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Original Article

Family Involvement Strategies on Health Outcomes of Critically Ill Patients in Hospitals in Africa- A Scoping Review

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Family Involvement, Family-Centred Care, ICU, Patient Outcomes, Surrogate Decision-Making, Critical Illness, Family Support.

ABSTRACT

Background: Critically ill patients, especially intubated, sedated, or delirious patients lying in ICUs, may not be able to express their care needs. For these specific patients, family participation in care has been recognised as a fundamental component of patient-centred care. Nonetheless, the effects of specific family participation approaches on these patients are a relatively unexplored area of research. Answering to these unsatisfied needs, family-centred care (FCC) frameworks have been elaborated on with the inclusion of family members in decision-making processes and emotional support in the care. Objective: This scoping review seeks to examine the family participation approaches researched in ICUs and their effects on patients' outcomes, particularly on their mental and physical health. It aims to synthesise the existing knