cycle. The strategies were modified to encourage the participants to be more active in the research process. The role of the researcher in this step was to reformulate the plan of actions in preparation for the next cycle of action research. The role of the participants was also to share their ideas and provide discussion for the revision.

Moreover, the nature of action research was a cyclic process. The criteria of success was not whether the participants had followed the steps faithfully but rather whether they had a strong authentic sense of development and evolution in their practices, their understandings of their practices, and the situations in which their practices were carried out (Kemmis & Taggart, 2008). Therefore, the researcher stopped the cycle when the criteria were achieved in the study.

Data Collection Methods

Data collection involved gathering continually in each phase. The data collection methods in the present study were individual interviews, focus group discussions, observations, field notes, and the collection of other documents that were relevant to the study. A tape recorder, camera, and camcorder were used to gather the data during the process of this study.

Individual in-depth interviews were conducted to understand the situation of the unit in the reconnaissance phase and to gain information and suggestions

for the model implementation along the action phase. In addition, a focus group discussion (FGD) was conducted to explore the family's satisfaction after the Islamic based caring model for critically ill patients had been implemented. The interview guide was used to carry out the interviews. Each interview was conducted by appointment when the nurse participants were free from their shift. The average length of each interview was forty-five minutes to one hour.

Observations were also conducted to obtain detailed information of caring practices for critically ill patients. Participant observation was conducted during the acting and observation phases of each cycle. Data collected from the participant observations were used to recognize the participants' subjective experiences and interpretations that had been discovered in the individual interview.

Field notes and diary entries were recorded during each phase of data collection in order to describe the process of caring and to reflect on the issues surrounding the process of this development. Informal communication and interactions (from field notes) with the participants in the unit were applied. Photography was also used to collect visual data from the situations and activities that occurred during the implementation of the research project. Photos could show the researcher and the participants the valuable moments and details of experiences during the study conducted.

Data Analysis

All kinds of data were collected through a variety of channels, namely interview data, field notes, written descriptions, and focus group discussion data. All of the data were organized before performing the data analysis. Which included

transcribing the data verbatim for analysis. To organize the data, the researcher ensured: 1) data reduction (data were transcribed, simplified, and focused); 2) data display (data were visibly presented to show possible relationships and similarities), and 3) verification (the possible conclusions and explanations were made from the data) (Miles & Huberman, 1994).

The analysis of the qualitative data that was carried out from interviews, focus group discussions, field notes, and observations were analyzed using content analysis. Content analysis is a method of analyzing written, verbal, or visual communication messages (Cole, 1988 as cited in Elo & Kyngas, 2008, p 109). The analysis according to Elo and Kyngäs (2008, pp. 109-111) was an inductive content analysis which consists of:

- Open coding. Open coding means the notes and heading are written in the text while reading it. The written material is read through, and as many headings as necessary are written down in the margins to describe all aspects of the content. The headings are collected from the margins on to coding sheets, and categories are freely generated at this stage.
- Creating categories. After open coding, the lists of categories were grouped under higher order headings. The aim of grouping data was to reduce the number of categories by collapsing those that are similar or dissimilar into broader higher order categories. The purpose of creating categories was to provide a means of describing the phenomenon, to increase understanding, and to generate knowledge. When formulating categories by inductive content

analysis, the researcher came to a decision, through interpretation, as to which things to put in the same category.

- Categorization. Each category was named using content-characteristic words. Subcategories with similar events and incidents were grouped as main categories.

The quantitative data were analyzed using frequency, and percentages were used to describe the demographic information of the patients, the nurse participants, and the families.

Trustworthiness of the Data

Trustworthiness was the means of demonstrating the plausibility, credibility, and integrity of the qualitative research processes (Holloway & Wheeler, 2010). The trustworthiness in this study was maintained by emphasizing four methods: credibility, dependability, transferability, and confirmability.

Credibility.

Credibility refers to the faithfulness to the description of the phenomena in the research questions. It addresses the issue of whether there was consistency between the participants' views and the researcher's representation of them. The researcher describing and interpreting his/her experiences and allowing the participants to read and discuss the research findings might enhance credibility (Koch, 2006). Credibility in this study was demonstrated by the prolonged engagement of the researcher, observation, and audit trails.

In this study, the strategies to achieve credibility involved member checking, prolonged engagement of the participants, and triangulation. Holloway and

Wheeler (2010, p. 305) explained that the main reasons for member checking are the feedback from the participants, their reaction to the data and findings, and their responses to the researcher's interpretation of the data which are obtained from them as individuals. Credibility requires adequate submersion in the research setting to enable recurrent patterns to be identified and verified. Thus, an important strategy employed in this research was to spend an extended period of time with the participants (prolonged engagement), which allowed the researcher to check perspectives and allowed the informants to become accustomed to the researcher. This prolonged engagement was important because as rapport increases, informants may volunteer different and often more sensitive information than they do at the beginning of a research project (Krefting, 1991).

Krefting (1991) stated that triangulation is a powerful strategy for enhancing the quality of the research, particularly credibility. Triangulation is based on the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated. To achieve credibility in this study, triangulation of data methods was used. This involved comparing by the data that had been collected by various means (e.g. data from interviews, participation observations, etc.).

Dependability.

Dependability involved the researcher giving the reader sufficient information to determine how dependable the study and the researcher are (Ryan, et al, 2007). According to Koch (2006), dependability is providing the reader with evidence of the decisions and choices made regarding theoretical and methodological issues throughout the study and entails discussing explicitly the reason for such discussion.

According to Krefting (1991), the strategies to achieve dependability consist of a dependability audit, dense description of research methods, stepwise replication, triangulation, peer examination, and code-recode procedure. In the present study, the researcher performed a dependability audit and triangulation to achieve dependability.

Accordingly, the strategy of the dependability audit was the researcher describing the situation of the setting, in which another researcher can clearly follow the decision trail used by the investigator in the study. Dependability could also be enhanced through triangulation to eliminate the weakness in any of the data collection methods, and the triangulation of the data was used in this study.

Transferability.

Transferability (fittingness) refers to whether or not the findings can be applied outside the context of the study situation. Transferability can be achieved when the results are meaningful to an individual, group, or unit of institutions not involved in the research study (Ryan et al., 2007). There are several strategies to achieve transferability, and these include nominated samples, comparison of sample to demographic data, time sample, and dense description (Krefting, 1991). This refers to the researcher determining whether the content of the interviews, the behaviors, and observed events are typical or atypical of the lives of the participants (Krefting, 1991).

In this study, transferability was achieved by providing adequate information of the participants, the setting, and the context of the study. Moreover, the researcher used the comparison of a sample to the demographic data to achieve transferability as one of the strategies for achieving transferability. The comparison of the sample to the demographic data means the researcher provided dense background information about the participants and the research context and setting in order to allow

others to assess how transferable the findings are. By considering the data rather than the subjects, the researcher can also look at the transferability.

Confirmability.

Confirmability required the researcher to demonstrate the findings, conclusions, and interpretations that had been achieved with regard to the aims of the study. This is concerned with establishing that the findings were clearly derived from the data. Confirmability is usually established when credibility, transferability and dependability are achieved (Ryan, Coughlan, & Cronin, 2007). Confirmability also demands intellectual honesty and openness from the researcher, as well as sensitivity to the phenomenon, thus incorporating the idea of the audit trail.

In this study, the researcher used the audit trail and triangulation strategies to achieve confirmability. The audit trail was the detailed record of the decisions made before and during the research and a description of the research process (Holloway & Wheeler, 2010). The components of the study that can be included in the audit include: raw data, data analysis product, data reconstruction and synthesis, process notes, and instrument development. Ideally, this audit should be ongoing throughout the research process. Triangulation of the data methods was used in the confirmability of this study, by using evidence from different types of sources including interviews, FGDs, observation, and field notes.

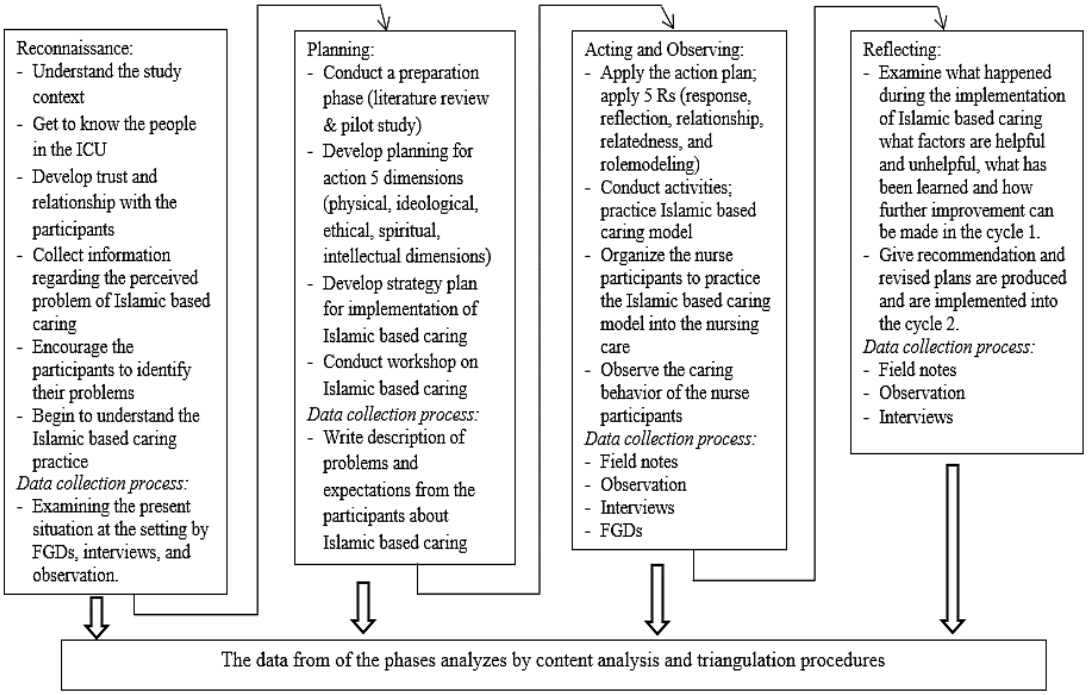


Figure 3.5 Overview of Action Research Phases, Data Collection Process, and Data Analysis of Development of Islamic Based Caring Model.

Translation Issues

This present study highlighted two translation issues and bilingual translators were used to help the researcher translate and check the quality of the wording verbatim. The first translation was the interview guides. They were originally written in English and translated into the Indonesian language *(Bahasa Indonesia)* in order to be able to interview the participants in either in-depth interviews or FGDs. The interview guide translations were reviewed by a bilingual translator. The second translation was of the audio-taped interviews, which were transcribed verbatim in Bahasa Indonesia, then checked (audited) for accuracy by a bilingual translator, and back translated. Fourteen interview transcriptions in *Bahasa* were translated into English in order to analyses the data. The checked transcripts of the 14 participant interviews were sent to a bilingual translator from Indonesia. The quality of the

translation of the interview guides and some of the verbatim answers was ensured by checking for errors on the transcription. Any errors in translation were then corrected again and re-categorized. Even though not all of the transcriptions were translated into English, the researcher translated a set of quotes or statements from participants on the key findings to create themes and support the research outcomes.

Ethical Consideration

Before conducting the study, the proposal was approved by the Institutional Research Board of the Faculty of Nursing, Prince of Songkla University. The researcher also asked for approval from the Ethical Committee in the hospital. The consent could be received in either verbal or written format. The potential participants were informed that there are no risks to them in participating in this study (Appendix G). Moreover, their anonymity was ensured by using codes for all data sources. Data photographs that were taken were only available to the groups and the participants' faces were covered. The participants could ask to withdraw from the study freely at any time, and there were no consequences on the health services.

To maintain confidentiality, all information that was gathered from the participants was used in this research only, and the data were erased after the study was completed. All data in the form of audiotapes, pictures, transcriptions, field notes, and computer files were kept confidential and were stored in a secured box. Only the raw data were accessible by the researcher and her advisor.

Summary

Action research was used in this study in order to identify the components of Islamic based caring, and to provide Islamic based caring practice to promote harmony of body, mind, and spirit for critically ill patients in an Intensive Care Unit. Three parties were recruited to participate in this study: nurses, patients, and primary family caregivers. These participant groups were comprised of 24 ICU nurses, 14 patients, 14 family caregivers, a head nurse, and the head of the unit. The setting of this study was the ICU of a hospital in Semarang, Central Java Indonesia.

The process of this study was organized into three steps: preparation, action, and final evaluation. The aim of the preparation step was to develop the tentative Islamic based caring model through literature reviews and conducting a pilot study. The steps of action were a cyclic processes that followed the steps of reconnaissance, planning, action, observation, and reflection in order to implement the Islamic based caring model in the daily practice of the nurse participants. The final evaluation step covered both the process and ultimate outcome.

The data were collected through qualitative methods, complimented by quantitative methods used for demographic information. Focus group discussions, interviews, observations, and field notes were used as the data sources. The data were analyzed by qualitative content analysis. To ensure the trustworthiness of the study, the researcher used credibility, dependability, transferability, and confirmability methods.

CHAPTER 4

FINDINGS AND DISCUSSION

This chapter presents the findings and discussions of the study. The researcher used action research methodology. The results of this study are based on qualitative data analyses which are organized as follows:

1. Demographic characteristics of the participants
2. The development of an Islamic based caring model for critically ill patients in the ICU
    - 2.1 Reconnaissance phase
        - 2.1.1 Understanding the caring situation in the ICU
            1) Uncomfortable environment due to the disruption caused by noise and light, inadequate cleanliness, and limited space arrangement
            2) Lack of caring practice
            3) Lack of awareness of the holistic approach
        - 2.1.2 Nursing practices for critical care in the ICU
            1) Providing nursing care and critical care technology
            2) Dealing with patients' crises
            3) Providing support to the family as needed
        - 2.1.3 Islamic based caring perspective in the ICU
    - 2.2 The spiral action research processes for developing an Islamic based caring model
        - 2.2.1 Cycle 1: Capability building; increasing awareness, knowledge, and improving the caring practice

1. Demographic Characteristics of the Participants

The key participants of this study were 24 nurses, and the associate participants were 14 patients and 14 family caregivers. All participants were Muslim. The demographic characteristics of the participants are described as follows.

1.1 Nurses.

A total of 24 nurses were involved in this study. The ages of the participating nurses ranged from 23-28 years (n =13) and 29-44 years (n = 11), respectively. There were 17 female nurses and 7 male nurses. Most of the nurses (n = 16) had earned Diploma III, and had less than 5 years of work experience. Based on the Indonesia Nurses Association (INA, n.d.), an ICU nurse should hold a minimum of nurse clinic level II or III. Nurses at clinic level I (novice) are diploma III nurses who have 2 years of work experience or a Bachelor degree with no work experience, and who hold a certificate of nurse clinic level I. Nurses at clinic level II (advanced beginner) are Diploma III nurses, with 5 years of work experience or with a Bachelor degree and 3 years of work experience, and who hold a certificate of nurse clinic level II. Nurses at clinic level III (competent) are Diploma III nurses, who have 10 years of work experience, or who have a Bachelor degree with 6 years of clinical experience and a certificate of nurse clinic level III. In this study, there were 12 nurses at clinic

level I, 7 nurses at clinic level II, and 5 nurses at clinic level III. Table 4.8 summarizes the demographic characteristics of the nurses.

Table 4.8

Demographic Characteristics of Nurses (N =24)

Characteristics	N
Age (years)	
23 – 28	13
29 – 44	11
Sex	
Male	7
Female	17
Education	
Diploma III	16
Bachelor	8
Work experience in ICU	
> 5 years	15
5 years	5
< 5 years	4
Level of Nurse	
Nurse clinic level I	12
Nurse clinic level II	7
Nurse clinic level III	5

1.2 Patients and family caregivers.

There were 14 patients (Table 4.9) and 14 family caregivers in the ICU who were recruited to participate in the study. The criteria for selection were that they must be Muslim, be able to communicate, be cooperative, and have no cognitive impairment. There were 9 male and 5 female patients. The participants' ages ranged from 25 to 60 years old. Half of the participants had a senior high school level of education. The relationships of the family caregivers to the patients were daughter (n = 2); husband (n = 5); mother (n = 2); son (n = 1); and wife (n = 4).

Table 4.9

Demographic Characteristics of Patients (N = 14)

Characteristics	N
Age (years)	
25-45	10
46-65	4
Sex	
Male	9
Female	5
Education	
Senior high school	7
Diploma	3
Bachelor	4
Employment status	
Government employee	3
Private employee	2
Entrepreneur	3
Unemployed	7
Diagnosis	
Acute myocardial infarction	6
Diabetic ketoacidosis	3
Stroke	2
Operative case	
Coronary arterial bypass graft	3

2. The Development Process of the Islamic Based Caring Model for Critically Ill Patients in the ICU

The development process followed two phases in this study: (1) the reconnaissance phase and (2) the spiral action research phase for developing the Islamic based caring model.

2.1 Reconnaissance phase.

The reconnaissance phase was conducted to assess which caring situations in the ICU needed to be resolved through focus group discussion. This process was conducted four times. Three themes were discovered in this phase: (1) understanding the caring situation in the ICU, (2) nursing practice in the ICU, and (3) Islamic based caring perspectives in the ICU.

2.1.1 Understanding the caring situation in the ICU.

In order to understand the situation clearly, the researcher conducted 4 rounds of FGD with 24 nurses and 14 families, and interviews with the patients. There were 3 main problems related to the caring situation in the ICU: 1) uncomfortable environment due to disruption caused by noise and light, inadequate cleanliness, and limited space arrangement; 2) a lack of a caring practice; and 3) a lack of awareness of the holistic approach.

1) Uncomfortable environment due to disruption caused by noise and light, inadequate cleanliness, and limited space arrangement.

The environment was one of the factors that influenced the caring situation in the setting. A quite, clean, and pleasant environment could help comfort patients and families and promote healing. The study setting was found to be uncomfortable for the patients and families due to disruption caused by noise and light, inadequate cleanliness, and limited space arrangement.

Disruption by noise and light. There was usually too much noise and lights in the ICU, which led to creating an uncomfortable environment. Noise was created from multiple sources, such as signals and alarms from monitoring equipment, telephones, health personnel, and visitors, as reflected by the statements below:

> We have 15 beds. The beds are always occupied. Especially in the morning shift, the unit is crowded with physicians, nurses, other health care providers, and nursing students. The noise was created throughout the day and by alarm equipment that was impossible to avoid. (Nurse A, 5th May 2014)

> The ICU environment usually created many stressors for the patients, families, and nurses. Visual and auditory alarms of equipment are the main sources of noise here. Lighting was also another cause of creating an uncomfortable environment especially at nighttime. Patients complained about lights but the nurses need to keep the place well-lit for emergency reasons. (Nurse B, 5th May 2014)

Moreover, one patient could not sleep because of too much lighting and noise. The statement below reflected the situation:

> I could not sleep well last night and this morning, due to too much light and noise created by the emergency case next-door (Patient 1, 6th May 2014)

Inadequate cleanliness. In the setting, the head nurse always reminded all staff to keep the unit clean. The system for removing the garbage from the infectious and noninfectious rubbish bins followed the standard operational procedure and the nurses were concerned about this matter. The unit had one toilet that was used only to discard urine and to place the dirty linen. However, the main problem was the limited bed linen supply for the patients especially at nighttime. If the linen was stained with blood, wound discharge or urine, there was sometimes not enough stock or it was difficult to obtain new bed linen, especially during holidays or on the weekends. One nurse said that:

> I wonder about the stockpile of linen for the patients. The supply for the ICU is limited. The patients surely need clean linen, due to replacing the bed linen stained with blood or feces. The ICU is supposed to have a lot of linen stock to maintain the cleanliness of the patients and create a comfortable environment. (Nurse H, 7th May, 2014).

Limited space arrangement. Appropriate space arrangement is important to promote caring and healing. Since the space of the ICU was limited, effective space arrangement was crucial. In the ICU setting, it was very difficult even to put a chair to accompany the patient at the bedside, as reflected by one family caregiver:

> "I really wanted to stay with my husband, but the space was very limited. I wish I could put a chair beside his bed without disturbing him." (Family 4)

The central nursing station was in the center of the room and big enough to accommodate all the necessary activities of the staff nurses. However, the location of the nursing station was far away from some beds while there were no computers connected to the central monitor in the nursing station. A nurse commented regarding this manner:

> The patients' rooms are often arranged in a semicircle or circle with the nursing station in the center. However, we do not yet have central computer monitoring of the patients' beds. More effort is required to give good care for the patients who are far from the nursing station. (Nurse Y, 5th May 2014)

The waiting area is located outside the ICU, and it should be a comfortable place for families to relax and do activities while waiting in the hospital. It was not a room, but a space around the ICU gate, and also a path connecting to other wards. The researcher took the chance to observe what families were doing while waiting for the patients. One family gave their statements:

> It is not a waiting room. Honestly, it was not a comfortable place to wait here. While waiting for our beloved one, it would be good if it also allowed us to pray, take a nap, and rest. We are away from home to take care of our family member. We actually need a place to stay overnight, as we do not have enough money to stay at a hotel. (Family 4, 6th May 2014)

2) Lack of caring practice.

A lack of caring practice was the main problem in the unit. The nurses said that they were aware about caring, but it was difficult to be applied due to the situations of emergency, critical, and routine care. The researcher found that the lack of caring practice was associated with a lack of trust; lack of communication from nurse to nurse and from nurse to patients/families, meaning that less attention was paid to the patients; lack of social interaction; heavy workload; stress levels of nurses; and poor

time management. Additionally, the young nurses in the unit generally focused on the physical care as they could learn a lot from the patients' physical data.

> We (families) need nurses, doctors, and ICU staff who kindly communicate whatever with us. We don't understand the rules. We don't understand the disease. We also sometimes don't understand about the treatment we receive. It really hurt that there was one member of the staff who was not nice in her communication and appeared to be in a bad mood. While we were in the waiting area, we were just sitting and praying for our family member in the ICU. (Family 1, 6th May)

> Sometimes some nurses would "*ngomel*" (grumble) because we visited my daddy after vising hours. They also have not talked much with the patients. I understand that they are busy with their job, but please understand us. (Family 2, 6th May 2014)

A nurse also gave her comments:

> I am new here, and there are many skills that I should improve in order to take care of critically ill patients. I also need to improve my status to be a nurse clinical level one within 2 years of work. Can you imagine the heavy workload here? So, the patients and families might have a bad feeling that the nurses in the ICU were not friendly, paid less attention, and they did not trust the nurses, because the nurses often "*ngomel*". For example, if they are patient's families who asked to visit the patients before or after visiting hours, then we tried to explain about visiting hours, but they did not listen. (Nurse Y, 7th May 2014)

Barriers in caring practice. Due to the adjunct of the situation, the lack of caring practice in the ICU, the main barriers were identified by the nurse participants, and divided into two aspects: (1) performing non-nursing administrative duties and (2) difficult team work.

Performing non-nursing administrative duties. As well as providing nursing care, the nurses in the unit were also assigned to do administrative duties, such as admission and discharge documentation. The nurses took responsibility for the completion of the patient's records. For instance, in the administration of a patient's

discharge or one who had died, the nurse was also responsible for administering the documents. For example, two nurses stated:

> Nurses perform administrative duties. For example, in the management of death, the nurses prepare a death certificate, all of the nursing care documents, bill payments, and a report on the patient's death. Therefore, too much time is spent on administrative duties. (Nurse I, 7th May 2014)

> We have been busy with the management of hospital admissions and discharges including moving the patients between wards, and completing the documents. (Nurse B, 8th May 2014)

Because of a shortage of staff in the unit, nurses were also responsible for the collection of specimens for investigation. The head nurse clarified this issue and he said:

> We have a machine that can deliver samples directly to the laboratory; however, this machine was out of service. There is also a limited number of people working here so sometimes the nurses ask the family to bring the specimens to the laboratory or otherwise the nurse needs to do it. However, we have followed the standard procedures of sending specimen correctly. (Nurse T, 8th May 2014)

The researcher also clarified this matter with a family caregiver and the family stated: "One time in the afternoon, the nurse asked me to send a urine sample to the laboratory" (Family 12).

Difficult teamwork. There were feelings of difficulty when working as a team in the ICU. Nursing demands collectivity, cooperation, commitment, and responsibility, due to the severity of the patients' conditions, the need to handle highly complex equipment, and the requirement of making clinical evaluations. Two experienced nurses reflected:

> It is difficult and stressful when there is a lack of responsibility from someone in the team. (Nurse A, 8th May 2014)

> Most of the time in the ICU, the nurses face the patients with critical conditions and need teamwork to support each other. It is so hard when the team is not a solid team, no friendship, and no respect. (Nurse R, 8th May 2014)

3) Lack of awareness of the holistic approach.

There was a lack of awareness of the holistic approach in the ICU, where the attention of the health care providers is mainly focused on medical problems and technology used to save patients' lives. The reasons for the lack of awareness of the holistic approach were identified based on the researcher's observations as follows: medical/disease oriented, Western/technology oriented, and no caring protocol. The nurses paid more attention to treatment based on scientific knowledge and relied very much on technology. It was evident that treating critical patients using advanced technology was more challenging for health care personnel.

> We relied on technology to understand the patient's condition. For example, the arterial line monitoring is a device to measure the blood pressure accurately, mean arterial pressure, etc., for patients with a severe heart attack. It is incumbent to maintain a thorough knowledge of the technology, with proven outcome data for knowing the condition of the patients. (Nurse U, 20th May 2014)

> The application of a holistic approach is still lacking here. For instance, music intervention to reduce a patient's anxiety actually can be applied here, because we have earphones and a music player for the nursing students who practice here. Unfortunately, it is never used for healing purposes. (Nurse S, 20th May, 2014)

2.1.2 Nursing practice for critically ill patients in the ICU.

From the data gathered from FGDs with the nurse participants, there were three themes in nursing practice for critical care in the ICU: 1) providing care with high technology, 2) responding immediately with high competence to save patients, and 3) understanding and supporting families.

1) Providing care with high technology.

In caring for patients in the ICU, a part of providing routine nursing care, the nurses needed to carry out critical care that usually involved critical care technology. For those in a critical condition the nurses relied on technology, as stated by a nurse:

> We spend hours monitoring biological variables such as blood pressure, temperature, ECG 12 leads, and more lifesaving equipment. It is evident that nurses in the ICU are required to take care of the patients and operate the machines. (Nurse T, 8th May 2014)

Nursing practice in the ICU employed a nursing process to guide the practice. The basic duties of the nurses in the ICU consisted of assessment, intervention, implementation, and evaluation the patient's outcome, as well as documentation of nursing care.

> We provided nursing care using the nursing process. We conducted assessments for the patients, nursing diagnosis, nursing implementation, and an evaluation the outcome of the practice. (Nurse M, 8th May 2014)

Since most of the patients were in a comatose condition, the nurses spent a considerable amount of time on providing them with total care. As a nurse stated:

> Some patients were under sedation drugs or they were at a low level of consciousness. They completely relied on nurses for their health care needs. (Nurse D, Nurse S, 20th May, 2014)

2) Responding immediately with high competence to save patients.

It was common for the nurses in the ICU to deal with critical health problems and with patients at risk of dying by providing immediate skilful nursing care and critical care technology. The critical patients were also suffering from being uncertain, fearful, stressed, and unconfident about their health conditions and emergent health care needs. The nurses needed to ensure that they were competent in providing emergency care and using critical care technology. Importantly, they were ready to respond to the patients' problems and needs when required. In critical cases, the nurses were expected to be able to assess and identify the problem and provide the necessary care as well as calling for help from the relevant physician. A nurse shared her experience as follows:

> For example, when a patient experienced cardiac arrest, we would immediately help the patient. Nurses perform CPR precisely and accurately, administer

> emergency drugs, provide oxygenation, and do more to deal with the patient's critical situation and save his/her life. Furthermore, nurses continue to monitor the patient's hemodynamic data in order to ensure the survival of the patient. (Nurse S, 21st May, 2014)

3) Understanding and supporting the families.

The patients' families need help from the nurses because they are also tired and stressful due to their beloved one being in a critical situation. The nurses provide the information about the patient's disease and treatment, and show their commitment and friendliness to the families during visiting times, or when the families were needed it. The nurses also provided psychosocial support to the families by allowing the family members to visit the patients before or after the visiting hours as needed.

> I sometimes encouraged families to become involved in the patient's care, and this helped them to feel they were doing something useful and positive for their loved one. I also communicate with the family to express their feelings while taking care of the patients at home and at hospital. In some cases, I have allowed the family to visit the patient after the visiting hours. (Nurse W, 20th May, 2014)

A family member gives the following statement about the support that the nurses provide to the family:

> My father was so distressed when my mother was in a critically ill condition. My father asked me to call the ICU to get new information about my mother. Some nurses were helpful with giving information about my mom. It decreased our fear and stress after getting the information. (Family 3, 5th June 2014)

2.1.3 Islamic based caring practice in the ICU.

In Islamic spiritual care, the nurses suggest that the patients and families pray for the patient during their visit. The nurses also motivate the patients to be patient (*sabar*), sincere (*ikhlas*), and faithful (*tawakkal*). A prayer room for Muslims is provided in the ICU. In fact, the exploration of Islamic based caring practice in the ICU found that the nurses were not concerned with providing spiritual care, even though

they thought it was necessary, and they mentioned two main reasons for this: 1) limited learning resources and no role model for the nurses in Islamic based caring, and 2) having no time due to the high workload in routine care.

1) Limited learning resources and role model for the nurses in Islamic based caring.

The nurses did not have adequate knowledge of Islamic based caring and there were limited resources to learn about it. They also have no role model to give them examples and inspire them to provide Islamic based caring. The following evidence was from the nurses' experiences:

> We consider that the nurses and the head nurse have not enough knowledge of Islamic based caring for critically ill patients. The hospital has prepared a Muslim cleric to provide appropriate spiritual care for the patients and families. (Nurse H, 3rd June 2014).

> We do not have nurses who can serve as a role model in caring for the patients. Some of the nurses here are young novice nurses. They certainly need role models from our colleagues to inspire us in Islamic based caring. I myself also need to learn more to be a role model for my nursing staff. (Head Nurse – Nurse T, 3rd Jun3 2014).

2) Having no time due to high workload in routine care.

Some nurses in the ICU were reluctant to offer Islamic based caring. They paid more attention to treating the patients' disease and ensuring the patients survive their critical situation, rather than offering spiritual care. They understood that spiritual care was part of holistic care, but they ignored it due to their work taking care of the patients. The following evidence is from the nurses' experiences:

> I have no spare time to learn the Islamic based caring. I only suggest to the patients and families that they pray as needed to release their tension. (Nurse A, 3rd June 2014)

> In daily practice, I remember to pay attention to spiritual care related to the patients' and families' belief in Islam. However, I forget to provide it due to my heavy workload. (Nurse R, 3rd June 2014)

2.2 The spiral action research process for developing an Islamic based caring model.

In the spiral action process, the researcher and the participants conducted the action research cycle phase, including planning, action and observation, and reflection of the cycle processes. The participants were asked to identify the problems and needs to be solved in the implementation phase for further development of the model. Since Islamic based caring was new for them, they might have practiced some Islamic caring without realizing it. At the beginning, they identified their needs to increase their knowledge and improve their practice of Islamic based caring. During their active involvement along the action research process, the participants provided a lot of input to develop the Islamic based caring further. The model was tested in the setting and modified until it worked well and satisfied the nurses, patients, and families. The implementation process was divided into 2 cycles: 1) capability building, which includes increasing awareness, knowledge, and improving the practice; and 2) strengthening caring practice for the sustainability of the Islamic based caring model. Each cycle is described in the following section.

2.2.1 Cycle 1: Capability building; increasing awareness and knowledge, and improving the caring practice.

The objectives of this cycle were: 1) to build the capability of nurses through increasing awareness and knowledge, 2) to improve the practice of caring based on Islam, and 3) to improve the caring environment. In order to achieve the goals, three main activities needed to be added into the plan: creating a comfortable and caring environment, creating Islamic based caring practice, and promoting awareness of a

caring and holistic approach (Figure 4.6). Each activity of action research is illustrated as follows.

Planning.

The researcher invited some nurses, the head nurse, nurse managers, and the chief of the unit to discuss the appropriate solution and activities required to solve the problematic situations and to apply Islamic based caring for the patients and families.

1.1 Creating a comfortable and caring environment.

A caring environment includes the physical and social environment. The nurses realized that a comfortable and caring environment helps the patients' healing. They agreed that they would try to create a safe and comfortable environment with access to fresh air, quiet, appropriate lighting and space for relaxing and resting. Then, the researcher and nurses conducted control over the noise and lights, and provided a clean environment promoting personal hygiene for the patients.

A quiet environment and adequate lighting were important in offering a comfortable and caring environment in the ICU. The nurses' roles are to place the patients in the best environment to encourage healing. The nurses tried to solve the problem of noise by requesting all nurses and other health care providers to be mindful of speaking in a low voice and to set their telephones on silent mode in the daytime and nighttime. All equipment was set to a low tone in order to create a calm and peaceful environment. Lights were turned off in the daytime if they were not necessary, and lighting was reduced at nighttime in order to stimulate patients' sleep. Night lighting must also be considered since the patients would frequently be checked and observed by the nurses and physician.

Moreover, the nurses provided a clean environment and personal hygiene care, especially to three parts; body, hair, and nails for the patients in order to prevent infection. They cleaned the patients every morning and afternoon, and changed any clothing if needed. Family members were encouraged to participate in the care. Nurses also maintained the cleanliness of the patients' beds and environment and ensured that they were free from droplets of urine, blood, or other discharge.

1.2 Creating Islamic based caring practice.

The nurses and family caregivers participated in planning and creating strategies to facilitate implementation of the Islamic based caring practice model. The Islamic concepts according to Barolia and Karmaliani (20008) were integrated into the plan. The plan was composed of physical, spiritual, intellectual, ethical, and ideological aspects as follows:

- Physical care: Nurses performed nursing interventions, i.e. nurses managed physical problems including ABC management (airways, breathing, and circulation), sleep, nutrition and electrolytes, personal hygiene, elimination, and mobilization and comfort. The nurses also gave medication appropriately to the patients based on the doctor's prescription. Pain was treated physically and mentally by praying and being patient.
- Ideological care: Nurse performed nursing interventions, i.e. nurses provided caring for self, caring for others (patient/family/colleagues) and caring for God according to Islamic doctrine.
- Ethical care: Nurses performed nursing interventions, i.e. nurses respected the decisions made by patients and their families;

cooperated with the physician to explain the patient's condition to the family if needed; and treated the patients with respect and fairness. The nurses also conducted all aspects in the interests of ethics, like beneficence and non-maleficence.

- Spiritual care: Nurses performed nursing interventions, i.e. nurses provided time to the patient for prayer (5 times per day and/or additional prayer/*shalah*); encouraged the patients to do "*Zikir'* (meditation); allocated and arranged a time and place to pray with patients; allowed the patients and families to recite and listen to the *Al Quran*; and expressed faith through being patient. Nurses could also help by calling the clergy if required by the patients and families.
- Intellectual care: Nurses performed nursing interventions, i.e. nurses gave information to the patients and families about the patient's disease/condition; taught them to manage pain, fear, and anxiety based on Islamic belief; and helped them to understand the current situation of their health and illness. The nurses, moreover, planned the continuing care for the patients and families in order to prepare for the patient's discharge.

1.3 Promoting awareness of caring and the holistic approach.

Working in the ICU, where it is medical oriented, the nurses easily overlook a wider caring and holistic approach. It was agreed that raising the awareness of the nurses about caring and holistic care was a necessity. Issues of caring and holistic practice as well as barriers to the practice were brought up in discussion during daily

conferences and regular meetings. Therefore, nurses performed nursing interventions for promoting awareness of caring and the holistic approach.

> Most of the nurses here had limited knowledge of the various aspects of patients' needs and paid little attention to their effects on healing process matters. Therefore, we need strategies to raise up the awareness and knowledge using discussion in daily conferences and regular meetings. (Head Nurse – Nurse T, 10th June 2014, 01.00 p.m.)

Strategies.

The researcher and participants together developed strategies to implement the plans. The strategies used to promote awareness and knowledge were: 1) conducting a workshop/training on Islamic based caring; 2) facilitating individual improvement by understanding self and situation, and self-education on caring; 3) creating caring relationships with good connections and communications with the patients and families; 4) using a caring protocol to guide the practice of Islamic based caring; 5) engaging in nursing rounds/conferences; and 6) providing a holistic environment.

In order to provide the participants with knowledge of caring and Islamic based caring, the researcher conducted a one-day workshop (Appendix H). The workshop also improved the nurses' understanding of self and situation. After the workshop, the nurses were able to improve their self-education on caring. Outcomes were evaluated based on the evaluation form that was created by the researcher. The form was composed of open questions related to the participants' satisfaction with the workshop and lessons learned from the activities. Most nurses stated that they were satisfied and gained more knowledge about Islamic based caring. They found that the workshop was useful and applicable in their practice. They also recognized action research as new knowledge in research methodology. Moreover, the Islamic based

caring protocol was developed by the nurses in the workshop, and used to guide the caring practice.

Caring relationships were established by applying Islamic based caring in daily work. In the model development process, the researcher and participants integrated the 5 Rs according to Barolia and Karmaliani (2008) into the action phases. Nurses were encouraged to participate in nursing rounds/conferences in order to work collaboratively in providing Islamic based caring to the patients and families. Strategies were identified and integrated into the actions and observation phase so that they might help the nurse team achieve successful model implementation.

Actions and observations.

The researcher and the nurse participants carried out the program actions. These actions were conducted to implement the tentative model in the setting. In addition, 5 nurse participants were assigned as action research core team members to encourage the engagement of other nurses in the model implementation, and a team leader was appointed to record the activities. The action research core team was selected by the nurse participants who willing to engage in caring practice into action.

Prior to the implementation of the tentative Islamic based caring model, the researcher organized a meeting with the directors of nursing services, head nurses, and nurse participants to discuss the research project and to inform them of the tentative model. This was set up to provide them with more detailed information about the research project, answer any questions that they might have, and obtain comments for the model implementation. They were also asked to participate in the implementation of the project. The nursing director gave suggestions to the researcher about ways of

improving the nursing care and caring practice in the unit. She suggested that the researcher should improve the nursing quality holistically in the unit by applying the Islamic based caring model. She hoped that it would create a big change in nursing practice for the unit after the implementation of the model. The five Rs (response, reflection, relationship, relatedness, and role modeling) according to Barolia and Karmaliani (2008) were used to guide the action and observation phase.

1. Response.

In the implementation phase, nurses should respond in four actions: a) respond to the patients' and families' needs quickly, b) respond to relieve patient's pain and suffering through Islamic based intervention, c) support the patient and family in decision making, and d) connect the patient to the hospital's Muslim cleric.

1.1 Respond to the patients' and families' needs quickly.

Based on interview data from nurses, patients, and family members, nurses should respond to the patient's and family's needs. The researcher found and summarized the needs as follows:

- Needs for connectedness. Nurses should try to maintain the social connectedness of the patients while staying in the hospital. Even though the familial connection among Muslims is quite strong, the nurses in the ICU still need to be involved in facilitating the family socializing because of the limitations on the number of family members visiting applied in the ICU.
- Needs for updated information. Nurses give updated information about the patient's health condition and disease to the family. By meeting this need, nurses might reduce family anxiety, and promote

a sense of controlled emotion in order to help with accepting the critical situation.

- Needs for support from the health care professional. Nurses contribute to taking care of the patients and their families as a team of health care professionals.
- Needs for spiritual care. Spiritual care is given to reduce distress by seeking power from God in order to increase inner energy. The nurses should maintain this need in order to preserve calmness and general wellbeing.

1.2 Respond to relieving the pain and suffering of the patient through Islamic intervention.

The nurse has a responsibility to relieve the pain and suffering of the patients and their families. For relieving the pain and suffering, the nurses facilitate the patients and families to perform meditation (*Zikir*) and *Al Quran* recitations. The nurses also allocate time for the patients and their family and allow them to be together at the patient's bedside. An experienced nurse stated:

> I know my patients and their families are in pain and suffering with their condition. In order to help them to reduce their pain and suffering, I facilitated them to do *Zikir* and *Al Quran* recitation, and allocated time for them to do it together. I also prepared "Tasbih" (prayer beads) and *Al Quran* for them. (Nurse G, 21st June 2014)

1.2.1 Support patients and families in decision-making.

The patients and families frequently asked to make a decision on their treatments. In the clinical situation, the patients and their families did not have adequate knowledge about the patients' condition, the treatment decision, and the prognosis.

They may not express their feelings spontaneously, so the nurses asked about the families' interest in order to share their feelings in the decision making for their loved one. A nurse said "It is useful to support the family members describe their expectations of the medical treatment's effects in the future. The nurses are prepared to provide emotional support (listening, hand touching, and empathy) when patients and family members verbally express their expectations of their loved ones in surviving." (Nurse R, 21st June 2014).

1.2.2 Connect the patient to the hospital's Muslim cleric.

The hospital has a Muslim cleric to serve the patients and families in terms of spiritual care. The Muslim cleric came to the ICU when the nurses connected with them as requested by the patients and their families. The cleric gave them additional *dua* and read a *surah Yassin* to connect with *Allah*. When the Muslim cleric gave the Islamic intervention, the nurses were responsible for accompanying the patients and families, and observing the patients' condition before and after giving the intervention.

2. Reflection.

Reflection is paramount. The nurses employed various methods of self and group reflection to increase awareness, knowledge, and practice related to Islamic based caring. Reflection allowed the nurses to evaluate themselves and improve their practice. They reflected through writing and discussing their actions. The verbal reflection could be conducted using dialogue. The nurses also organized a regular meeting for group-reflection every three weeks.

In the reflection, the participants could express their feelings regarding what they had done for the patients and families. They reflected positively on how they provided physical, spiritual, intellectual, ethical, and ideological care according to the plan. They also reflected on their own caring practice. Reflection was very beneficial to enhance the participants' practice and understanding of what should be done next. Acceptance of a critique from other people was encouraged in this stage in order to understand one's own self. One nurse stated that:

> It is not easy to critique my own action. I accepted subjectively and objectively critiques and comments from my colleagues about caring behavior and practice. It is useful for self-improvement. (Nurse S, 21st June 2014)

The researcher and the nurses agreed to have a regular meeting every three weeks in order to reflect on the past three weeks. In the meetings, we could report, share, and discuss in more detail the problems or barriers that could block Islamic based caring practice. In the reflection sessions, the nurses were encouraged to share their thoughts and ideas, write things as they were, be optimistic, be spontaneous, and express themselves in a way that was meaningful to themselves. Reflection prompted purposeful inquiry and problem solutions.

3. Relationships.

In establishing and strengthening the relationships with the clients, this required the nurses to perform several actions: 1) pay attention to the patients and families; 2) intentionally listen to the patients and families; 3) allow the families to provide traditional treatment based on Islam, such as honey and *Zamzam* (holy) water, and 4) promote healing presence.

3.1 Pay attention to the patients and families.

In this action of relationships, the nurses showed their attention to the patients and families in various ways, including being friendly, greeting, and spending time with patients and families. The nurses also mentioned their concern that attention should be paid to the comatose patients as well.

The nurses were encouraged to greet and introduce themselves to new patients and families in a friendly manner. The nurses were required to know each patient's name, to address the patient personally, and to show respect as well. The nurses should introduce their names in order to facilitate friendly interaction and communication with the patients and families. The nurses kept eye contact, outwardly displayed a happy mood, and smiled during interactions and communication with patients and families.

Spending time with patients during visiting hours allowed the nurses to interact directly with not only the patients but also their family members. This was an effective way to gain trust, communicate, and build relationships between the nurses, patients, and their family members. The nurses also practiced polite communication when interacting with their colleagues and other health care team members by using 3 phrases: "help me please", "pardon me", and "thank you". These simple techniques helped to promote friendly communication in order to express their caring practice.

3.2 Intentionally listen to the patients and families.

Intentionally listening is attentively receiving both the verbal and nonverbal messages of another person, which is important to improve mutual understanding and strengthen relationships. The nurses paid attention to the patients' and families' facial expressions, gestures, and even their comments. They needed to

listen to the patients and families about their needs and concerns with their heart as well as with their ears. The nurses also should be sensitive to the patients' and families' feelings. These actions could paint a picture of how the patient was really thinking and feeling, and led nurses to be more aware and practice caring. One nurse gave an example of intentionally listening:

> "I know you have a lot of words to say. I would be happy to help you". When I said it to the patients and families, I showed my intention to the patients and families when they were expressing their feelings. (Nurse D, 21st June 2014)

3.3 Allow families to provide traditional treatment based on Islam.

Muslims believe that traditional treatments based on Islamic thought could heal their sickness. These treatment are described in the *Al Quran* and *Sunnah*. Nurses in the ICU were often asked for permission from family members to give traditional treatments to the patient, such as honey, *Zamzam* (holy) water, and water that had been prayed over by a Muslim cleric. The families were also encouraged to participate actively in the treatment that was congruent with Islamic teaching. The nurses were encouraged to pray with the patients, perform meditation (*Zikir*), allow the family to read the *Al Quran* for the patients, and facilitate them to pray 5 times daily.

In many cases, the patients and families needed assistance from a Muslim cleric. The nurse could invite him to come to the ICU. However, the setting was a public hospital, and the cleric had not been assigned to provide spiritual care for the patient and family. The Muslim cleric, therefore, usually gave the patients a suggestion and motivation to express their faith through being patient, as commanded by *Allah* in the *Al Quran* and *Hadith*. The Muslim cleric also advocated the patients and families to perform additional prayers based on the patients' and families' needs. A nurse gave his comment about this manner:

> A Muslim cleric provided advocacy to the patients and families such as suggesting them to be *sabar* (patient), *ikhlas* (sincere), and *tawakal* (have faith in God), and rely on Allah. A cleric may do the specific prayer to help the patients and their family asking recovery from the illness. (Nurse M, 21st June 2014)

3.4 Promote a healing presence.

A healing presence is important in the caring practice. In promoting a healing presence, the nurses are always required: 1) to smile at the patients and their family members; 2) to show affection to the patients and families by giving a touch on the hand or shoulder for extra impact of caring; 3) to provide time, love, and nice words and to listen to the patients and families; and 4) to respect the patients and their families. By doing so, the nurses help patients to feel that they are receiving proper assistance, have more emotional and spiritual support, and are not alone in the ICU. A nurse gave a positive statement as follows:

> I said to my patient, "You are not alone. I will be there here during my shift work". I can see the expression of the patients when I am present for them. They look like calm and smooth. (Nurse E, 21st June 2014)

4. Relatedness

Relatedness refers to feeling connected to others or having a sense of belongingness (Custers, Westerhof, Kuin, Gerritsen, & Riksen-Walraven, 2012). In this study, tangible actions conducted by the participants in this respect included promoting inner peace by expressing their faith, enhancing human bonding/connectedness, showing compassion to the patients and families, showing empathy by understanding the patients' conditions, encouraging patients and families to be patient, being friendly and cheerful, and having a sense of humor for the patients and families. A nurse with a

sense of humor added a lot of fun to the conversation. One family commented about the sense of humor of a nurse:

> We like to talk to one nurse who is funny and can make us laugh. Having a sense of humor implies that the nurse is witty. Also, she or he is going to make us smile when we are feeling low. (Family 14, 22nd June)

5. Role modeling

Role modeling in the caring context was useful to inspire other nurses in the caring practice. The researcher also played a role as a nurse in the unit, as well as following some nurse participants to observe the whole day of nursing practice including the morning, afternoon, and night shifts. The researcher and participants together organized a nursing care plan for the patients. The researcher was also a consultant and role model in the caring practice. The researcher trained the action research core team members to practice caring and worked closely with the nurses. Thus, they could also be a role model for their colleagues, particularly for young novice nurses. In promoting caring practice, the researcher encouraged staff nurses to use caring protocol/guidelines, be involved in creating a caring environment, and show others how to achieve the goals. The nurses were willing to share knowledge and positive attitudes with other nurses to practice Islamic based caring. Three nurses gave these positive statements:

> When I and other nurses take care of a patient, I truly want to show my colleagues how a nurse can successfully take care of patients through caring. I want them to experience the power of caring from the real practice. I hope this can help inspire and encourage them to practice it. (Nurse G, 21st June 2014)

> I want to guide them through practice. I realize that I had learned from other nurses too, so I have been able to improve myself to practice caring in my natural way to show professionalism to other colleagues. (Nurse T, 21st June 2014)

> To be a role model of caring practice is not easy. Knowledge and inner awareness of caring are necessary for genuine caring practice. I need to make a conscious effort to become a professional and human role model. (Nurse Y, 21st June 2014)

Reflection Phase/Evaluation.

The reflection phase here was a part of the action research cycle, which was conducted for different objectives from that of reflection on the 5 Rs according to Barolia and Karmaliani (2008). The reflection here was performed to evaluate the intermediate outcomes and identify the influencing factors, barriers to the model implementation, and suggestions given by the participants to be used for implementation in the next cycle. The phase of cycle 1 took four months.

Intermediate outcomes of cycle 1.

Nurse caring behaviors, nurse-patient relationships, and a family's satisfaction were the expected intermediate outcomes of the study. The evaluated information was obtained from the nurses, patients, and families. The researcher also evaluated the environment change during cycle 1 implementation of the tentative Islamic based caring model. The researcher used field observations and interviews to evaluate the nurse-patient relationship, nurse caring behavior, family satisfaction, and environment changes. Overall, the evaluation of the intermediate outcomes is summarized as follows:

1.1 Nurse caring behavior.

Nurses called the patients or family members by name when interacting with them. They also talked with the patients politely; showed attention to the patient's and family's needs, problems and concerns; and used a caring touch where appropriate according to Indonesian culture. Many of the nurses showed improvement

in their caring practice. However, not all of them could improve their caring behavior. One positive statement from a family was as follows:

> I feel there has been a change in the behavior of caring nurses here, such as paying attention to the patients and giving priority to the fulfillment of the patients' needs. I am glad…..the nurses are become aware of caring for the patients. (Family 10)

1.2 Nurse-patient relationships.

Nurses gained capabilities of good relationships with others and respected others (patients/families/colleagues). To evaluate the nurse-patient relationships in this stage, the patients' feelings in their relationships with the nurses were described narratively. The results revealed that the nurses could make good relationship with the patients and their families in various ways, such as by preserving dignity, promoting well-being, healing, promoting a sense of wholeness, and creating a sense of safety. However, not all of the nurses were able to display good behavior in this respect. Several nurses were still not responsive about their relationships with the patients. One nurse participant gave this statement:

> …we built relationships with the patients, families, as well as with others in this unit. We were aware that the relationship is important in caring practice. Even though some of my colleagues don't show their awareness in caring yet, I believe they are trying to change and practice it. (Nurse P, 24th June, 2014)

1.3 Patients/families satisfaction.

The patients and families felt happy and satisfied with the nurses' caring behavior and presence. They were also satisfied with the Islamic based spiritual care (prayer, *Zikir*, and read *Al Quran*) that they obtained from the nurses. They said that they felt more calm and peaceful. However, several nurses stated that they sometimes forgot to remind patients about Islamic rituals, as they were too busy with their duties.

> I like nurse "A", when she was taking care of me the first time, she reminded me about praying to Allah (*Shalat* 5 times). She also provided a *Zikir* books one day. She said that whatever my condition is now, I should pray to Allah to seek His help. (Patient 3)

1.4 Environmental change.

The caring environment could be observed after the implementation of the tentative model. The changes included both physical and social changes. The physical change was mainly on the space and time arrangement to facilitate spiritual performance among patients and family members. Nurses also participated in the spiritual activities. The activities and behaviors reflecting the social change of the nurse included being kind, sincere, and helpful; allocating space for the family to be with the patient; allocating time for the family to read the *Al Quran* in critical situations; reducing unimportant lighting in the unit, particularly at night time; and keeping the environment clean and comfortable. One nurse's experience is stated in this comment:

> ….I am impressed. The environment in this unit has changed a bit. It seems comfortable for the patients and families. The social interaction among people here is warm, kind, smiling, and helpful. If we can maintain the environment like this, I am sure it can improve the quality of nursing care here. (Nurse, 24th June, 2014)

Participants' experiences in implementing the tentative Islamic Based Caring model.

The participants reflected on their experiences of applying the tentative model with the caring protocol in terms of the changes that took place during the implementation, their feelings, any barriers they faced, and their suggestions. The participants' experience in the implementation of the model encompassed the following:

1.1 Nurses' experiences in Islamic based caring practice.

The nurses' experiences in Islamic based caring practice consisted of the changes during the implementation of the model, as well as the nurses' feelings and satisfaction with the model implementation.

1.1.1 Changes during the implementation of the model.

According to the participants, there were some changes in their daily practice during the implementation of the tentative Islamic based caring model. They were more aware and active in working. They also informed the patients of their upcoming treatment before providing nursing care, and introduced themselves to their patients. Observations of these changes are summarized in the following statements from the nurses:

> On the morning shift, Nurse X received a new patient who was referred from the VIP room in the hospital. She introduced herself by name, informed the patient of all the procedures to be given to him, presence, and providing Islamic intervention to support the patients and family members. (Observation, 4th July 2014)

> When I practiced caring following your advice and the caring protocol, I experienced something different from before. There was a connection that could not be expressed with words, but I could feel the changes. (Nurse Y, 4th July 2014)

> Don't wait for something big to occur. Just start where you are, with what you have, and that will always lead you into something greater. (Nurse D, 4th July 2014)

The nurses also stated that their caring behaviors were better than before. They confirmed that a greater degree of caring was given to the patients and families; they paid more attention not only to routine care but also to promoting holistic health. They were more open with the patients and families and built good relationships with them. Two nurses shared their comments on the improvement of their caring behavior as follows:

> In my experience after implementing this model, the patients' problems were solved more easily. Caring helps patient better and the families get closer to the nurse. (Nurse N, 4th July 2014)

> I was thinking that kindness, compassion, and sensitivity are important. What if we don't have these kinds of characteristics? How could we practice caring? (Nurse E, 4th July 2014)

Nurses' feelings and satisfaction with the model implementation.

The tentative Islamic based caring model included new knowledge for the participants. Most of the participants realized the benefit of the implementation of the model. However, initially they were reluctant to participate in the project. Because they did not have good knowledge about Islamic based caring, they recognized that they would have to work more on the scope of their routine. They were invited to join training sessions to improve their knowledge and participate in brainstorming of a caring protocol and model development to support implementation of the model. The satisfaction of the nurses was the consequences of gaining knowledge about Islamic based caring. They were also very proud of the contribution that their successful caring made to the patients and families as well as the nursing profession. Following are some statements of the nurses' feelings of the implementation of the model.

> Caring practice is challenging. I observed that the nurses changed their caring behavior a lot. We should go forward to improve the quality of nursing care for our health care system. This model makes us understand that Islamic based caring is needed to improve holistic health for patients and families in the critical situation. (Nurse Tujo, 6th July 2014)

> When practicing caring, I felt good as well as being valued by the positive responses of our clients. (Nurse S, 4th July 2014)

Patient/family caregivers' satisfaction and experiences of receiving Islamic based caring.

The families expressed their experiences and feelings of the caring provided by the nurses during the implementation of the tentative model. They were satisfied with the nurses' attention and efforts in responding to the clients' needs. The nurses' understanding and support while their loved ones were in critical conditions could help the clients feel calm and at peace. Some of the family members gave the following positive statements:

> They (nurses) tried everything that they could do. We were satisfied. We found that the nurse tried to give good nursing care to my mom, but still *Allah* has decided on it. (Family 1, 8th July 2014)

> She assured me that she would keep a good eye on my father. The families also could freely ask about the nursing care that was provided for their loved one." (Family 2, 8th July 2014)

> I had a chance to discuss my father's condition. The nurse talked to me politely and patiently. After talking with him, I felt calm and peace in my heart. (Family 10, 8th July 2014)

> I was worried about my mom. My mom is everything to me, and I was weeping when I saw mom's condition. Then, she (nurse) gave me a big squeeze, a big cuddle. I felt a connectedness. (Family 6, 8th July 2014)

> …..I stay at the hospital every night for my husband, mostly in a chair by his bedside. The nurse gave me a space to stay with my husband. I felt so happy and satisfied, as I learned more about my husband's condition. Moreover, my husband also did not feel alone. (Family 3, 8th July 2014)

A patient shared her experience of receiving care from a nurse. The patient said, "Do you know you are amazing". Then the nurse said, "I never lost my hope. I believe *Allah* is with me." (Patient 4, 10th July 2014)

Families were also asked about their satisfaction at the end of this cycle. They stated that they were satisfied with what the nurses were doing for them. They

characterized the nurses as kind, quick responding, sincere, and helpful. Most of them gave testimonials, some of which are presented here:

> The nurse gave us some private space to discuss the situation with our family members for decision-making. (Family 2, 8th July 2014)
>
> The ICU nurses were quick responding when I asked to be with my wife for a while; they gave me a place and time. They also provided me with a chair by the side of my wife's bed. (Family 8, 8th July 2014)
>
> I still remember, a nurse stayed with me and spent a lot of time, because she was worried about my husband's condition. She was very kind and sincere in taking care of my husband. (Family 4, 8th July 2014)

Facilitating factors in the implementation of the tentative Islamic based caring model.

During the implementation of the tentative model, the researcher noted that there were some factors which facilitated the application of the model in the setting. The facilitating factors were highlighted on 1) having more motivation for improving caring practice and 2) having a good relationship among nurses and with patients and families.

1. *Having more motivation for improving caring practice.*

Nurses had more motivation for improving the caring environment that helped promote Islamic based caring in the setting particularly for the patients in a critical situation. The nurses were motivated as they felt satisfied with their work, and willing to improve the caring practice in the future. Moreover, they also gained more knowledge about Islamic based caring that could enable them to give nursing care holistically.

2. Having good relationships among nurses and with patients and families.

Additionally, the relationships between nurse and nurse as well as between nurse and patient/family were better after the implementation of the model. In terms of good relationships, the nurses also had better connection and communication among nurses and with their patients, which helped the application of the model. The relationship between the nurses improved even if it was just between some of them, as they were more aware about interpersonal communication and more compassionate to their colleagues. Moreover, as most of the nurses were Muslim and they understood the Islamic concepts and values for humanity, it enabled the researcher to transfer caring knowledge and practice based on Islamic teaching to them. The emotional support from the head nurse was also one factor that facilitated the implementation of this model. The head nurse consistently motivated the participants to continuously implement the tentative model. He also served as an example of a good caring nurse for the participants.

Barriers to implementation of the tentative model.

The researcher also discovered some barriers. Based on the interviews with the participants and field observation, the barriers were identified as follows.

1. Too much work in the implementation of the model.

This barrier was mentioned by the nurses because the implementation of the model into caring practice was time consuming. In addition, there was a lack of motivation among the nurses to put the model into practice due to a lack of knowledge

and skills in caring, and a lack of encouragement from other health care providers. The following statements describe the barriers as reflected by the nurses:

> I was confused and unable to understand about caring. What I have done for the patients every day, it indicated that I didn't care, didn't it? What if I only knew a little bit of information about the patients? It means I was uncaring … (Nurse E, 10th July 2014)
>
> I think I should spend a lot of time to practice caring, as critically ill patients have many treatments. When I tried to practice caring by following the guidance, it seemed everything needed to be done in the nursing care. (Nurse D, 10th July 2014)
>
> …. But that is a hard thing to do, I had many sleepless patients on night shift. My responsibility as a nurse in ICU was already overwhelming. Sometimes, I felt tired to do more because of the heavy workload in ICU and it is time consuming. (Nurse R, 10th July 2014)
>
> I have done my job in terms of giving the patients hygiene care, medical care, and so on. For me, it is enough. (Nurse H, 10th July 2014)

2. Lack encouragement from other health care providers.

In implementing the model in the ICU, the researcher also felt that there was a lack encouragement from other health care providers. One of them said, "I couldn't really see what nurses did in terms of caring. It looked very abstract". Therefore, the researcher and the nurses agreed to find ways to make caring visible, and show them that caring could really help to heal the patient. Caring also improved the quality of care and could satisfy the clients as well as the nurses themselves.

Lesson learned.

After completing Cycle 1, the participants evaluated the achievement of the model implementation and made suggestions for the development of the model. They suggested that they needed strong leadership from the action research team leaders to lead the application of Islamic based caring and the establishment of nurse-

patient relationships. Adjunctively, they suggested that the interventions for patients, such as prayer, reading *Al Quran*, etc., should be integrated into the nursing care plan to promote serenity and peace in the patients and their families while the patients are in a critical situation. The model needed further improvement to make it suitable and applicable.

After the implementation of Cycle 1, there was an increase in the caring capability of the nurses in the setting. The nurses stated that they learned something new, such as nursing knowledge, caring practice, Islamic thought, and action research. The nurses understood more about the caring practice based on Islamic values, and they were excited to provide Islamic spiritual care for patients and families experiencing critical situations. Furthermore, the family caregivers had learned Islamic based caring regarding the implementation of the model in this cycle. They had gained knowledge about caring for their loved ones. They also stated that they could give caring based on Islam in the same way that the nurses provided to them during critical situations. Figure 4.6 summarizes the action research of Cycle 1.

Revised plan.

Overall, it took 4 months for the researcher to complete the process of Cycle 1. The outcomes of Cycle 1 were then evaluated, and it was revealed that the environment in the ICU had improved. The patients and their families could feel that it was more comfortable, friendly, warm, and helpful. The physical environment of the ICU was also clean, neat, and free from bad smells. Most nurses had a good understanding of the importance of maintaining a pleasant environment to support patients' healing. Most nurses showed good caring practice in terms of their

relationships with the patients while taking care of them as well as among their nursing colleagues. The findings from the researcher's observations confirmed that the nurses practiced caring behaviors, such as introducing themselves to the patients by name, being friendly in greeting the patients and their families, and paying more attention to communication with the patient and family. The nurses were more aware of the family's needs and wholeness. Issues of recognition, good relationships, and respectfulness were raised as means of improving the caring practice. However, it needed further strengthening in order to be imbedded as part of natural nursing care. Based on the barriers identified in Cycle 1, the researcher needed to continue to the next cycle to strengthen the caring practice for the sustainability of the Islamic based caring model in the setting.

Figure 4.6 Cycle 1 Capability building: Increasing awareness and knowledge on Islamic based caring and improving the caring practice

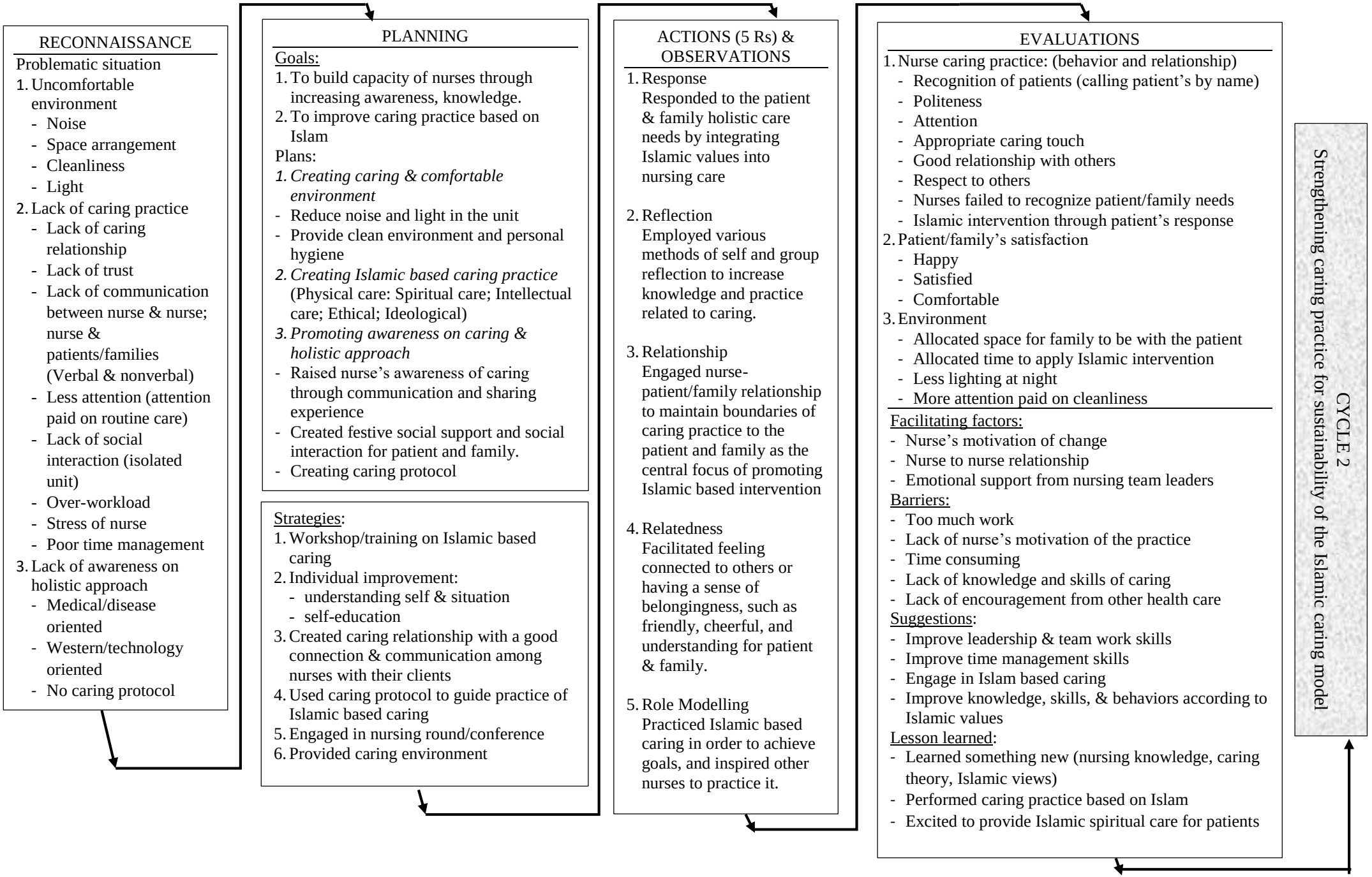


Table 4.10

Caring Protocol for Critically Ill Patients in the Intensive Care Unit

When the patient is admitted	1. Greet the patient and family by saying "*Assalamualaikum*". 2. Introduce yourself to the patient/family, speak calmly, and pay attention to the patient's condition. 3. Actively listen to the patient and family. 4. Maintain eye contact. 5. Explain admission procedures to the patient/family 6. Provide orientation including rules in the unit to the patient/family. 7. Perform nursing assessment and collect baseline data 8. Carry out standard procedures for newly admitted patients including monitoring device application, laboratory examinations, and other procedures as needed.
When carrying out a procedure	1. Greet the patient by saying *Assalamualaikum.* 2. Call the patients by their name. 3. Give an explanation before starting a procedure. 4. Ask the patient to mention "*Bismillahirohmanirohim*" with the nurse before starting a procedure. 5. Keep communicating with the patients during the procedure. 6. Communicate with the patient after the procedure is done and ask the patient to say "*Alhamdulillah*" with the nurse.
Patient-focused procedure standards	1. Monitor the patient by doing hemodynamic checks every hour. 2. Respond promptly when a patient's alarm is activated. 3. Perform immediate actions when the patient has a problem, whether physical, psychological, social, spiritual, or environmental. 4. Document all findings from assessment, monitoring, and other important evaluations. 5. Provide Islamic spiritual care for the patient and family as needed (prayer 5 times, read *Al Quran*, *Zikir*, and *Zamzam* Water). 6. Allow the patient's family special visiting hours when the patient is in an end-of-life condition.
During visiting hours	1. Accompany the patient and family for at least 10 minutes. 2. Explain the patient's condition and progression. 3. Explain to the family the actions or procedures which have been completed and will be done to the patients.
Standards for team collaboration	1. Communicate the caring process and actions which will be performed including the patients' progression to the physician, other nurses, or other health care team members. 2. Anticipate colleagues' needs for help without request. 3. Avoid making or receiving calls via mobile phones in the unit. 4. Say the phrase "thank you" to colleagues who are willing to help.
When the patient is discharged	1. Prepare a summary of the patient's discharge. 2. Provide health education to the patient/family. 3. Prepare drugs which are needed to be continued. 4. Prepare the documents for patient discharge. 5. Pray for the patient and their family members.

2.2.2 Cycle 2: Strengthening caring practice for sustainability of the Islamic based caring model.

Based on the findings from Cycle 1, there were some problems with the caring practice that required strategies to adapt its implementation for better achieving its goals. Existing barriers of the model implementation were identified as follows: 1) heavy workload, 2) lack of nurses' motivation in implementing the practice, 3) heavy time requirements, 4) lack of knowledge and skill in caring, and 5) a lack of encouragement from other health care providers. Thus, the goal of Cycle 2 implementation was to strengthen the caring practice for the sustainability of the Islamic based caring model (Figure 4.7). Moreover, the evaluation of the whole process in the implementation of the Islamic based caring model was evaluated at the end of Cycle 2. The harmony of critically ill patients was evaluated in this cycle. This stage took approximately 4 months for the implementation and development of the model.

Planning.

The findings from Cycle 1 revealed that there were still some problems. It needed to be addressed in terms of increasing the capability of the nurses in delivering caring practice and being more aware of holistic caring practice. Therefore, the researcher and participants emphasis on maintaining and strengthening awareness of the holistic approach and caring practice in the ICU. Therefore, we prepared a plan consisting of 5 dimensions according to the work of Barolia and Karmaliani (2008):

1) Physical dimension. The nurses conduct nursing interventions of physical care which include managing ABC (airways, breathing, and circulation), problems regarding pain, sleep, nutrition and

electrolytes, personal hygiene, elimination, mobilization and comfort. The scope of physical nursing care follows the existing scope of the ICU.

2) Ideological dimension. In ideological care, the nurses practice caring as duties for themselves, others, and *Allah* based on Islamic teachings.
3) Ethical dimension. The nurses respect the clients' decision-making and treat the patiens with respect based on their belief in Islam.
4) Spiritual dimension. The nurses offer prayer, meditation, a space for praying, recitation and listening to the *Al Quran*, and strengthen the patients and families through being patient.
5) Intellectual dimension. The nurses provide information and teach the patients and their families in order to meet their needs.

In this plan, the researcher and the participants also aimed to maintain and to strengthen awareness and the use of the holistic approach by sustaining the caring environment, maintaining the holistic approach of care for patients and families, and focusing on the healing process for the patients. The sustainability of the caring environment was focused on the physical and social environment to make patients and families feel comfortable during their stay in the ICU. The nurses maintained the cleanliness of the environment and the patients, maintained the neat arrangement of the space, and created a good environment to increase pleasant feelings. Moreover, the nurses also maintained the social environment to preserve good relationships among the nurses and their clients.

The maintaining of the holistic approach of care for patients and families was planned to provide comprehensive nursing services that include physical, psychological, social, and spiritual care. Physical care refers to the patients' treatments including all medical interventions, nutrition, and symptom management. Psychological care is given to release stress, tension, fear, and anxiety during hospitalization, such as listening to Islamic music, prayer, and *Zikir*. Spiritual care based on Islam is clearly identified and systematically integrated into the care.

The nurses in the unit planned to focus on the healing process for the patients. The planning of the healing process was to convey the holistic care and respect to the patients and their families. The nurses built relationships with the patients and families and were actively involved in critical care nursing. The nurses planned to focus on the healing process by: 1) gathering comprehensive information about the patients and families, 2) giving information about the critical care environment at the time of the patients' admission, 3) responding to the patients' and families' needs, and 4) offering holistic care to the patients and families. Therefore, in Cycle 2, some new strategies were set up to facilitate implementation of the plan.

Strategies.

In fulfilling the goal of the plan in Cycle 2, many strategies had been raised in the meetings between the researcher and the participants. The strategies were set up to ensure the fulfilment of goals encompassing:

1) Giving rewards and recognition to the nurses who provided good caring. This reward can improve and sustain the nurses' caring

behavior toward the patients and their families. It can also inspire other nurses to improve their caring skill in the unit.

2) Utilizing the caring protocol in caring practice to guide the nurses in the implementation of the holistic care for the patients and families.
3) Reporting the results of the study to the nursing manager to obtain support from the nursing manager in the unit or hospital.
4) Strengthening caring practice by strengthening the nurse-patient connection and interaction to obtain healing outcomes
5) Building and strengthening the leadership of the nurses to lead the accomplishment of the caring healing process.
6) Holding regular meetings every 3 weeks in order to discuss the problems, engage in self-reflection, and take suggestions from others to improve the nurses' caring practice based on Islam.
7) Providing workshops on caring for nurse leaders to train them to become caring leaders in the unit.

Actions and observations.

In maintaining and strengthening caring practice, mutual interventions were carried out involving all parties (nurses, patients, and families). Based on the 5 Rs of Islamic based caring theory of Barolia and Karmaliani (2008), the researcher integrated Islamic concepts into the action phase in Cycle 2. The actions were:

1. Response.

The researcher conducted four caring actions in this cycle: 1) promotion of Islamic spiritual care for patients and families in critical situations; 2) improvement

of interpersonal communication and interrelationships based on Islamic values; 3) allocation of time and space for Islamic spiritual based practice; and 4) recognition of the connectedness of body, mind, and spirit of patients.

1.1 Promotion of spiritual care for patients and families.

The nurses promoted Islamic spiritual care for patients and families in the unit. The spiritual care had been systematically included into the care in order to provide them with hope and strengthen their inner power. One nurse noted that:

> Nurses played an important role in providing spiritual care for Muslim patients. Islamic spiritual care is more than clerical responsibility in the critical situation for patients in the ICU. The nurses responded to the holistic needs of a person suffering from illness, loss, and grief. In addition, family caregivers also played an important role in inspiring the patient's spiritually. They also helped them to nurture spiritual growth and draw inner strength and hope. (Nurse T, 1st August, 2014)

1.2 Improvement of interpersonal communication and interpersonal relationships based on Islamic values.

The nurses agreed that interpersonal communication and interrelationships were very important, because these enhanced the connection with the patients and families. The nurses in the unit put a lot of effort into improving their skills in communication, such as being a good listener, showing respect to others, and being compassionate. The nurses also improved their interpersonal relationships with the patients and their families in order to achieve the goals of Islamic based caring. One nurse stated that:

> Nurses are expected to be good listeners, respect others, and show compassion to others. These caring actions can help heal the patients. Therefore nurses should pay more attention to interpersonal communication and interpersonal relationships. (Nurse A, 1st August, 2014)

1.3 Allocation of time and space for Islamic based spiritual care.

The allocation of time and space for religious activities is important for Islamic based caring. This allows the client to be close to God (*Allah*), strengthen their faith, and give them hope. One nurse said that:

> Space in this ICU is very limited. Family members cannot pray with their sick family members if we don't arrange a space as well as time for them. We therefore allow the family to pray together at the patient's bedside. (Nurse R, 5th August, 2014)

1.4 Recognition of the connectedness (harmony) of body, mind, and spirit of patient/family.

Nurses should recognize the harmony of the body, mind, and spirit of their clients from time to time, whether they were happy, satisfied, or unconscious. The connectedness of body, mind, and spirit in this study was evaluated by using both quantitative and qualitative methods. A comment on this from one nurse was:

> It is not easy to measure the balance of the body, mind, and spirit of our clients especially in a critical situation, as some of the patients have cognitive problems or are unconscious, but it doesn't mean they can't perceive anything and we don't need to care about their mind and spiritual aspects. (Nurse A, 1st August, 2014)

2. Reflection.

We conducted reflection using group discussion and dialogue or narrative reflection. A regular reflection session was conducted every 3 weeks after the ward meetings. The main purpose of the reflection was to allow the nurse participants to discuss any problems and concerns regarding the caring practice as well as to share any suggestions that they might have for improving the model. The nurses, moreover, were requested to reflect on their caring practice based Islamic values of humanity.

There are 5 Islamic values of humanity: 1) life (*Al-Nafs*) is all those who can provide a healthy body to lead a purposeful life; 2) religion (*Al-Din*) is for providing guidance, peace, tranquility, comfort, and purpose in life; 3) knowledge (*Al- Aql*) is the intellectual nature of man which is made up of mind or intelligence or reasoning power; 4) family life (*Al-Nasab*) includes family as the very heart of society; and 5) wealth (*Al-Mal*) is obviously a fundamental human value. During their reflections, the nurses reflected on their own nursing care with regard to the Islamic values.

In the reflection of life (*Al-Nafs*), the nurses reflected that they tried to give better nursing care to the patients to save their lives. For the reflection of religion (*Al-Din*), the nurses stated that they had provided the Islamic intervention for the patients and their families in order to give them positive feelings and calmness for dealing with their crisis. For the reflection of knowledge (*Al-Agl)*, the nurses stated that they understood the Islamic based caring's role in healing the patients in order to achieve harmony of life. *Al-Nasab* is about family life, so the nurses reflected that they had encouraged the family members through nursing care and caring practice. Further, wealth (*Al-Mal*) was financial support, which means that the nurses should understand the patients and their families' condition regarding this manner, and they advocated the health care team members regarding treatment support.

The nurses wrote their reflections in a book provided by the researcher in order to record their ideas and experiences during their participation in the project. They wrote everything about their caring practice to reflect their service for their patients in their daily work. The analysis of their reflections revealed that they gained better understanding about the meaning and the significance of Islamic based caring practice. They found that it was challenging to introduce a new model of Islamic based

caring to the ICU. They also helped coordinate the way to integrate Islamic values into the caring practice including the development of the Islamic based caring protocol.

3. Relationship.

In terms of relationships, the researcher and participants saw the relationships between nurses and patients/families as the central focus of promoting Islamic based caring. Islam teaches Muslims to treat the patients and families with fairness and not to discriminate against them on age, race, or religion. A nurse gave her comments regarding her relationship with the patients and families as follows:

> …. set aside five minutes every day to reflect on the relationship of a particular patient or family. Patients are like family. Nurses should be sincere in taking care of them without exception. (Nurse U, 1st August 2014)

The relationships between the nurses and their patients were enhanced through empathy and compassion using both verbal and nonverbal communication skills.

3.1 Enhanced empathy and compassion: nonverbal communication skills.

The nurses used nonverbal communication with the patients who could not talk by showing them pictures or by writing. Nonverbal techniques could ensure a strong foundation for an empathetic connection with them. The common nonverbal communications consisted of: (1) body orientation (body position was toward the patient), (2) eye contact (showing genuine attention paid to the patients), and (3) head nods (showing that the nurse was listening to what the patient was expressing). A nurse's experience of being affectively attuned, having empathy, and showing compassion took on a truly transformative power when it could be communicated to the patients.

3.2 Enhanced empathy and compassion: verbal communication skills.

There were numerous verbal communication skills used in enhancing empathy and compassion for the clients. The nurses in the unit demonstrated empathy using parroting responses and paraphrasing. With parroting responses, the nurses repeated, verbatim, what the patient had said with empathy. Sometimes, the patient talked either with an exclamation or with a questioning tone of voice. The nurse should be actively listening to encourage the patients to tell more. In addition, with paraphrasing, the nurse used his or her own words to re-communicate the same meaning of what was said by the patient. This technique frequently used verbal strategies for effectively communicating empathy accurately.

Moreover, with compassion, a nurse shares in the suffering experienced by the patients and expresses that shared experience to both strengthen and comfort the patient. The enhancement of empathy and compassion through verbal and nonverbal communication, although basic, can be a powerful method for demonstrating accurate empathy and fostering great comfort. When practiced with Islamic based caring, the use of these skills could facilitate a powerfully transformative healing process. One nurse stated that:

> After completing some actions in Islamic based caring, I think that to take care of patients in a critical condition is a noble task, especially showing compassion in the relationship with them. To do the right thing based on Islamic teachings is challenging. This requires compassion in the daily practice. The nurse, as human being, might not be perfect, but I believe that Islamic based caring benefits in improving compassion. (Nurse B, 5th August 2014)

4. Relatedness.

The actions of relatedness in this cycle were intended to maintain friendly, cheerful, and empathetic relationships with the clients; to improve the sense

of belonging in the holistic environment; and to enhance compassion for the patient and family. In exhibiting relatedness, the nurses tried to keep the family members informed about the patients' progress at their bedside. The nurses encouraged family members to come to the patient's room or bedside for around 15 minutes every day to be provided with some information of the patient's progress and current condition, such as being informed about the procedures that had been performed, and the results of diagnostic tests. The nurses performed "*dua*" (praying) together with the family members who came to visit. The nurses also encouraged the family caregivers to express their affection to their loved one through words and touch, such as holding the patient's hand without hesitation, to let the patient know that the family supported him/her. The nurse also provided the family members with more time to be together with their loved one. Two patients and a family gave the following positive agreements regarding relatedness:

> I love the nurses who are friendly and welcoming, not only coming to give injections and medicines. I liked the nurses who had a sense of humor the most. She or he can make me laugh even when facing the illness. (Patient 2, 10th August 2014)

> I had my birthday here (ICU) … again the nurse was great. She put up birthday cards around my bed, and every one (nurses, doctors, visitors) wished me happy birthday on that day. (Patient 3, 10th August 2014)

> We were visiting my husband. Then, the nurse came, introduced herself, and told us what procedures were done for the treatment. She asked us to pray together while I touched my husband's hands to express the connection between my husband and me. I felt something different at that time, and could not say anything and cried. The nurse then hugged me. I was very touched by the relatedness between the nurse and our family. (Family 14, 10th August 2014)

5. Role modeling.

The researcher and the participants practiced and established Islamic based caring for patients, families, and others, based on compassion, presence,

connectedness, and openness. The researcher and her peer colleagues also performed some observations. Most of the nurses became more aware about caring practice for their clients. Moreover, the nurses ascertained their motivation to practice Islamic based caring in their daily work. From the observations, there were five nurses who performed well in terms of caring practice, exhibited good communication, formed good relationships, and also actively supported other nurses, especially young nurses to practice Islamic based caring in their daily work.

> After implementing this model, having some friends who can be role model was awesome. They have inspired us to do something good that is very useful for the patients and their families. (Nurse J, 12th August)

A physician as a head of the unit also gave his comments as follows:

> I can see the nurses' effort in this initiative. I understand how they pay attention to the patients and family and show awareness of their caring practice in terms of Islamic teaching. I am happy. The nursing staff can improve their awareness and knowledge especially in maintaining their caring towards the patients and families. My expectation of the core team in this project is to always set a good example and inspire others to deliver good caring practice. (Doctor J, 20th August 2014)

Reflection Phase/Evaluation.

The reflection phase/evaluation was conducted with the participants in order to appraise the impacts of the model's implementation. The participants were interviewed to gather information on their experiences of the model's implementation in the setting. The expected health outcomes were patients' and families' satisfaction, nurses' caring practice, and the harmony of the critically ill patients.

1.1. Nurse caring practice.

After the completion of the two cycles, the nurses stated that they had gained more knowledge and skills. They were aware that caring was important in the nursing service. They stated that the benefits of the caring practice consisted of self-

improvement, good relationships with others, a greater sense of caring for others, good collaboration with other health care providers, and appreciation of others as human beings. Other improvements included quick responses to the patient's needs, better communication skills, and the nurses' self-confidence. One of the nurses commented on her own improvement after the model implementation as follows:

> Patients in the ICU need more attention from families and nurses. For example, the need to be accompanied and need nurse's presence beside them. By applying the caring model, I can know the patient's needs, and I can start to practice it from the beginning of the patient's admission up to the patient's discharge from the unit. When we place emphasis on sensitivity and awareness and establish communication, then we will understand the needs of the patients and they will be satisfied with the services. We can assist our patients to accept their condition sincerely, motivate them, and suggest that they be thankful to *Allah*, to grace us every time before and after experiencing sickness. (Nurse A, 25th August 2014)

Another benefit was the harmonious relationship between the nurses and patients, the nurses and other nurses, and the nurses and other health care providers. One of the nurse participants pointed out:

> Certainly, after applying the Islamic based caring model, I learned a lot that nurses should understand about the pathophysiology of disease, for controlling, managing, and performing nursing care. I learned to be a good listener in active communication with others. I learned to be kind in my relationships with others. I can see changes of awareness in our ICU. (Nurse Y, 25th August 2014)

After the implementation of the tentative Islamic based caring model, the participants were satisfied with the results of the program. They put their efforts into working and were proud because they were able to provide nursing care holistically, and the patients were recovering well. One nurse participant expressed her satisfaction in the following quote:

> I was feeling good with my involvement in the implementation of the program. For example, if the patient is feeling chest pain from myocardial infarction, the nurse does not only give a drug to decrease pain, but also performs a nursing intervention to decrease the patient's anxiety. By communicating with the patient about his or her pain management, and helping the patient to pray and

> surrender to God, I also provide a soothing environment for the patient when he/she is suffering from his/her illness. I will explain the conditions to the clients now. I will also provide any information before I perform a nursing intervention, so that the patients know what the purpose of the procedure is. (Nurse G, 25th August 2014)

1.2. Participants' feelings and their satisfaction.

In the second cycle, the patients and family caregivers were also asked about their feelings and their satisfaction with the implementation of the Islamic based caring model. Their feelings and satisfaction are described as follows.

1.2.1 Family feelings and their satisfaction with the implementation of the tentative model.

After the implementation of the tentative Islamic based caring model, the family expressed their positive gratitude to the nurses who provided their sick family member with very impressive caring. They were feeling warm and confident from the compassionate communication and information related to the patient's health condition as well as the useful advice they received as reflected by the following quotes:

> The friendly nurses explained what was going on all the time about my father's condition, and what treatment and procedures would be given. This was very useful and decreased the grief and worries, also the concerns we had about our father's condition. I really respect them. They kept explaining in terms of my father's health progression. (Family 12, 28th August 2014, 01.00 p.m.)

The family members, furthermore, expressed their appreciation to the nurses who provided them with good care and concern for their loved one. The families gave positive comments regarding this manner.

> The nurses always asked about our (family) feelings and condition. I really appreciated their concern about our family's condition in facing this critical situation. (Family 9, 28th August 2014, 01.20 p.m.)

> I met the nurse who took care of my father. The nurse explained patiently despite my repeatedly asking the same things. At the end of the conversation, she said not to hesitate to contact her if there was anything further I needed to know about my father. (Family 11, 28th August 2014)

Moreover, the families also mentioned about being encouraged to use religious activities to strengthen their inner power in facing the critical situation of their sick family member. They mentioned that the nurses gave guidance, offered prayer, and reminded them of the rituals of Islam for Muslim patients and families during hospitalization. The families stated that:

> I was reminded by a nurse that my husband was allowed to drink holy water (*Zamzam* water), and she was happy to help feed it via a tube if needed. (Family 5, 28th August 2014)

> I appreciated the nurse who gave me "tasbih" (prayer beads) and suggested to me that I do *Zikr* at the bedside. It was very helpful because at that time I felt so anxious about my husband. (Family 9, 28th August 2014)

> At lunchtime, the nurse asked me to give lunch to my husband and reminded us of the time of prayer (*Zhuhur*). If my husband and I needed help, I could just let her know. (Family 12, 28th August 2014)

In terms of satisfaction, the families expressed their satisfaction to the nurses after the implementation of the tentative Islamic based caring model in the ICU. The nurse participants paid good attention to the patients' and families' needs. They also treated the patients as human beings. Some families shared positive statements of satisfaction as follows:

> The nurses in this room are very kind. We do hope that my husband will recover well. I really appreciate the effort of some nurses in reminding, facilitating, and even helping my husband to perform prayers five times a day. I never thought of it before because my husband is in a critical situation. It is great that the nurses are keeping us close to *Allah*. They perform prayers with me for the healing of my husband. They also listen and are willing to take our complaints towards the nurses. Definitely, I feel glad and satisfied with the nurses who have been caring for my husband. (Family 11, 29th August 2014)

> There was a memorable event when a nurse reminded me to pray for my wife who was in a state of agony. I was very touched by her concern, providing a feeling like being a mother. The nurses in the ICU demonstrated good relationships and good communication. I feel very satisfied with the services of the nurses in the ICU, especially nurse "X". (Family 13, 29th August 2014)

1.2.2 The patients' feelings about implementation of the tentative Islamic based caring model.

The patients had positive comments about the nurses who were kind and compassionate. They felt secure, happy, and comfortable during their stay in the ICU. The following statements demonstrate the patients' feelings toward the ICU nurses:

> ….. their (of the nurses) sense of humor. It not only helps relieve the stress and tension but also enhances the caring relationship with the clients. (Patient 13, 30th August 2014)

The patients expressed their appreciation to the nurses who showed caring behaviors and treated them as individuals. The nurses tried to spend time with them in order to get to know them and their needs. A patient noted his feelings:

> I feel that he gives me genuine attention and he knows me pretty well. He is kind, funny, and helpful. He always gives me verbal support: "please don't lose hope". Allah will help us and I am with you. (Patient 14, 30th August 2014)

Based on the findings from the observations, the patients also appeared to be happy when the nurses provided them the interventions based on Islam, such as prayers, *dua*, and remembrance of *Allah*. The patients' happiness was also articulated as follows:

> I feel happy when the nurse provides "*dua*" to the clients. The nurse is doing well. She is always with us and understands us. (Patient 4, 30th August 2014)

> I always remember that nurse 'Y' always said 3 words: "*Assalamualaikum*, *Bismillahhiromahnirohim*, and *Alhamdulillah*. (Patient 14, 30th August 2014)

Most patients expressed their satisfaction with Islamic based caring practice as the nurses truly showed their professional role. They described the professionalized roles as providing holistic care covering the spiritual dimension that they had not experienced before. Their satisfaction was reflected in the following quotes.

> Thank you for all the nurses in the unit. The nurses understand the importance of our religion because it influences our feelings and thus affects our decision and compliance with a prescribed treatment. My family and I felt satisfied with you. (Patient 10, 29th August 2014)

> During the visiting time, the nurses do not leave us alone. They come to meet the visitors and sometimes offer '*dua*' to the patient together. This is a good way to strengthen the relationship with the nurses. We are truly satisfied with her involvement. (Patient 12, 29 August 2014)

Facilitating factors of strengthening caring practice for sustainability of the Islamic based caring model.

Successful implementation of the model required good and feasible strategies. In a meeting, the action research team identified important strategies: the provision of support especially emotional support from the chief of the unit, and nursing colleagues; the strengthening of the relationships between team members; and the development of a practical caring protocol based on Islam.

Barriers.

The researcher and participants noticed barriers that existed after the implementation of Cycle 2. The barriers were workload, time constraints, and the need for more role models. The researcher considered that the barriers might not be solved within this timeframe. Therefore to overcome the barriers, the researcher and nurse participants implemented four steps: impressed the nursing team acted as role models for the team , kept good relationships with nursing colleagues, applied the lessons learned from all experiences into the implementation of Islamic based caring, and required the top managers to solve any problems.

Lessons learned.

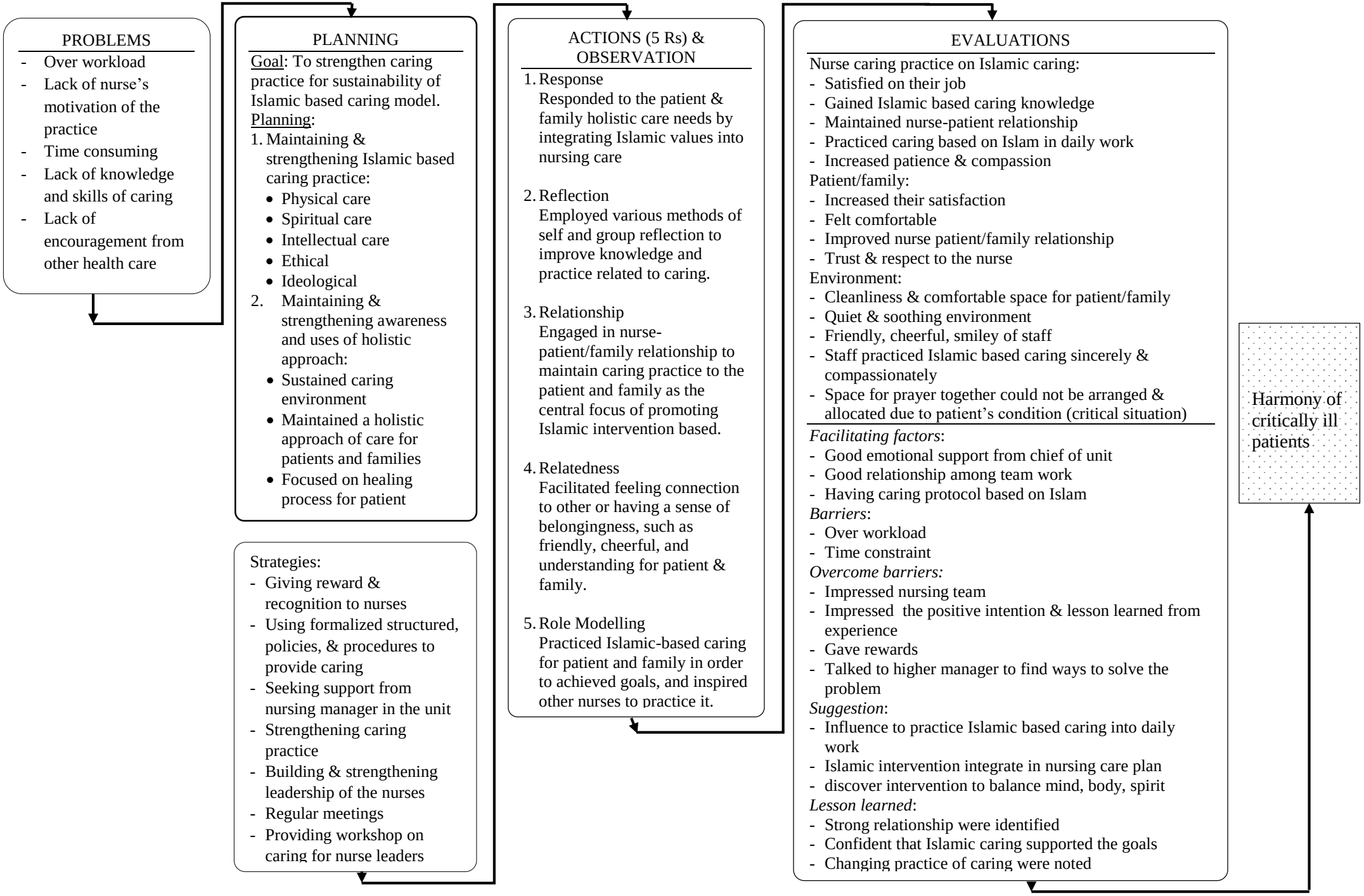
The researcher and the participants evaluated the lessons learned after the implementation of Cycle 2. In strengthening the caring practice for the sustainability

of the model in the ICU, we realized that there were positive and negative lessons learned. However, we were satisfied with the learning processes in the study. The researcher and the nurse participants could get emotional support from the nurse managers, the head of the ICU, the head nurse, and other colleagues.

A strong relationship was identified between the researcher and the participants, and among the nurses. The researcher conducted actions and shared experiences related to caring practice. When the nurses were taking action in applying the model, they were confident that Islamic based caring supported the goals. Changes to the practice of caring were noted in the setting, and the satisfaction of all parties was reported. Although a significant amount of time was spent in the setting to connect with key participants (nurses), patients, and families, at the end of the Cycle 2, the nurses were impressed with this project. The participants' activities in learning and translating of the theory into Islamic based caring are shown in Appendix J.

The changes to the practice have been categorized into 4 aspects: 1) knowledge and awareness, 2) Islamic based caring practice, 3) relationships and team work collaboration, and 4) outcomes of the practice. However, there were still barriers and suggestions for further development. The three main suggestions from the whole process of the Cycle 2 are: 1) a role model caring nurse is required to facilitate the Islamic based caring practice; 2) Islamic interventions such as prayer, reading *Al Quran*, etc., should be integrated into the nursing care plan; and 3) the provision of an intervention to harmonize the life of the patients and their families in critical situations is required.

Figure 4.7 Cycle 2 Strengthening of caring practice for sustainability of the Islamic based caring



2.3 The final caring outcome: the harmony of critically ill patients.

In the present study, the harmony of the critically ill patients was expressed explicitly and implicitly through connectedness. The harmony of critically ill patients in the recent study refers to the happiness (*Sa'ada/farah*), inner peace (*Assalam alddkhili*), and surrender/acceptance (*Aitislam*). One of patients in the study group said: "the nurses help me to awaken and connect with myself due to my condition, and I stay connected with Allah. That is the most important value for me." The harmony of critically ill patients is achieved through 4 dimensions of connectedness being valued in Islam: 1) maintenance of good connection with self; 2) maintenance of good connection with family, nurses, others; 3) maintenance of good connection with God; and 4) maintenance of good connection with the environment.

2.3.1 Maintenance of good connection with self.

Harmony is a result of the maintenance of good connection with the self. This connection with the self deals with the physical and psychological dimensions of human beings. The nurses are required to help the patients maintain their physical and psychological condition through truly understanding themselves; as a result, the patients are able to deal with their disease and the crisis in a realistic and appropriate way. They accept the will of God *(Allah SWT*) and passion in order to survive and encounter the balance of body, mind and spirit. From the observations of the process in achieving the harmony of the patients, it could be seen that the nurses provided the patients with Islamic based nursing care and enhanced their positive thoughts toward illness. One patient stated:

> I try to get the best treatment for getting well. I am *Ikhlas* (sincere) with my illness. Even when *Allah* calls me to die, I will also be sincere. (Patient 5, 7th August, 2014)

Two nurses also shared their thoughts about this point:

> The harmony of critically ill patients in the ICU can be described as a situation where the patients are free from fear and anxiety. As a result, feelings of comfort, calmness, and peace can be achieved. Thus, nurses need to enhance their understanding about their health situation. (Nurse Y, 30th January 2015)

> A patient who can achieve the state of harmony usually appears as having calmness and acceptance. He or she takes the illness as a test from *Allah*. (Nurse U, 30th January 2015)

The nurses realized that even when a patient's condition in the ICU was not stable or they were even unconscious, some of these patients had no complaints in terms of psychological problems during the progression of their illness, meaning that they were in a state of harmony. This could be seen from the patients' feelings that they were free from fear and anxiety whatever their physical condition was. The following quote from a nurse describes the harmony in the patients' psychological and spiritual condition.

> Most of the patients in the ICU were agitated, and had fear and anxiety of their condition and even feared death. By implementing the Islamic based caring, my patients feel more calm and peaceful in facing their condition and so do their family. The faith of a person is dignified due to his sincerity in the face of psychological burden. Sincerity in accepting *Allah's* will is proof that patients are in harmony psychologically and spiritually. (Nurse Y, 30th January 2015)

2.3.2 Maintenance of a good connection with others (nurses, family, and significant others).

Harmony is described as a result of the connection between the nurses, family members, and others. The connections between the nurses, family members, and others are strengthened through the caring actions that the nurses give to the patients and families with courteousness, kindness, love, and sincerity. The nurses realized that enhancing the good connections of the patients with the nurses, their family members, and others was necessary in order for all of the relevant people to get induced to

participate in the care of the patients. It also helped ensure the feelings of trust toward the nurses and the confidence that they would be cared for when needed. The nurses' feelings on this are exemplified in the following statements:

> The nurses should maintain a good connection with their patients and families, by practicing caring and a willingness to help the patients sincerely. This caring practice is useful to harmonize the relationships between the nurses, patients, families, and others. The nurses give good services for the patients and their families as well as to the others in order to receive charitable kindness from *Allah*. (Nurse G, 30th January 2015)

> In providing nursing services for the patients, the core of a relationship between patients and nurses is trust. If the patient trusts the nurses, the patient will feel more comfortable and close to the nurses. Then, the trust and relationship between us (nurse-patient) will create harmony for the patients. (Nurse E, 30th January 2015)

> The nurses should maintain the relationships between nurse and patients or families in order to gain trust among us. (Nurse D, 30th January 2015)

From the families' perspectives, they believed that families were central to the healing of the patients. The families had an important role in dealing with the patient's crisis as well as providing financial, emotional, psychological, and social support systems. One family member stated that:

> Our family has the responsibility to take care of the needs of our loved one, such as financial, emotional, psychological, and social support. In doing so, we hope that our family member can recover and be discharged soon. (Family 12, 30th January 2015)

Muslims will seek help from a professional health care team to heal themselves. The nurse is one of the professional health care providers in the system, and provides a service for patients based on the nursing process independently or collaboratively. The service given by the nurses is bio-psycho-social and spiritual, using a holistic approach. Two nurses expressed their agreement with this as follows:

> Muslims know that illness is linked to biological and psychological causes and they require medical treatment and other professional attention in order to heal their illness and create their harmony. (Nurse N, 5th January 2015)

> Nurses give nursing services for patients holistically and continuously. The nursing cares includes whole aspects of human life. (Nurse O, 5th January 2015)

2.3.3 Maintenance of good connection with God.

This study found that harmony happens when the patients maintain a good connection with God. Harmony of life in Muslim patients is gained primarily through the existence of a faith in God. As the Muslim patients perceived the suffering from illness to be a test from *Allah*, thus, the patients were sincere (*Ikhlas*), accepting in dealing with their crisis in the ICU, and were required to pray to *Allah*.

> The maintenance of a good connection with *Allah* during the crisis situation helped the patients and families pass their critical situation. They realized that *Allah* is the oneness of all, and it is required to pray to *Allah*. The nurses should help the patients to maintain this connection in order to achieve balance and harmony in their life. (Nurse T, 5th January 2015)

2.3.4 Maintenance of good connection with the environment.

The setting of the environment in the ICU was not the same as in the general wards. The nature of the ICU could make the patients and families fearful, stressed, and having thoughts about dying there. Numerous patients might feel isolated, having no connection with the outside, so day or night looks no different. To achieve the harmony of patients in the ICU, the nurses should maintain the connection with the environment to influence patient healing. The positive statements from nurses were as follows.

> After the implementation of Islamic based caring, the caring environment is a factor that facilitates harmony and supports a caring atmosphere in order to maintain the nurse-patient relationship (Nurse B, 5th January 2015)

> With a caring environment, I think it is useful in accelerating the healing process of the patients. In participating in this project, I have directly experienced and

> witnessed the health outcome of caring relationships, a caring environment, and faith in God in giving better provision for the patients and families. (Nurse G, 5th January 2015)

3. The Islamic Based Caring Model for Critically Ill Patients

The Islamic based caring model for critically ill patients was developed as outlined in the following sections.

Introduction.

Harmony for critically ill patients is achieved through the participation of the nurses, patients and families in the development of the Islamic based caring model. The model was derived from the findings of this study through the action research process (Figure 4.3), based on the patients' problems and needs. The final Islamic caring model was re-conceptualized from the results of two cycles of action research process. The model can be used as guidance in the caring practice for Muslim patients in the ICU. This model is composed of three components: 1) action research team, instruments, and strategies; 2) caring-healing process; and 3) outcomes.

Moreover, the Islamic based caring model for critically ill patients in the ICU provided a context and structure for nurse-patient relationships in the caring-healing process. This model aims to ensure the quality of holistic nursing care for Muslim patients. The model can also be applied in other similar socio-cultural settings related to critical care. The Islamic based caring model provides a framework that is used to enhance and facilitate the balance of the body, mind, and spirit, through the establishment of nurse-patient relationships to support the caring healing process, and eventually achieve harmony. The description of the Islamic based caring model is as follows.

Objectives.

This model had two main objectives: to understand the components of the Islamic based caring model, and to identify how the nurses provide Islamic based care for critically ill patients.

Core values.

The Islamic based caring model for critically ill patients in the ICU has four core values: healing presence, caring relationship, caring environment, and faith in God. The core values of the Islamic based caring model are the main concepts that need to be transformed into practice in order to influence the expected caring practice. The four core values underline nursing practice and guide the nurses on how they should interacted with each other and others, as well as the strategies they can employ to fulfill the mission.

The healing presence involves the nurses' presence, both physically and mentally, to support the healing process of the patients in the ICU. Caring relationships are the relationships between nurses, patients, and family members, and between the nurses and other critical care team members. The caring environment is a comfortable environment created by nurses in order to promote comfortable feelings for the patients and their families during their stay in the hospital. Lastly, faith in God is the belief of Muslim patients in Allah in facing their critical health problems and risk of dying, and dealing with the associated psychological and spiritual problems. In conclusion, the core values guide critical care nurses to perform a caring healing process in Islamic based caring.

Problems and needs.

Muslim patients in the ICU in the context of this study were experiencing crisis resulting from critical health problems including a risk of dying, and were subsequently in psychological and spiritual crisis. Critical health problems commonly found in the ICU include pain, illness suffering, heart failure, respiratory failure, multi organ failure, and facing death (end of life). In these situations, the severity and complexity of their illness often leads to patients experiencing psychological and spiritual crisis that includes fear, stress, uncertainty, lack of confidence, and isolation.

In dealing with the psychological and spiritual crisis, Islamic faith was integrated into the caring for the patients and their families. The families' social support was needed to deal with the crisis situation. Moreover, in dealing with patients' critical health problems and risk of dying, the nurses should be skillful in providing nursing care with critical care technology. Thus, the nurses need to be capable of providing integrative care in the caring-healing process to respond to the clients' problems and needs.

Caring-healing process.

The caring-healing process was an important process in this model, as it included all processes of nursing care and caring practice in order to help the patients in dealing with their crises (Figure 4.8). The model was named the Islamic based caring model for critically Ill patients in ICU (IBC-ICU). The nurses were required to perform both the caring and healing roles in order to facilitate the patients to move along their journey toward harmony that was congruent with the clients' beliefs.

The development of the IBC-ICU in Indonesia involved nurses, patients, and families in the action research team. The nurses were the key persons who were responsible for two main jobs. First, the nurses should develop their capability in: a) improving knowledge and caring skills (compassion, patience, politeness, respectfulness); b) creating a comfortable and caring environment; c) creating Islamic based caring practice; and d) promoting awareness of caring and the holistic approach. Second, the nurses were responsible for strengthening the caring practice by maintaining and strengthening: a) a comfortable and caring environment; b) the caring practice; and c) awareness of the holistic approach. Moreover, the patients and families were required to be present for the sick family member, be involved in the caring, and seek help from *Allah*.

The implementation of the model required instruments to guide, facilitate, and monitor the practice in the setting. These instruments consisted of an Islamic caring protocol, training and workshops, and evaluation forms. The Islamic caring protocol was developed by the nurse research team based on the work of Barolia and Karmaliani (2008). Training and workshops were conducted in order to meet the requirements of the nurses in caring practice, i.e. knowledge, attitude, and skills of caring. The evaluation forms were used as tools to evaluate the caring in the form of interview guides, observations, and field notes.

The action research team developed strategies that were used to facilitate the model development and implementation. Regular meetings were organized throughout the action research process to discuss and brainstorm the plan and strategies for enhancing the model's implementation. The strategies employed consisted of: 1) workshop/training on Islamic based caring; 2) individual improvement; 3)

establishment of caring relationships; 4) utilization of a caring protocol; 5) nursing rounds/conferences; 6) provision of rewards & recognition to the nurses; 7) utilization of formalized and structured procedures to provide caring; 8) obtaining support from nursing managers; and 9) introducing and reporting Islamic based caring to the nursing managers.

The caring-healing process incorporates several phases that might occur simultaneously: assessment, planning, actions and observation, and evaluation of the outcomes. The process was relational, wherein the bio-psycho-social-spiritual was recognized as mutual participation in the nurse-patient relationships. The 5 Rs according to Barolia and Karmaliani (2008) were used to guide the integration of the Islamic based caring into the caring healing process. The components of the caring-healing process are described as follows.

Assessment.

The critical care nurses assessed the patients in order to gather information and appraise the pattern of response, and to identify health patterns and prioritize concerns. Family members were encouraged to share information and concerns about the patients. Within the process of assessment, the nurses acknowledged the influence of his or her own patterns on the healing relationship. Through interpersonal interaction, observation, and measurement, the nurses gleaned information about the client's needs. Caring-healing assessment was an ongoing process, and provided continuous data for identifying the pattern of changes that occurred over time. Assessment data were documented in the patient's record. New information gained from nurse-patient interaction validated previously collected data and conclusions and served to guide the caring-healing process.

Planning.

The critical care nurses were required to develop an appropriate caring healing plan that focused on the patients' crises of physical, psychological, and spiritual health problems. The critical care nurses aimed to assist the Muslim patients to identify ways to re-pattern their health conditions towards well-being. The plan outlined the nursing interventions chosen to facilitate the achievement of the identified outcomes. The intervention treatments based on the assessment phase that nurses initiated resulted from medical diagnoses, nursing diagnoses, and the performance of the daily essential functions for the patients. The critical care nurses provided not only intensive care with and without technology but also integrated Islam into the care, and strengthened social support for the Muslim patients who were admitted into the ICU. The integration of Islam into the nursing care plan included prayer (comfort the soul), *Zikir* (meditation), and healing presence (nurses and family members).

Actions and observations.

During the actions and observation process, both the nurses and clients participated in undertaking the plan of care. The nurses employed response, reflection, relationship, relatedness, and role modeling (5 Rs) in accordance with the work of Barolia and Karmaliani (2008) in order to facilitate the healing. The five Rs were used to guide the action of the nurses related to Islamic based caring to achieve harmony for the critically ill patients. In brief, 'response' refers to the patient and family's holistic care needs by integrating Islamic values into the care. Various methods of self and group 'reflection' were employed to increase knowledge and the reflection was performed to improve the practice skills in caring. 'Relationship' refers to the engagement of the nurse patient relationships used to maintain boundaries of caring

practice for the patients and their families as the central focus of promoting Islamic based intervention. ‘Relatedness’ means that the nurses facilitated feelings of connection with others or feelings of having a sense of belongingness such as through the nurses being friendly, cheerful, and understanding the patient and the family. The last ‘r’ was ‘role modeling’, which involved the nurses practicing Islamic based caring for the patient and family in order to achieve the goal.

Within the holistic framework, an action on any aspect of bio-psychosocial-spiritual being created a corresponding response in the other aspects. In employing the healing presence, caring relationship, caring environment, and faith in God as the core values of the Islamic based caring practice, the critical care nurses yielded the bio-psychosocial-spiritual responses in the nurse-patient relationships. Observations in this model were conducted to obtain information to be used for revising the plan. All the actions and observation results were documented in the patients’ records.

Evaluation.

The critical care nurses evaluated the patients’ responses to holistic care regularly and systematically, continuing the holistic nature of the healing process. Caring-healing evaluation was a mutual process between the nurses and the patients, and was used to identify the factors facilitating the desired outcomes. Evaluation provided an opportunity to review the bio-psycho-social-spiritual data that had been collected to compare an identified crisis with the outcome criteria in order to evaluate the caring healing actions results. All of the patients, nurses, and families were evaluated as focus participants in the caring healing process. Evaluation was also continuous and contributed to the revision of the care plan with the observable or

measurable, and developed new outcomes. The caring-healing evaluation was extended beyond the nurse-patient relationship and self-awareness reflections by the nurses.

Outcomes.

The expected health outcome of the Islamic based caring implementation was the harmony of the critically ill patients. The harmony of the critically ill patients in this study could be defined as the patients' sense of satisfaction and comfort, and pleasant feelings (happy, calm, peace,) to *Allah's* will in their crisis situations.

Summary.

The Islamic based caring model (Figure 4.8) focuses on the spiritual practice of Muslim patients to gain a deeper understanding of how the body and mind are in line with the spirit. For Muslims, Allah is the oneness of God, and there is no power other than God's help. Therefore, Muslim patients who were admitted into the ICU believed that spiritual care was crucial for them in order to create balance between their body, mind, and spirit beside the physical care performed by professional health care providers. Furthermore, Muslims were primarily encouraged to practice Islamic beliefs in their connection with God in dealing with any crisis. *Allah* tests Muslim patients in many ways and therefore they need to be steadfast in His worship constantly. These are the reasons that the Muslim patients attach Allah in the decisions of their life to achieve the harmony.

The spiritual practice in the ICU was performed to achieve harmony in critically ill patients to become aware of the body and mind condition that was affected

by the disease and its consequences. The spiritual practice helped the patients release stress, anxiety, fear, and so on to be more humble, understandable, and patient. Spiritual practice could boost energy to be the spirit of life, and motivated individuals in the healing process. Therefore, emphasizing the nurses' role in spiritual practice was crucial to achieving harmony in the patient's life.

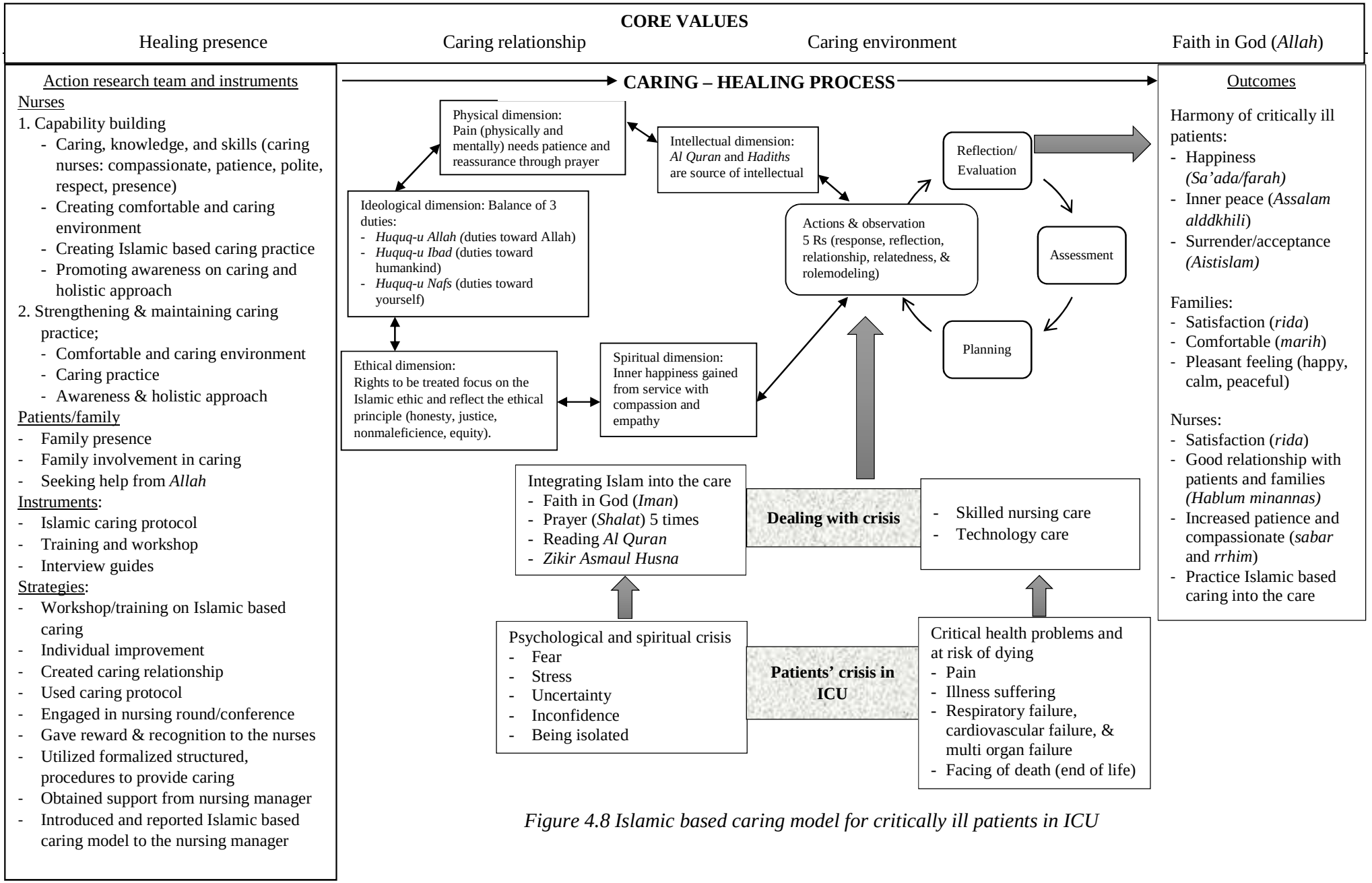


Figure 4.8 Islamic based caring model for critically ill patients in ICU

4. Discussion

The findings of this study were discussed under six topics: 1) the development of the Islamic based caring model, 2) the core values of the Islamic based caring model, 3) the caring-healing process, 4) the harmony of critically ill patients, 5) contributions to nursing knowledge development, and 6) lessons learned.

The development of the Islamic based caring model.

The nurses in the study began the process of model development with a nagging question that evolved from a practice situation in the ICU in their daily work. This model was developed based on the actual situation of caring practice and the desire of the participants for changes. The model components were described and the health outcomes as a result of the model intervention were also identified. This model was developed to enhance nurses' understanding of their nursing practice situations and their use of available health resources to improve the nursing practice in order to produce the expected health outcome.

The development of this model was guided by the Islamic caring theory developed by Barolia and Karmaliani (2008). The model is considered to be valuable for assisting Muslim patients and their families in critical situations by using a holistic approach. In this model, the nurses provide caring practice in order to meet the needs of the patients and families; covering the physical, psychological, social, and spiritual needs. The results of this present study with regard to meeting the needs of the patients and families were similar to those from the study of Al-Mutair, Plummer, Clerehan, and O'Brien (2014). Al-Mutair et al (2014) found that the needs for critically ill patients include assurance and information as well as cultural, spiritual, and social support. It is implied that Islamic based caring is concerned with the patients' and families' needs in

order to promote feelings of happiness during their time of crisis. Thus, in order to meet the clients' needs, the ICU nurses should practice continuous interaction and caring relationships with the patients and their families in dealing with their crisis situations (Buckley & Andrews, 2011).

Caring is considered an Islamic attribute in the Islamic teachings, so Islam underlines caring not only for humans but also for other creatures of the world (Rassol, 2000). The concept of caring for patients originates from the perception of caring as serving God (Allah). In Islamic religion, caring has a religious consequence that is followed by love of God and His Prophet (Bradshaw, 1994 as cited in Talegani, Alimohammadi, Mohammadi & Akbarian, 2013). In the concern of Islamic based caring, the recent study of Halligan (2006) found that the meaning of nurses' experience in caring for Muslim patients in Saudi Arabia highlighted three themes: family and kinship ties, cultural and religious influences, and the nurse–patient relationship (Halligan, 2006). The results indicated that the families' role, religion and culture were important in providing care. As were the beliefs and practices of Islam.

Core values of the Islamic based caring model.

The core values of the Islamic based caring model were derived from these findings as important influential concepts that guided or dictated the Islamic caring practice in this study. Four core values were identified: healing presence, caring relationships, caring environment, and faith in God.

Healing presence.

The practice of healing presence in the present study included touching, hand shaking, deep listening, attentive communicating, loving, and providing spiritual care. In promoting the healing presence, the nurses in this study were polite,

affectionate, generous, and considerate of others. The nurses also assisted by providing emotional and spiritual support to the patients and their families by truly being present with them. A healing presence contributes to the patient's health and well-being by using compassion and empathy throughout the nurses' presence (Koerner, 2007), and it is a practice that seems to be easily achieved through spiritual care.

Strategies used in the present study to facilitate a healing presence in a limited time included providing genuine attention and sincere communication when interacting with the patients and families. During every visit to the patients at their beds, the nurses paid attention to the patients rather than focusing only on the treatments and medical technology. Active listening, eye contact, and warm touches were used to convey their attention, concern, and love to the patients. In the Islamic context, touching tends to be performed only among the same sex and within families. Similarly with the present study, the nurses could not touch the patients or families who were members of the opposite sex. When the patients or families were given bad news, nurses of the same sex could touch their hands and hug them to give them a feeling of comfort. Touching is an integral part of the nurse-patient relationship, regardless of the cultural context (Halligan, 2006). Thus, the patients could feel that they were being cared for even with little physical presence. The healing presence brought calmness to the patients during their stay in the ICU. By engaging in this project and following the caring protocol, the nurses could perform the healing presence in their daily activities.

Caring relationships.

In this model, a caring relationship was considered a core value to promote healing effectively. A caring relationship is essential in facilitating health care team coordination and collaboration, and as a consequence, it leads to the client's health

and well-being (College of Nurses of Ontario, 2013). Building such relationships requires the nurses to meet the needs of the patients and their families. In fact, nurses need to use effective strategies to establish caring relationships. The strategies used in this context consisted of the nurses paying attention to the patients and their families, promoting a healing presence, listening enthusiastically to the patients and their families, and showing empathy and compassion both verbally and nonverbally. The strategies were easy to follow as the nurses frequently fulfilled the patients' needs in terms of daily nursing practice. The nurses who participated in this study claimed that the practice of cultivating a caring relationship in the already busy nursing routine was challenging and involved the art of relationship.

Moreover, the positive impact of the caring relationships between nurses and patients in this study was similar to the findings of a previous study in which the nurses developed and strengthened abilities to reflect over the good caring relationships they had developed with the patients (Bergdahl, Benzein, Ternestedt, & Andershed, 2011). From the patients' and families' views, a caring relationship can increase their trust and respect of the nurses as the nurses assist them with their hearts (Setiawan, 2010). In contrast, a caring relationship may bring unhappy experiences for the nurses, due to the lack of commitment to providing care, their lack of appropriate knowledge and skills, and a lack of commitment to respect others (Kitson, 2003). Kitson (2003) further explained that a lack commitment to provide care means that nurses were neither prepared nor able to provide a level of service that is required. Any lack of appropriate knowledge and skills might be due not just to a lack of nursing staff ability, but also to the patients' conditions that require a higher level of expertise and assistance. A lack of commitment to respect others was due to the caring relationships creating extra

pressure; if the nurses were unwilling to provide the care and manipulate the situation, then the caring relationship was in trouble. Even though the caring relationships might have positive and negative impacts, the nurses should be aware and be able to maintain the caring relationship in an objective and professional manner.

Caring environment.

Making a caring environment requires design elements and physical attributes that facilitate the healing process. The nurses in this study created a caring environment by maintaining a clean and quiet physical environment with appropriate lighting as well as good interpersonal relationships. They maintained adequate night lighting for observation of the pateints' conditions by the health care team members. The nurses ensured that a softened lighting option should be used in order to provide a more relaxed feeling for the patients and families. Additionally, they also organized appropriate cleanliness of the environment which was kept neat and free from odors, and the floors and windows were kept spotlessly clean. In a caring environment, the nurses understood the issue of interpersonal relationships to convey care and respect. This started from gathering and giving information at the time of admission, to responding to the patient's needs, and acknowledging the patients and their families when in need.

Furthermore, part of the attempt to make a caring environment was also to create a physical environment designed to support spiritual beliefs. It was expected that a spiritual care environment would have a positive contribution to the health and recovery of the patients comprised of diverse cultural groups of people. Thus, implementing the model in the ICU should include awareness of not disturbing others non-Muslim patients in the unit.

Previous studies supported the importance of a caring environment in this study. For example, the control of hospital odors can decrease anxiety and decrease heart and respiration rates (Rubert, Long, & Hutchinson, 2007). Appropriate lighting in the ICU promotes the relaxation of the patients (Stichler, 2001). Moreover, good interpersonal relationships (Felgen, 2004) and a spiritual environment (Kopec & Han, 2008) are part of a caring environment.

Faith in God.

In this study, the nurses acknowledged that Islamic faith in God related to a sense of peace, inner power, personal well-being, and hope in a crisis situation. Islamic faith plays a significant role in the caring and healing of Muslim patients. According to Islam, the concept of caring for patients originates from the perception of caring as serving God. The nurses were encouraged to practice faith by taking care of the critically ill patients and their families and by performing the 5 dimensions of the Barolia and Karmaliani's theory, which includes physical, ideological, ethical, spiritual, and intellectual dimensions. According to the theory, the nurses succeeded in keeping a balance among all dimensions through their caring practice. Consequently, harmony in the life of the critically ill patients was achieved. Then, from the patients' side, they were encouraged to practice their faith by performing prayers five times a day (*Shalat*), meditation (*Zikir),* and recitation of the *Al Quran* to maintain a balance of body, mind, and spirit through their faith in God. Moreover, the patients and their families in this study were also encouraged to be patient and sincere with the illness and risk of death by praying and asking for help from *Allah*. They also asked to accept the illness as atonement for their sins and death as a part of a journey to meet *Allah*.

Furthermore, it was not completely successful to apply faith in God in this study because of the nature of the ICU, which was in a setting of universal beliefs. Universal beliefs in this study means the policy and the system applied in the hospital are not based on any specific religion or culture. Thus, the hospital provided the clergy to help the patients and their families in supporting their faith in God. In this case, the participating nurse suggested integrating the spiritual needs into the nursing care and into the system.

In the Islamic religious framework, care has a religious consequence, which is to love God and the Prophet Muhammad, and this is what humans are supposed to do (Taleghani, et al., 2013). Muslims believe in the "Oneness of *Allah*" (Saeed, 2006) and through illness, they achieve purification of sins as well as increasing their faith in God (Sajid, 2009). *Shalat* is a way to communicate with Allah for Muslims and in doing so the patients get spiritual energy that has the potential to heal them (Henry, 2013). Therefore, faith in God in this model was an important value, as the sense of spirituality was sincerity towards God's will in dealing with a crisis situation. When the patients and families could followed this value, they increased the spirituality and balance of the body, mind, and spirit in their faith.

Caring-healing process.

In the Islamic caring model, the caring-healing process is the main process in dealing with a patient's crisis in the ICU. The process was derived from action research cycles and the 5 Rs according to Barolia and Karmaliani (2008). The nurses practice nursing through the caring-healing process for the patients and families in critical situations based on Islamic teachings. The actions of the 5 Rs were integrated

into the caring-healing process in a non-sequencing manner. The integration was guided by a caring protocol developed by the participating nurses in this study. Thus, it was feasible and practical in the study context. The findings from this study revealed that the nurses responded to the patient/family holistic needs covering the physical, psychological, social, and spiritual domains. The model also emphasized the interrelationships among the five domains of Islam through the process of response, reflection, relationship, relatedness, and role modeling (5Rs) according to the Barolia and Karmaliani theory.

The action research approach was used in the caring-healing process. It required five components in each cycle including assessment, planning, actions, observation, and evaluation. The nurses conducted patient assessments to seek all information regarding the physical, psychological, social, and spiritual aspects. The assessments were conducted both objectively and subjectively in order to obtain a set of data. The assessment was a systematic process of collecting and analyzing information on the patient's needs to identify the gaps between current and desired situations. The results were used to develop plans and strategies in each cycle. Assessments were also conducted by the nurses to record the patient's condition each time.

In order to implement the plan successfully, specific strategies were required to motivate and encourage the nurses to perform the caring actions and to achieve the health outcomes at the end; for example, create and maintain a comfortable and caring environment, create and maintain Islamic based caring practice, and promote awareness of caring and the holistic approach. During the planning step, the researcher and participants needed to consider both objective conditions (i.e. availability of

resources, time and space, and physical and material opportunities) and subjective conditions (i.e. expectations, relationships, and the ways people think now). Throughout the actions and observations of the caring-healing process, the nurses and the patients carried out the plan of care. The act of compassion in a caring relationship touched the patients physically, psychologically, socially, and spiritually to achieve harmony. In the action and observation phase, the researcher collected a variety of evidence on what happened regarding mutual observations and the realization of the opportunities and constraints the researcher and participants had planned. Concerning the actions, the researcher conducted observations in order to follow and evaluate the nurses in performing caring practice.

The evaluation of the caring-healing process included nurse caring behavior, patients and family satisfaction and their feelings, and the caring environment. The participating nurses were evaluated on their satisfaction with the model and their feelings towards the caring practice. The patients and families were also evaluated regarding the nurse caring practice and their satisfaction with the nurses' behavior in the caring practice. The evaluation of the process was conducted in each cycle of action research based on the planning and actions, which were customized. The nurses evaluated each patient's response to holistic care regularly and systematically. The ultimate outcomes of the caring-healing process in Islamic based care were explored qualitatively because harmony is rather abstract and has personal meaning. The evaluation phase revealed the nurses' efforts in caring practices were enabled in the setting.

Overall, in the action research cycles in this study, the researcher experienced some barriers related to time constraints, and not all nurses engaged in this

study. The researcher always reminded the nurses of their commitment to this study to consider their caring practice. In addition, the support system from the top nursing managers as policy makers was only mental support in the development of the model in the setting, as they were not directly engaged in the study process. As a result, the change created by this model was at a micro level and did not involve any structural change of the care system.

The response, reflection, relationships, relatedness, and role modeling (the 5Rs) in the caring healing process were linked to the actions and observations of the action research process. In the response, the researcher and the nurses responded to the needs of the patients and families. The findings from this study regarding the nurses' responses showed that the patients and families felt satisfied and comfortable, and they confirmed the trust and respect they had for the nurses. For the reflection, the nurses applied self-reflection through discussions and writing. Through their reflections, the nurses reported that they had not only enhanced their practice but also participated in the model development. They also stated that they had gained knowledge regarding the caring healing process in Islamic perspectives. In order to have a successful relationship with the patients, the nurses maintained their attention on patients and families by always listening to them, being present, and allowing the families to give traditional treatment based on Islam, such as honey and holy water. The patients and families felt a close, kind, and comfortable relationship with the nurses.

Moreover, relatedness was initially important in the caring practice in Islamic based caring. Relatedness refers to feeling connections with each other in social relationships. The feeling of connection among Muslims basically results from their strong family ties (Ramadhan, 2016). Concerning the relatedness in this study, the

nurses provided inner peace by expressing faith towards the patients and family and exhibiting friendliness, cheerfulness, and empathy for the patients and families. They strengthened the social connections by encouraging friends and family members to pray (*dua)* during their visiting hours. As a result of the relatedness, the patients and families felt closer to the nurses. Finally, role modeling in Islam refers to the way a Muslim gives good examples to other Muslims on what is good and honorable. The nurses in this study practiced caring regularly and showed the caring practice to the other nurses to inspire them to do the same, particularly for novices and young nurses in the setting. As a result, the young and novice nurses were encouraged and became more confident in practicing caring.

In the caring healing process, the spiritual dimension was necessary as it indicated the characteristic of a Muslim who is sensitive to the spiritual obligations in everyday life. Indeed, the spiritual dimension is the first priority in Islamic based caring, followed by the psychological, social, and physical dimensions. The healing process is centered on an attachment to God. *"Verily, God is the sole sustainer: possessed of night; the unshaken"* (*Al Quran* 51:58). The nurses and the clients required good understanding of Islamic concepts and the ways to apply them in the caring-healing process. In this study, the caring-healing process provides a context and structure for the nurses in critical care to provide Islamic based caring for Muslim patients holistically in a crisis situation. It creates a framework in which to refine and enhance as well as to describe and document Islamic based caring. The caring healing process integrates the practice of the healing presence, caring relationships, caring environment, and faith in God in providing care as the core values of the Islamic based caring model.

The nurses served and built mutual respect and had a shared commitment to the healing. The healing of the critically ill patients in the present study occurred as a result of the power of caring from the nurses and the power of faith in God of the patients. The nurses in this study focused on caring as a way in which the nurses interrelated with the patients, families and other health care members by paying attention and showing genuine interest in the inner needs of the patients and families. Caring helps in building positive relationships in which people have mutual experiences and are able to flourish and adapt proactively. The impacts of caring have been explored in many studies, including successful caring for people at the end of life (Iranmanesh, Abbaszadeh, Dargahi, & Cheraghi, 2009) and quality of caring in clinical practice, education, and leadership (Duffy, 2009). It is evident that caring on its own is a powerful component of healing (Dossey, et al., 2005). However, in the present study, the caring power of the nurses could be enhanced by God. The nurses believed in the existence of God who takes care of the patients in the curing of illnesses through the nurses' hands. The nurses always reminded, guided, and practiced Islamic rituals together with the patients and families. Therefore, the nurses in this study showed their pride and satisfaction in taking care of the patients and their families in a crisis situation.

In conclusion, the caring-healing process is a unique process as the individual regards to human dignity and develops relationships between the members of the healthcare team and the patients with a reliance on the power of caring and God in the process of healing to achieve harmony.

Outcomes.

The outcomes of this study were the satisfaction of the participants (nurses, patients, and families); the pleasant feelings of the participants; and harmony of critically ill patients.

Participants' satisfaction.

After implementation of the two-cycle action research, all parties felt satisfied with the implementation of the Islamic based caring model and the achievement of harmony in the critically ill patients.

Patients'/families' satisfaction.

This study revealed that both the nurses and the patients and families were satisfied in each cycle of the implementation of the Islamic based caring model and the caring behavior of the nurses in the practice of caring. The important aspects of caring in this study, as perceived by the families, included the presence of the nurses, offering health education and information sessions, offering sessions of prayer together, and providing good caring practice based on Islam. The findings were congruent with many existing studies indicating that caring increased the satisfaction of the patients and their families (Azizi-Fini, Mousavi, Mazroui-Sabdani, & Adib-Hajbaghery, 2012; Setiawan, 2010). There was evidence that Islamic based caring increased client satisfaction while they were dealing with their crises.

The accompaniment of a nurse with the patient and family during visiting hours was considered a kind of caring presence and resulted in the satisfaction of the patient and/or family in this study. According to Du Plessis (2016), a caring presence is an encompassing element in spiritual care as it begins with "being with" and the presence is the core variable of all the other characteristics of spiritual nursing

care. Therefore, the evidence supported the findings of this study that the nurses in their practice of Islamic based caring were enthusiastic at being with the patients and their families and exhinited their values such as compassion, empathy, respect, and concern.

Health education and information sessions were offered by the nurses in this study. In this way, the nurses provide knowledge to the patients and families regarding the patient's disease and its treatments. The information was important for the patient's self-understanding and health decision making, which led to satisfaction. According to Chien, Chiu, Lam, and Ip (2006), nurses are well placed to provide information about a specific illness to a family immediately following the admission of a patient into the ICU. Nursing interventions and their interactions with the patient's family members over the first few days of hospitalization could enhance the family's understanding of their loved one's condition and prognosis. In addition, the nurses provide informational and emotional support to help these families cope with any changes. The findings from this study also confirmed that health education and information sessions in the action research process provided improvements in the knowledge of the family, the nurse and patient/family relationship, and the patient/family's trust and respect towards the nurse.

Through the implementation of the Islamic based caring model, the patients and families were satisfied with the prayer sessions that were offered by and performed with the nurses. They believed that it was useful for the health of the patients and helped them obtain peace, which was conceptualized as the harmony of the patient and family. A study by Henry (2013) revealed that Islamic prayers can produce spiritual energy that may yield many psychological benefits, such as the amelioration of stress and improvement in subjective well-being, interpersonal sensitivity, and mastery.

Islamic prayers can be integrated into mainstream therapeutic interventions with Muslim patients. This integration can transform and invigorate the harmony of life.

An additional example of an Islamic intervention that the nurses provided in the ICU was recitation and reading of the *Al Quran* (Holy Book of Islam). The nurses invited the family members to conduct the session. For Muslims, the *Al Quran* is the source of Islam; everything is explained in the Holy Book, and it is one of the Islamic beliefs. In the *Al Quran*, there is healing for mankind's hearts as well as light and illumination for the blind. Allah says: "We send down of the *Al Quran* that which is a healing and a mercy to those who believe…" (*Al Quran*: al-Isra' 17:82).

The families moreover were satisfied with the nurse's caring practice according to Islam. For example, the nurses in the unit incorporated caring practices into their daily work starting with "*Bismillahhirrohmanirohim*" (in the name of *Allah*) and finishing with "*Alhamdulillah*" (All the praises and thanks be to *Allah*). These two words in Islam have power, because these words imply that Muslims rely only on *Allah* to help them. *Bismillahhirrohmanirohim* gives power, honor, satisfaction, and pleasure. In every effort, Muslims are asked to do, say, and grant endless good (Al-Hakkani, 2010). When a Muslim says '*Alhamdulillah'*, it implies exclusivity and entirety, meaning that praise is entirely and only for *Allah* (Amatullah, 2008). Therefore, by saying these words when the nurses implement nursing practice, it indicates that the nurse and patient are praying together to *Allah* to seek help in their daily lives.

Nurses' satisfaction.

The findings revealed that the nurses in the study obtained several benefits from and were satisfied with the model implementation. They gained good relationships with others and respect from others, including colleagues, patients, and

patients' families. In addition, their caring behavior also improved their communication skills and increased their sensitivity to the needs of the patients and families. These findings imply that implementation of Islamic based caring brought about their satisfying sense of feeling good and proud to be with the patients and families in critical situations. Numerous studies have shown that the implementation of caring into the nursing practice improves the nurses' satisfaction (Duffy, 2005; Kynoch, et al., 2011; Setiawan, 2010).

However, Beeby (2000b) found that nurses can also be frustrated in delivering care due to the rigors, constraints, and difficulties within the team. For nurses, the rigors of caring can include certain attributes of the patients and families that were difficult to manage, such as the inability to communicate, patient and family agitation, restlessness or violence. Time constraints also inhibited the nurses in the practical aspects of caring. A lack of time for the nurses in the ICU is the worst problem as their working days are filled with activities and procedures to perform regarding patient treatments. Difficulties within the team caused problems for the nurses in caring at times. Since numerous nurses lacked experience and were still young diploma nurses, it was difficult to provide caring because they were being trained as part of their job orientation in taking care of the patients. However, their strength was their openness and willingness to change.

This study also demonstrated that a caring relationship promotes professional accountability and professional growth opportunities. The nurses in the setting maintained nurse-patient relationships, practiced caring based on Islamic values in their daily work, and enhanced patient compassion. The findings from this study were consistent with a study by Mayasari (2013) who looked for the definition and

expression of caring using the 5 dimensions and 5 Rs of the Islamic caring theory (Barolia and Karmaliani, 2008). Mayasari (2013) asserted that the use of the model encouraged the nurses to demonstrate a caring expression in the clinical workplace. The outcome of increased nurse satisfaction was also consistent with that of a previous study by Glasson et al (2006) which evaluated nursing care provided during the implementation of the nursing care model. It is a lesson learned that Islamic based caring can increase the quality of nursing care for both nurses and patients/families.

Harmony of critically ill patients.

The harmony of critically ill patients in the present study is described as a balance of happiness *(Sa'ada/farah),* inner peace (*Assalam alddkhili*), and surrender/acceptance *(Aistislam).* The patient participants in this study embodied the concept of harmony as happiness *(Sa'ada/farah).* They felt happy in whatever condition they currently found themselves. They always believe that *Allah* will cure the physical sickness and offer them happiness in their life psychologically, socially, and spiritually as well as for their families. In Islamic perspectives, happiness refers to the state of balance of life. It is based on non-material concerns.

The holy *Al-Quran* provides knowledge of how to attain perfect happiness for both body and soul, both in this world and in the eternal Hereafter. *Allah* has said: "Whoever does good whether male or female and he is a believer, We will most certainly make him live a happy life, and We will most certainly give them their reward for the best of what they did." (*Al-Qur'an*, 16:97). In addition, the patients in this study believe in Allah through their faith, which gives them a feeling of strong support in critical moments and gives them continuous hope in life.

In the present study, the patients' state of inner peace was a result of their faith in God (Allah) by remembering of God (*Zikir*), offering prayer (*Shalat*), and reading/listening of Holy *Al-Quran.* The patients were seeking help from *Allah* beside the medical treatment that they should receive. The remembrance of God is that hearts find the inner peace (Philips, 2007). Allah says "Perform the prayer for My remembrance…" (Al-Quran 20:14). Allah also says in Al-Quran 6:162 "Indeed, my prayer, my sacrifice, my living and dying are for God, Lord of all the worlds." The remembrance of Allah in praying, living, and even dying brings the Muslims ultimately to accept God in their hearts and then find their inner peace.

Surrender/acceptance *(Aistislam)* was a kind of state of the harmony of life for the critically ill patients in this study. They accepted that they should surrender (*Aistislam*) and be pleased with whatever Allah had destined for them, thankful for all the good things in their life and with the patience to think positively. Allah says "And whosoever follows My guidance, on them shall be no fear nor shall they grieve." (*Al-Qur'an, 2:38*). "Truly, in remembering Allah do hearts find rest." (*Al-Qur'an, 13:28*). This made the patients feel that they was being observed by Allah every time and everywhere.

In achieving harmony for critically ill patients, the patients in the present study experienced four way of the maintenance of good connections: 1) with the self, 2) with others (nurses, family, and others), 3) with God, and 4) with the environment. The interrelationship of good connections of those components created a harmonious life. Similarly, these four ways implied that harmony was a result of the balance of the physical, psychology, social, and spiritual. The maintenance of good connection with the self implied the physical and psychological balance of the patients in critical

situations. The maintenance of good connection with nurses, family, and others implied social balance. Moreover, the maintenance of good connection with God implied the spiritual balance of the patients in dealing with their crises. Meanwhile, the maintenance of good connection with the environment implied that the patients accepted the environment around them sand its influence on the harmony of life. A Muslim lives in a way that reflects unity of body, mind, and spirit with *Allah*. It also implies that there is no separation of any components from God (Lovering, 2008). The unity of harmony in this study focuses on the relationship with *Allah*.

The harmony of life was achieved primarily through God centered healing. The caring of the nurses facilitated the healing. Thus, the nurses' role in this study was to serve as a motivator for the patients and families to effectively connect with God through the action of reshipment and practice according to God's guidance. The nurses in the implementation of this model also carried out the healing role that contributed to the harmony of the patients and families. Thus, the patients and families who were in a state of harmony had energy and resources available that would otherwise be squandered in fighting (Hatley & Ratliffe, 2006).

In the present study, the patients required faith in God for dealing with their crises. Faith in God means the possibility of a personal relationship through contact and communion with God (Levin, 2009). Muslim patients have faith in *Allah* as it gives them an inner peace, energy, and hope in the will of *Allah*. The nurses provided spirituality in the Islamic faith, such as prayer which could produce spiritual energy that might yield many psychological benefits, for example, reduced stress and improvement in subjective well-being (Henry, 2013). The Islamic faith is noted for offering holistic direction for a way of life that promotes health and harmony (Ohm,

2003). Harmony is significantly related to balance, peace, cooperation, agreement, and meditation (Garcia, Al Nima, & Kjell, 2014).

The findings from this study revealed that good connections with nurses, family and others were important for the critically ill patients to achieve harmony. The nurse-patient relationships in this study were congruent with several studies which have indicated the therapeutic power in healing of such relationships (Rafii, et al., 2008; Scott, et al., 2008). The nurses in this study were responsible for maintaining connections with other nurses, patients, family members, and others through the healing presence. The presence of a nurse was crucial to increase psychosocial support for the patients. The nurses' presence existed as both actual and potential and with a willingness to respond in an appropriate way (Ghobary Bonab, Miner, & Proctor, 2013). Thus, the healing presence of the nurses could serve as a bridge between patients and God in terms of maintaining spirituality in a critical situation in order to achieve harmony.

In addition, the families' presence in the ICU during treatment, such as treating life conditions, pain management, and recovery state, was important. By being present, the family could see the patient and seek information about the patient in order to ensure that their loved one was cared for. The importance of the support that comes from having family members present in the ICU has been reported in many previous studies (Garrouste-Orgeas, et al., 2010; Olsen, Dysvik, & Hansen, 2009). These studies have revealed that family presence in the ICU could help in providing emotional, social, and psychological support for the patients during a crisis situation.

Furthermore, everything in the ICU environment should be fashioned to support the healing of patients and help the nurses do their work joyfully in order to

produce a balance and achieve harmony among the nurses and patients/families. The Standards of Holistic Nursing Practice (1998) stated that the environment includes everything that surrounds the individual, both the external and internal, including physical, mental, emotional, and spiritual aspects. Ibn Abi Ad-Dunya narrated from Ibn ‘Umar that the Prophet said: "The most beloved people to Allah are the ones who bring the most benefit to people, and the most beloved deeds to Allah are making a Muslim happy, or relieving him of hardship, or paying off his debt, or warding off hunger from him” (Isgandarova, 2011).

In summary, harmony is a condition when a patient feels better in all dimensions of life as a human being. Islamic faith supports the Muslim patients to be strong in dealing with crisis situations as a result of the power of faith in *Allah*, and it creates a sense of happiness (*Sa’ada*/*farah*), inner peace (*Assalam alddkhili*), and surrender (*Aistislam*) in their life. Then, central to Islamic based caring is the connections between the self, nurses, family members, others, God, and the environment, so that the patients achieve the state of harmony of life.

Contribution to nursing knowledge development.

The Islamic based caring model was drawn up and implemented for critically ill patients at a Hospital in Semarang, Indonesia. The model was constructed based on the Islamic caring theory of Barolia and Karmaliani including 5 dimensions of Islam and the 5 Rs which were implemented in the ICU. This model provided components of Islamic concepts for nurses and their actions when demonstrating caring practice for critically ill patients. The nurses performed their nursing practices based on Islam under this theory and achieved harmony between the patients, family members,

and nurses. The model contributed to the development of nursing knowledge, in terms of empirical, ethical, aesthetical, and personal knowledge (Carper, 1978).

As for the empirical knowledge, the Islamic based caring model is a new caring model, which provides ways for critical care nurses to respond to the patients' and families' needs. The nurses made commitments to practice caring and showed continual interest in improving their nursing practices and professionalism. In the Islamic based caring model, the nurses endeavored to bring the Islamic concepts into the caring practice in dealing with patients in a crisis situation. This model required the nurses to interact with patients and family members regularly and closely, and enabled the nurses to create a strong caring relationship with them. Nurse-patient relationships developed during the study and through the implementation of this model in the unit.

The caring relationships in this study were maintained. As every patient had their own characteristics and needs, deep interactions with patients enabled the nurses to apply the 5 Rs of Islamic based caring in an aesthetic manner, which further improved the nurses' aesthetic knowledge. The caring relationships between nurses, patients, family members, and other health care providers constituted the art of effective communication in the limitations of time and critical situations. The nurses in this study maintained their boundaries in their caring relationships by respecting their clients and colleagues, providing good communication, and showing loyalty to their commitment to providing better nursing care for the patients and family members without exceptions. Hence, the patients and families felt that the connections with the nurses and other health care providers resulted in harmony. In addition, the nurses felt happy to express the beauty of caring moments through the caring relationships. By being

fully engaged in the nursing situation, the nurses in the unit actually comprehended the nature of caring as it related to the nursing practice.

Nurses' role in health service provision is as the members of the health system who are responsible for giving care to the patients based on ethical issues. This model supports the ethical issues. It supports the beneficence principle for the patients and their family members. This model also aligns with nurses' moral responsibility in caring practice in order to provide healing for the patients and families. Therefore, based on this theory, the nurses need ethical knowledge to conduct their appropriate function to manage the situations and to give safe care to their clients.

By applying the Islamic based caring model, the nurses transformed their personal knowledge in terms of their caring behavior and knowledge, and implemented these into their everyday practices. Strengthening the caring practice together with building and strengthening the leadership of the nurses, in the end, produced satisfactory results in the study. Nevertheless, some barriers still existed, for example, the young nurses or novice nurses need to increase their caring knowledge through training. Overall, however, the Islamic based caring model assisted the nurses in the unit by increasing their knowledge, caring practice, self-awareness, holistic approach, and development of caring relationships.

Lessons learned.

By conducting action research for the first time, the researcher gained valuable lessons and meaningful experiences. These emerged in all processes in each cycle, starting from the understanding of the situation in the unit and then continuing

through entering a research setting, starting the study, collecting and analyzing the huge amount of data, and finalizing the findings.

Lessons learned from conducting the action research.

The researcher conducted the study in the ICU, which by the nature of the setting, was a hectic environment with technological requirements. Understanding and exploring the problematic situations in the ICU was not easy. The researcher had to be proficient to see and find the linkages of problematic situations in the unit, including an uncomfortable environment, lack of caring practice, and the lack of a holistic approach. Conducting the research topic of caring based on Islam to achieve harmony in critically ill patients was challenging because of the abstract concept of caring-healing and the complexity of the problems with limited nursing resources. Thus, action research was a conceivable method to learn and explore the topic of interest. In addition, the researcher had no prior experience of conducting action research and was an outsider in the study setting. Hence, there were doubts and underestimations of the caring actions from the beginning of the project. However, with support from academic supervisors, nursing managers at the hospital, the chief of the unit, and the head nurse of the unit, together with positive participation from all parties, the researcher is convinced that this study was successful.

At the beginning of the research project, the researcher assumed that the nurses in the unit had both positive and negative views of their current caring situation. This Islamic based caring model answered the researcher's assumption that the nurses had positive views in caring practice and were able to change both their minds and the practices. Plans and strategies were set up in each cycle and remained to involve the participants in the unit to ensure productive teamwork. Arranging meetings with all the

parties in the unit was difficult due to time constraints. However, with coordination and understanding, the overall process of the study was properly achieved. Previously, the nursing practices in the ICU provided by nurses in the unit were based on routine work, and focused on the medical and technological aspects rather than on the understanding of patients as human beings. The nurses utilized the Islamic based caring model to guide Islamic spiritual care for integration into nursing practice, nurse-patient relationships, and the caring-healing process in order to achieve harmony for critically ill patients.

Some barriers in this study existed throughout the action research process. Some of the nurses seemed to lack a commitment and motivation for participation in this study due to a perceived heavy workload, personal interests, and a lack of work experience in the ICU. Due to the time constraints, some of the nurses resisted change.

Lessons learned from the researcher's self-development.

The initial intention of the researcher to conduct action research was to produce significant and suitable outcomes from the ICU and integrate local wisdom into the model development. In order to achieve the goals, the researcher placed great effort into the action in each cycle. Changes and improvements were promoted in the unit and throughout the whole process. The researcher and participants were trained to be problem solvers. In this way, action research was beneficial in introducing changes in the nursing practice, including action, coordination, and reflection, to be a caring-healing person for critically ill patients.

While conducting the whole process of this study, the researcher learned how to use various research tools in the appropriate way, such as interviews, FGD, field notes, and discussions. A huge amounts of data were gathered from the whole process,

which helped the researcher understand more about the qualitative analysis of data through codification and categorization techniques. The researcher gained experience from collecting the high volume of data, analyzing the data, and discussing the emerging findings from the qualitative data.

During the entire process of this study, the researcher experienced numerous challenges. For example, it was a challenge to develop plans, strategies, and actions in order to make adjustments and apply the model. The development of plans and strategies involved the nurses, family members, and the head nurse/chief of the unit. Therefore, different approaches were necessary in the development process in order to ensure that the actions would be approved. These experiences gave the researcher considerable self-development in areas that included system thinking, self-reflection, and relationships between participants and others. The advisor was helpful from the development process through to the end at the stage of writing the results and discussion. Therefore, the researcher was able to overcome the difficulties. Eventually, the journey of developing the Islamic based caring model in the ICU provided the researcher with many important professional relationships and inspired her to engage in continuous critical self-inquiry as a qualified nurse.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

This chapter presents the conclusion, nursing implications for the profession, research recommendations, and the limitations of the study.

Conclusion

This study was an action research, which aimed to develop an Islamic based caring model for critically ill patients. The goal of the study was to achieve the harmony of the critically ill patients. Two objectives were obtained: 1) the composition of an Islamic based caring model and 2) the ways nurses delivered the Islamic based caring model to foster the harmony of critically ill patients. This study involved 24 nurses, 14 patients, 14 families, and a physician. The research setting was an ICU in a public hospital in Semarang, Indonesia. The data were gathered from focus group discussions, interviews, field notes, observations, and the evaluation of other documents. Data analysis used qualitative content analysis according to Elo and Kyngäs (2008), which includes open coding, creating categories, and abstraction.

This present study includes two cycles in the action research, and each cycles consists of reconnaissance, planning, actions, observations, and evaluations. In the reconnaissance phase, the researcher identified: 1) the caring situation in the ICU; 2) nursing critical care practice in the ICU; and 3) Islamic based caring perspective in the ICU. The cyclic process development of the Islamic based caring model consisted of two cycles. Cycle 1 covered capability building: increasing awareness, knowledge, and improving practice. Cycle 2 focused on strengthening the caring practice for the sustainability of the Islamic based caring model.

The first cycle had two aims: 1) to build the capability of the nurses through increasing awareness and knowledge; and 2) to improve the caring practice based on Islam. Planning and strategies were drawn up by the researcher and participants which consisted of creating a caring environment, creating Islamic based caring practice according to Barolia and Karmaliani's theory, and promoting awareness of caring and the holistic approach. Furthermore, the actions phase integrated the five Rs (Response, Reflections, Relationship, Relatedness, and Rolemodeling) according to Barolia and Karmaliani's (2008) theory. In the evaluation phase, the outcomes were explored. The barriers identified in this cycle were the heavy workload, a lack of nurses' motivation for the practice, a lack of knowledge and skills of caring, and a lack of encouragement from other health care providers. Therefore, the researcher continued to the second cycle.

The second cycle aimed to strengthen caring practice for the sustainability of the Islamic based caring model. The researcher and the nurse participants developed a plan and strategies. The plan consisted of; 1) maintaining and strengthening caring practice and 2) maintaining and strengthening awareness and the holistic approach. The caring action followed 5 Rs according to the theory of Barolia and Karmaliani (2008). The evaluation in the end of this cycle explored ways of increasing the nurses' caring practice and the nurses' awareness and holistic approach. Overall, in the end of each cycle, suggestions were gathered from the participants and lessons learned by the nurse participants and the researcher were identified.

The implementation of the Islamic based caring model had significant impacts on the nursing outcomes. This study revealed that the nurses and families were satisfied with the Islamic based caring that was applied in the unit. Additionally, there

were positive changes in the caring environment and better relationships between nurses and patients, as well as between nurses and other health care team members. The ultimate goal of this study was to achieve harmony for critically ill patients in dealing with their crisis.

The Islamic based caring model was eventually created. The model was composed of four core values: healing presence, caring relationship, caring environment, and faith in God/*Allah*. To achieve harmony as the ultimate outcome, the Islamic based caring model required nurses, patients, and families to be involved in the caring-healing process. Several instruments were used to support the caring practice, i.e. Islamic caring protocol, training, a workshop for nurses, and evaluation forms.

The caring healing process is the nursing intervention applied when dealing with patients' crises in the ICU. The caring healing process includes assessment, planning, actions, observations, and evaluation. Meanwhile, the five Rs according to Barolia and Karmaliani were used as the nursing actions in this model. The outcome for patients/family and nurses were clearly identified and included satisfaction, pleasant feelings, good relationships, and more. As the harmony of critically ill patients was the ultimate goal in this study, it was defined as a sense of happiness (Sa'ada/farah), inner peace (*Assalam alddkhili*), and surrender (*Aistislam*). The harmony was gained through four ways of maintaining good connections with the self; nurses, family members, and others; God; and the environment.

Nursing Implications for the Profession

There were three nursing implications for the profession in the recent study: 1) for quality of care, 2) for nursing education, and 3) for nursing practice.

1. For quality of care, this study provided a good example of the use of standardized nursing care to practice caring for patients and families in the ICU. This model guided the nurses to provide Islamic based caring for Muslim patients hospitalized in the ICU. The model contributed greatly to improving nursing care and thus increasing the quality of nursing care in the critical care setting.
2. For nursing education, this study provided new knowledge on the systematic integration of Islam into caring for Muslim patients. The model highlighted the caring-healing role of the nurses who spent a lot of effort on utilizing both the power of their caring and on faith in God into healing for the critically ill patients and their families. The model also provided a comprehensive approach to integrate Islam into their caring practice. Thus, this model can be used as a basic theoretical framework for further research related to Islamic based caring. It is important to use this model in nursing education and to develop it in order to increase the body of knowledge in nursing science.
3. For the nursing practice, the nurses continued the caring practice, which required good relationships and communication between all parties in the ICU. The nurses are equipped with specialist-level knowledge and skills on caring, and they stand in an ideal position to provide the best nursing care for patients and families. However, the nature of the unit is dealing with critical situations, and the shortage of ICU nurses may cause difficulty in meeting clinical and

practical needs. Although, the Islamic based caring model needs further research for the complete success of its implementation in a situation with high demands on the quality of care, new perspectives on nurses' caring healing practice in the ICU have been provided through the application of this model.

Research Recommendation

The recent study has found some techniques of nurse Muslim values on the self-awareness in caring for patients and families in critical situations. Further testing of the Islamic based caring model is needed in order to examine the recommendations of the model in caring practice. Further study using the quantitative approach is recommended so as to compare and develop a valid caring model for caring practice in the Islamic culture. Stronger evidence is needed on the effectiveness of the model on specific groups and the opportunity to apply it in other settings.

Limitations of the study

This study was conducted in a public hospital in a city in central Java, so the application of this model may be limited to the study setting. The nature of the key participants in this study was mainly Diploma III level nurses with less than 5 years of work experience. This was indicated the nurses were young novice to dedicate to this study.

Muslims often seem to be a homogenous community due to their similar cultures, lifestyles, and beliefs, as they believe in the attachment of God in all dimensions of human being. Since the situation was specific in the ICU, this model

needs necessary modifications if it is to be applied into other contexts. The nursing strategies and planning for Muslim patients should be adjunct for particular needs such as end of life needs. The study also failed to include participants at a policy making level such as a manager of nursing or manager of human resources and development in this study. Therefore, necessary support for the model development and implementation has not been provided in terms of, for example, time allocation for the action research work, financial support for the action research activities such as training and workshops, or recognition given to the participants for their efforts in contributing to the improvement of the caring practice. Hence, expected changes in the ICU after completion of the study that require support at the policy level may not be achieved at a satisfactory level. This includes, for example, the need for the caring role of the nurses and the integration of Islam into their caring practice to be identified clearly in the job description of nurses. These changes require authority at the policy maker level; otherwise, the model implementation may not be successful.

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Appendix A-1

Demographic Data Form for Nurse Participants

Please complete the following questions using check sign (√) to help us know a little about you

1.	I am : Male (_____)	Female : (_____)
2.	I am _____ years old	
3.	I am a: Muslim (____)	
4.	I have been working as a critical care nurse for _____ years	
5.	I have earned: (_____) Diploma 3 (_____) Bachelor degree (_____) Master degree (_____) Doctoral degree	
6.	I have learned about caring from: (____) studying in nursing program (____) training/short course (____) discovering with colleague (____) reading articles (____) attending seminar/conference	

Appendix A-2

Demographic Data Form for Family Participants

Please complete the following questions using check sign (√) to help us know a little about you.

1.	I am : Male (_____)	Female : (_____)
2.	I am _____ years old	
3.	I am a: Muslim (____)	
4.	I am the patient's:	
	(_____) wife	(____) father
	(_____) husband	(____) mother
	(_____) daughter	(____) sister
	(_____) son	(____) brother
5.	Do you live with the patient?	(____) yes (____)
6	If no, on average how often do you see the patient in the hospital? (____) more than weekly (____) weekly (____) monthly	

Appendix A-3

Demographic Data Form for Patient Participants

Please complete the following questions using check sign (√) to help us know a little about you.

1.	I am : Male (_____)	Female : (_____)
2.	I am _____ years old	
3.	I am a: Muslim (____)	
4.	I completed the highest education level of : (___) senior high school (___) diploma (___) bachelor (___) other, please specify _____	
5.	I work as: (___) public service government (___) private sector (___) entrepreneurship (___) retired (___) I do not work	
6.	How many times have you been admitted to the ICU? (___) 1 time (___) 2 times (___) more, please specify _____	
7.	If you have ever been hospitalized in the ICU, did you have the same medical diagnose? (____) yes (____) no	

Appendix B

Interview Guide for Focus Group Discussion (FGD) and In-depth Interviews with Nurses

I would like you to describe your experience relating to Islamic based caring for critically ill patients in the ICU you belong to.

Questions:

1. How do you describe the situation of caring for critically ill patients in the ICU where you are working?
2. What are the problems inhibiting caring for critically ill patients in ICU?
3. What are the factors facilitating caring for critically ill patients in ICU?
4. How does Islam influence your caring practice for critically ill patients in ICU?
5. What does Islamic based caring mean to you?
6. How do you integrate Islam into your caring practice for critically ill patients in ICU? / How do you practice Islamic based caring for critically ill patients in ICU? Please give some examples from your own experience.
7. What are the expected health outcomes of Islamic based caring for critically ill patients in ICU?
8. What are the components in harmony of life for critically ill patients? Can you give the examples in your experience?
9. How does Islamic based caring promote harmony for critically ill patients in ICU?
10. How do you describe harmony of critically ill patients in ICU?

Appendix C

Interview Guide for Focus Group Discussion (FGD) and In-depth Interview with Families

I would like you to describe your experiences in obtaining Islamic based caring provided by the nurses in the ICU.

Questions:

1. How do you describe the situation of caring for critically ill patients in the ICU?
2. What caring actions do you obtain from the nurses and how do you like them? How do you feel about their caring actions? Please provide some examples.
3. From your view, what are the problems relating to caring for critically ill patients in ICU?
4. What does Islamic based caring mean to you?
5. How does Islam and caring promote the patients' harmony?
6. How do you describe the harmony of critically ill patients in ICU as a result of the caring provided by the nurses?
7. What should the nurses do to improve their Islamic based caring practice in order to fulfill the clients' needs?

Appendix D

Interview Guide for Family's Satisfaction with Islamic Based Caring in the ICU

This interview guide will be used for assessing the family's satisfaction of critical care nurse in Islamic based caring. There are 3 questions that will be asked to you.

Questions:

1. Do you feel satisfied with the caring provided by the nurse in the ICU? Why? Please provide some examples.
2. Do you feel satisfied with the nurse caring relationship in the ICU? Why? Please provide some examples.
3. What level of Islamic care is the nurse providing your family? Is the level low/moderate/high? Please provide some examples.

Appendix E

Interview Guide for Nurses' Satisfaction with Islamic Based Caring in the ICU

This interview guide was used for assessing the nurses' satisfaction in the implementation of Islamic Based Caring model. There are 3 questions that will be asked to you.

Questions:

1. Do you feel satisfied with the implementation of Islamic Based caring model in the ICU? Why? Please provide some examples.
2. Do you feel satisfied with the nurse-patient caring relationship in the ICU? Why? Please provide some examples.
3. What level of Islamic care are you providing your patients and their families? Is the level low/moderate/high? Please provide some examples?
4. What do you plan for maintain and sustain the Islamic Based Caring model for next time?

Appendix F

Observation Guide Nurse Caring Behavior

This observation guide used for assessing the nurse caring behavior (verbal and non verbal) in caring practice during the implementation of Islamic Based Caring model. Please give ✓sign on the box of listed below are things you might do or not.

Observation	Yes	No
Verbal caring behavior		
1. Introduce her or himself by calling the name to the patient or family members		
2. Call the patient's or family' name when interaction to the patient.		
3. Talk with patient politely using low intonation.		
4. Give an explanation before and after doing nursing intervention.		
5. Convey the overview of patient's health condition to the patients and the family.		
6. Give a general information to the patient or the family about the patient's state.		
7. Steady the patient or the family who have anxiety due to the patient's condition.		
Nonverbal caring behavior		
1. Discuss a problem or an issue of the patient that may make the family anxious.		
2. Accompany patient's families when they are visiting the patient.		
3. Show a caring touch frequently when interacting with the patient or family.		
4. Keep eye contact when interacting with the patient or the family.		
5. Give a nursing intervention to increase comfort physically and physiologically.		
6. Sincere pay attention to the patients and the family.		
7. Listen carefully to the patient and the family.		
8. Commit to care the patient as individual unique.		

Appendix G

Informed Consent Form

Dear Participants,

I am Suhartini Ismail. I am a Doctoral student of the Faculty of Nursing, Prince of Songkla University, Thailand. I am conducting a research study entitled **Development of Islamic based caring Model for Critically Ill Patients in the Intensive Care Unit in Indonesia: An Action research.** The aim of the study is to develop an Islamic based caring model for critically ill patients.

You are being asked to participate in this study. The information that is gathered from you will be kept confidential, no name will be published, and will only be used in a dissertation report. You are going to take part in four phases of the research process. In the first phase, you will be interviewed about personal information and your opinion of caring from an Islamic base. The interview time will take around 30 minutes. In the second phase, you will be an integral part of planning and collaborating in the action process. In the third phase you will asked to implement the planning from the second phase, and will be observed on what and how the model is implemented. In the last phase, you will be asked to conduct an evaluation to reflect on what we need to improve and revise in the model development. During the phases, I will obtain information from you by recording with a camcorder, recorder, or by using a camera to take any pictures, as well as filling in questionnaires. The information from the data gathered will be kept securely and there will be no publication without your consideration or permission. Moreover, during the interview or group meeting, you have the right to drop out or withdraw if you feel uncomfortable with, or feel unhappy to participate in this study. I guarantee there will be no effect on the service or treatment that you have.

If you have any questions about this study, I am willing to provide more information. You can ask me to come and see you anytime, and freely call me on my phone number (+6281288439996).

Thank you for your kind cooperation.

Suhartini Ismail

For those who are willing to participate in the study (nurse/patient/family)*,

I have understood the explanation, and acknowledge that I will provide detailed information. Therefore, I decide to take part in this study. I agree to be interviewed, observed, fill in questionnaires, or conduct any implementation as you have explained in the each phase. I do hope my participation will result in noble findings for your study.

Participants

_____

Date …. /month ….. /year …..

Note:

**please circle according to your position as participant*

Appendix H

Proposal Workshop on Islamic Based Caring for Critically Ill Patients

Background

Caring is important in nursing practice. Research evidence supports that caring could improve quality of care (Setiawan, 2010), increase nurse-patient/family relationship (Kongsuwan, 2011; Kynoch, Paxton, & Chang, 2011; O'Connell & Landers, 2008); and even improve a patient's health as caring requires the presence of nurse to be with the patients and to listen to them (Azizi-Fini, Mousavi, Mazroui-Sabdani, & Adib-Hajbaghery, 2012). In ICU however, caring practice needs improvement in order to change the practice and apply caring in the critical situation for a patient and his/her family. The researcher found 3 problematic situations of caring in the ICU: 1) uncomfortable environment; 2) lack of caring practice; and 3) lack of awareness on holistic approach. Therefore, follow up is needed to change the environment, practice, and awareness in caring. In this project, Islamic based caring was the pinpoint to develop a nursing model. Based on the data gathered, some problems related to caring existed in the setting, such as lack of knowledge and awareness to practice caring. Therefore, in order to refresh and increase a nurse's knowledge about caring and Islamic based caring, the researcher held a workshop on Islamic based caring for critically ill patients.

Objectives

After completing this workshop, the participants will:

1. Gain knowledge about caring and Islamic based caring
2. Understand action research process
3. Develop caring protocol
4. Understand how to change practice

Date & Time: April 12, 2014 from 08.00 a.m. – 15.00 p.m
Venue: Aula of Kariadi Hospital
Participants: Nurses in Kariadi Hospital

Speakers:

1. Dr. Mark Donald Renosa (Faculty of Nursing, St. Paul University, Philippines)
2. Suhartini Ismail, SKp, MNS (PhD Candidate, FoN, PSU)

Topics:

- Quality of nursing care through nurse caring relationship
- An overview of participatory action research
- Islamic based caring for critically ill patient

Tentative schedules

Time	Activities	Speakers	Methods
08.00 – 08.30	Registration	Committee	
08.30 – 09.00	Opening	Committee	
09.00 – 11.00	1. Quality of nursing care through nurse caring relationship 2. Action Research	Mark Donald Renosa	Lecture & discussion
11.00 – 12.45	3. Islamic based caring	Suhartini Ismail	Lecture & discussion
12.45 – 13.15	Break (lunch & prayer)	Committee	
13.15 – 15.30	Workshop: Caring protocol	Mark Donald Renosa Suhartini Ismail	Group work & discussion

Evaluation

Process

Before taking action, to provide, refresh, and improve nurses' knowledge on caring for critically ill patients, the researcher collaborated with the director of the nursing service to run a one-day caring workshop sharing knowledge and experience, for all nurses in the unit. However, some nurses could not participate in the workshop as some of nurses needed be on duty. The invited speaker in the workshop was Dr. Mark Donald Renosa from St. Paul University, Philippines. He is an expert in nursing caring and had been working as an ICU nurse for almost 10 years. He gave a lecturer on the "quality of nursing care through the nurse caring relationship", and "an overview of participatory action research". In addition, the researcher shared about caring based on an Islamic perspective. This workshop was presented to 80 nurses, including those on the medical ward, surgical ward, pediatric ward, critical care unit, emergency department, operating room, and hemodialysis unit, and lecturers from the School of Nursing Diponegoro University. In the workshop session, the participants were asked to draw up a caring protocol based on the Islamic perspective and caring theory. The caring protocol will apply to their situation in the ICU.

Outcomes

Outcomes have been made based on the evaluation form that was created by the researcher. The evaluation form was composed of open questions that related to the participants' satisfaction of the workshop and what they learned from the activities. Most of them stated that they were satisfied and had gained knowledge about the caring theory, Islamic based caring, and the impact of caring in nursing care. Moreover, they recognized action research as new knowledge in research methodology.

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Appendix I

Application of Islamic Caring Theory in Nursing Care with a Patient in ICU

Islamic Caring Theory	Nursing activities
Physical Dimension	- Pain management - Piety/cleanliness - Prevent/control infection
Ideological dimension	- Concern of duties toward Allah - Concern of duties toward self - Concern of duties toward mankind
Ethical dimensions	- Non maleficence - Justice - Honesty
Spiritual dimension	- Give an inner satisfaction/inner peace - Do human bounding/connectedness - Show compassion to the patients and family - Show empathy - Encourage patient and family to have patience
Intellectual dimension	- Apply knowledge related to pathophysiology of diseases - Apply knowledge related to Islamic caring

Case:
Mr. J, 65 years old, was admitted to ICU at 08.30. He reported that he had chest pain last night, which woke him from his sleep. The pain started at around 02.00 a.m. He thinks it lasted about 20–25 minutes. He reported that he felt sweaty during the pain. He did not want to bother anyone so he rested and the pain eased. He reported that it was very painful and therefore wanted to get it checked. He has been a smoker for the past 40 years. On average, he has around 10 cigarettes a day. He has no past medical history of chest pain, ischemic heart disease or heart failure.
On admission at 09.00 a.m. his heart rate was 85 beats per minute (bpm) and his blood pressure was 127/80 mmHg. A nurse conducted an initial assessment. He is currently not in any pain, although he feels quite tired. ECG recorded ST depression. Normal sinus rhythm.

Nursing Diagnosis: Acute pain due to the imbalance of supply and demand of oxygen in blood circulation

Subjective data:
- He reported that he had chest pain last night, which woke him from his sleep
- He reported that it was very painful and therefore wanted to get it checked
- He said the pain started at around 02.00 a.m. He thinks it lasted about 20–25 minutes

Objective data:
- RR 85 bpm
- BP 130/80 mmHg
- Pain scale 4
- He looked tired
- ECG recorded ST depression, normal sinus rhythm.

Nursing Intervention and Implementation:
Physical dimension:
1. Pain management:
    - Assess if the chest pain may be cardiac. Consider history of the pain, any cardiovascular risk factors (smoking), history of ischemic heart disease and any previous treatment, previous investigations for chest pain.
    - Observe nonverbal expression to see if patient is uncomfortable
    - Use good communication to assess patient's pain experience.
    - Provide a comfortable environment for patient
    - Teach patient to do pain management non-pharmacological: listen to Islamic music, *Zikir*.
    - Collaborate for giving pain medication
2. Cleanliness and Preventing infection:
    - Wash hands before and after performing the treatment on the patient
    - Tell the family to limit the number of visitors
    - Clean equipment after use on the patient
    - Use gloves, mask and protective clothing to prevent infection
    - Instruct the patient's visitors to wash hands coming into and out of ICU.
    - Disinfect the aseptic area before performing actions as invasive collaboration
    - Monitor signs of infection
    - Monitor vital sign
    - Monitor numbers of leukocytes

Ethical dimension
- Give explanation to the patient about all the treatments that the patient gets, the benefits, side effects, etc.
- Give time to the patient to listen to any complaints
- Tell the truth about his pain and ask about any recent pain

Spiritual dimension
- Respect what the patients believe
- Ask the patient about his spiritual needs
- Encourage the patient to perform his usual rituals, such as prayer, *dua*
- Give inner satisfaction/inner peace by providing for patient's spiritual needs
- Do human connectedness based on Islam
- Show compassion to the patients and family as like family
- Show empathy to patient and family
- Encourage patient and family to be patient in facing suffering

Intellectual dimension
- Give information to the patient/family about the patient's disease
- Teach patient/family to manage pain (*Zikir*, praying)
- Teach patient/family to manage a healthy lifestyle
- Encourage patient to apply his belief (Islam) in taught situation
- Guide patient to do spiritual activities such as praying.

Ideological dimension:
The ideological dimension is integrated in all the nursing activities in each dimension.

Evaluation: (SOAP)
Subjective:
- Patient did not have complain about pain

Objectives;
- Pain score was less → 4
- Facial expression was calm and peaceful
- No sign of infection
- Blood pressure 127/80 mmHg, RR 28 bpm, Pulse 80 bpm, T 37^0 C
- No sign of redness on skin and clean
- Patient understood about his disease and having a healthy lifestyle

Analysis
Data show that pain can be managed. Based on the data of an ECG patient with acute myocardial infarction that causes pain in the cardiac region because the supply and the demand for oxygen in the cardiac system increased. The increase of the demand for oxygen is because there is a thrombus that obstructs the blood circulation in the cardiac system.

Planning
- Control pain frequently by measuring pain scale
- Monitor vital signs and change of ECG recorded
- Give patient time to rest by limiting the visitors
- Provide calm environment
- Give patient spiritual care to make him feel at peace
- Collaborate with the physician about cardiovascular drugs

Appendix J

Learning and Translating of Theory into Islamic Based Caring

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
<u>Cycle 1:</u> Capacity building: Increasing awareness, knowledge, & improving practice Aimed: 1. To build capacity of nurses through increasing awareness, knowledge 2. To improve practice of caring based on Islam 3. To improve caring environ-ment	1) Creating comfortable & caring environment - Control over the noise - Control over the lights in the unit - Provide clean environment and personal hygiene 2) Creating Islamic based caring practice <u>Physical dimension,</u> managed: - Airway, breathing, circulation - Pain - Sleep - Nutrition & electrolytes - Personal hygiene - Elimination	- Workshop/ training on Islamic based caring - Individual improvement: understanding self & situation; self-education - Created caring relationship with a good connection & communication to the patients & families - Used caring protocol to guide practice of Islamic caring - Engaged in nursing round/ conference	- Responded to the patients' & families' needs quickly - Responded to relieve pain & suffering of the patients through Islamic intervention - Supported patients & families in decision making - Connected the patient to the Muslim cleric in the hospital	Practiced reflection: Writing/ discussing; positive reflection; or dialogue/ narrative on caring and issue in some cases	- Paid attention on patients & families - Intensively listened to the patients & families - Allowed families to provide traditional treatment based on Islam (honey, holy water, & water that give from Muslim scholars) - Promoted healing presence	- Inner peace through expressing faith to the patients & families - Facilitated human bonding/ connectedness - Showed compassion to the patients & families - Showed empathy/ provide understanding - Encouraged patients and families to be patient - The nurse was friendly, cheerful, & had empathy for patient & family.	-Practiced Islamic based caring such as compassion, presence, connectedness, & openness) to patient, family & others <u>Between nurses:</u> - Encouraged staff to use caring protocol/ guidelines - Contributed to create caring environments - Showed others how to achieve goals - Inspired young nurses to practice caring	Nurse Caring behaviors. - Nurse called the patient's or family's name when interaction with the patient. - Nurse talked to patient politely - Nurse showed attention to the patient & family - Nurse used caring touch where appropriate - Some nurse had uncaring behaviour e.g. failed understand patient needs Nurse-patient relationship; Nurse gained capabilities: - Gained good relationship with others - Respected to others (colleagues, patient, family)

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
	- Mobilization & comfort <u>Spiritual dimension</u> - Provided time for prayers (5 times & additional prayer) - Encouraged patient to do meditation '*Zikir*' - Allocated space & arranged a plan to pray with patient - Allowed to recite & listen to the *Al Quran* - Expressed faith through being patient <u>Intellectual dimension</u> - Gave information to patients/ families about the patient's disease, condition, & treatment	- Provided holistic environment						Patients/families: - Felt happy & satisfied with nurse's behaviours - Participated in intervention of Islamic spiritual care (prayer, *Zikir*, & read *Al Quran*) - Satisfied with nurse's response (kindness, sincerity, & help) - Felt comfortable Environment: - allocated space for family to be with the patient - allocated time to the family to apply Islamic ritual in critical situation - Unimportant lights were switched off, particularly at night time (observation). - Cleanliness of patient & environment. Facilitating factors: - Nurse was motivated to

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
	- Enabled patient/ family to manage pain, fear, anxiety based on Islamic belief - Assisted patient & family to understand current situation, health, & illness according to Islamic belief. <u>Ethical dimension</u> - Respected decision making of patient & family - Cooperated with a physician to tell diagnosis and treatment plan to family if needed - Treated patient with respect & fairness							change behaviour & environment - Nurse to nurse relationship - Nurse-patient/family relationship - Emotional support from nursing team leaders Barriers: - Too much work - Lack nurse's motivation of the practice - Time consuming - Lack of knowledge and skills of caring - Lack of encouragement from other health care providers Suggestions: - Improve leadership & have a good team work - Manage time more efficiently - Engage in caring based on Islam - Evaluate an Islamic intervention through patient's response.

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
	<u>Ideological dimension</u> - Caring for self - Caring for others (colleague, patient, family) - Caring for God 3) Promoting awareness on caring and holistic approach - Raised nurse's awareness of caring - Created and discovered social support and social interaction for patient and family.							- Improve knowledge, skills, & behaviour based on Islamic values Lesson learned: Nurse: - Learned something new (nursing knowledge, caring theory, Islamic though) - Understood to do caring practice based on Islam - Excited to provide Islamic spiritual care for patient in the critical situation Family: - Gained knowledge about caring for patients - Understood caring based on Islam

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
Cycle 2: Strengthening caring practice for sustainability of the model Aimed: To strengthen caring practice for sustainability-of Islamic caring model.	Maintaining and strengthening comfortable and caring environment - Strengthening caring and comfort environment - Allocating space for applying Islamic spiritual for patients and families Maintaining & strengthening caring practice: - Continuing the plan as the plan in cycle one Maintaining and strengthening awareness and holistic approach: - Sustaining holistic environment - Maintaining the use of holistic approach	- Gave reward & recognition to the nurses who had a good caring relationship - Utilized the caring protocol - Obtained support from nursing manager in the unit or hospital - Introduced the model to the nursing manager - Reported the results of the study to the person in charge regularly - Strengthened of caring practice - Built & strengthened leadership of the nurses	- Promoted spiritual care for patient & family in critical situation - Improved interpersonal communication & inter-relationship based on Islamic values - Allocated time & space for group spiritual care - Recognized the connected-ness of body, mind, & spirit of patients/ & families through Islamic intervention	Practice reflection: writing/ discussing; dialogue/ narrative Reflected on Islamic values for humanity: - Life (*Al-Nafs*): provide a healthy body to lead a purposeful life. - Religion (*Al-Din*): for providing guidance, peace, tranquillity, comfort and purpose in life. - Intellect or knowledge (*Al-Aql*): the intellectual nature of man is made up of mind or intelligence	- Maintained relationship: nurse to nurse, nurse to patient/family, & nurse to other health care team in providing better Islamic based caring - Enhanced empathy and compassion: nonverbal communication skills - Enhanced empathy and compassion: verbal communication skills	- Maintained: friendly, cheerful, & empathy to the patient & family - Enhanced and maintained a sense of belonging of holistic environment	- Practiced & established Islamic based caring for patient/ family and other: such as compassion, presence connectedness, & openness for patient & family - Assisted young nurses to ascertain their motivation to practice Islamic based caring	Nurse caring behaviours: - Satisfied on their job - Gained Islamic based caring knowledge - Maintained nurse-patient relationship - Practiced caring based on Islamic values in daily work - Enhanced patient & compassion Patient/family: - Enhanced their satisfaction - Felt comfortable - Enhanced nurse patient/family relationship - Trusted & respected to the nurse Environment: - Cleanliness & comfortable space for patient & family - Quiet & soothing environment - Friendly, cheerful, smiley from staff

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
	- Focusing on healing process for patient	- Maintained regular meetings every 3 weeks - Provided workshop on caring for nurse leaders		or reasoning power. - Family life (*Al Nasab*): family life as the very heart of society - Wealth (*Al Mal*): wealth is obviously a fundamental human value				- Staff practiced Islamic based caring sincerely & compassionately - Limitation in space allocation and arrangement due to patient's condition (such as many equipment, critical situation) Facilitating: - Having a good emotional support from chief of unit - Support given to nursing care team - Support given to individual nurse to facilitate them to grow - Good relationship among team work - Having caring protocol based on Islam Barriers: - Heavy workload - Time constraint

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
								Overcome the barriers: - Impressed nurses' effort and keep relationships good - Impressed the lesson in all experience, even those that appear negative - Gave rewards to the nurse who practiced good caring - Required involvement of top managers for solving the barriers Suggestions: - Integrated Islamic based caring into practice into daily work. - Interventions such as prayer, read *Al Quran*, etc. should integrate in the nursing care plan - Maintain interventions to harmonize of body, mind & spirit of patient in the critical situation

Cycle	Plans	Strategies	Actions					Evaluations
			Response	Reflection	Relationship	Relatedness	Role Modelling	
								Lesson learned: - Maintained strong relationship among nurses and clients - Maintained a confidence to practice Islamic based caring - Changed practice of caring - Satisfied on collaborative with other health care providers and all parties (nurses, patients, families) - Spent a lot of time in the ICU to connect with key participants.

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RSUP Dr. KARIADI
Sahabat Menuju Sehat

SURAT IZIN
MELAKSANAKAN PENELITIAN

DL.00.02 / I.II / 1854 / 2014

Yang bertanda tangan di bawah ini :

Nama	:	Dr. Agus Suryanto, Sp.PD-KP, MARS
N I P	:	19610818 198812 1001
Jabatan	:	Direktur SDM dan Pendidikan RSUP Dr. Kariadi

Memberikan ijin melakukan penelitian untuk :

Nama peneliti	:	Suhartini Ismail, S.Kp, MNS
Institusi peneliti	:	Universitas Diponegoro (Program Studi Doktor Ilmu Keperawatan)
Judul Penelitian	:	Development of an Islamic Based Caring Model for Critically Ill Patients in the Intensive Care Unit Of Kariadi Hospital, Semarang, Indonesia : Participatory Action Research
Pembimbing	:	1. Assist. Prof Dr.Urai Hatthakit, RS 2. Assist. Prof. Dr. Tippamas Chinawang, RN
DPJP	:	–
Lokasi penelitian	:	Instalasi Rawat Intensif (ICU)

untuk melaksanakan kegiatan penelitian selama ± 6 Bulan.

Peneliti wajib melakukan :
1. Informed Consent dilampirkan pada rekam medis responden
2. Laporan monitoring evaluasi penelitian secara periodik
3. Laporan selesai penelitian dengan menyerahkan monitoring evaluasi penelitian
4. Menyerahkan laporan hasil akhir penelitian (1 berkas)

Semarang, 08 JUL 2014

An. Direktur Utama
Direktur SDM dan Pendidikan

Dr. Agus Suryanto, Sp.PD-KP, MARS
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KOMISI ETIK PENELITIAN KESEHATAN (KEPK)
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ETHICAL CLEARANCE
No.313 /EC/FK-RSDK/2014

Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Universitas Diponegoro- RSUP Dr. Kariadi Semarang, setelah membaca dan menelaah Usulan Penelitian dengan judul :

THE DEVELOPMENT OF AN ISLAMIC BASED CARING MODEL FOR CRITICALLY III PATIENTS IN THE INTENSIVE CARE UNIT IN INDONESIA; PARTICIPATORY ACTION RESEARCH

Ketua Peneliti	:	Suhartini Ismail, S.Kp,MNS
Pembimbing	:	1. Assist. Prof Dr. Urai Hatthakit, RS 2. Assist. Prof. Dr. Tippamas Chinawong, RN
Penelitian	:	Dilaksanakan di Ruang ICU RSUP Dr. Kariadi Semarang.

Setuju untuk dilaksanakan, dengan memperhatikan prinsip-prinsip yang dinyatakan dalam Deklarasi Helsinki 1975, yang diamended di Seoul 2008 dan Pedoman Nasional Etik Penelitian Kesehatan (PNEPK) Departemen Kesehatan RI 2011

Peneliti harus melampirkan 2 kopi lembar Informed consent yang telah disetujui dan ditandatangani oleh peserta penelitian pada laporan penelitian.
Peneliti diwajibkan menyerahkan :
- Laporan kemajuan penelitian (clinical Trial)
- Laporan kejadian efek samping jika ada
- Laporan ke KEPK jika penelitian sudah selesai & dilampiri Abstrak Penelitian.

Semarang, 23 MAY 2014

Komisi Etik Penelitian Kesehatan
Fakultas Kedokteran Undip-RSUP Dr. Kariadi
Ketua

Prof.Dr.dr.Suprihati, M.Sc, Sp.THT-KL(K)
NIP. 19500621197703 2 00

VITAE

Name Mrs. Suhartini Ismail

Student ID 5510430009

Educational Attainment

Degree	Name of Institution	Year of Graduation
Bachelor of Nursing	Universitas Indonesia	2001
Master of Nursing	Prince of Songkla University	2010

Scholarship Awards during Enrolment

- Directorate of Higher Education Scholarship, Ministry of Research and Technology, Indonesia Goverment
- Thesis funding Graduate School Prince of Songka University

Work – Position and Address

Lecturer in Nursing School, Adult Nursing Departement, Emergency and Critical Nursing Division. Faculty of Medicine Diponegoro University. Kampus Universitas Diponegoro, Jalan Prof. H. Soedarto, S.H. Tembalang, Semarang. Email: titin_yayub@yahoo.com.

List of Publication and Proceeding

1. Ismail, S., Hatthakit, U, & Chinawong, T., *Islamic based Caring in Nursing Science; A Literature Review* (proceeding). Oral presentation at AASIC 3, Chulalongkorn University. Mei, 2015
2. Ismail, S., Hatthakit, U, & Chinawong, T., *Caring Science within Islamic Contexts; A Literature Review* (proceeding). Oral presentation at 3rd Java International Nursing Conference, Diponegoro Universtiy. September 2015.
3. Ismail, S., Hatthakit, U, & Chinawong T., (2015). Caring Science within Islamic Contexts: A Systematic review. *Nurse Media Nursing Journal*, 5 (1), 34-47.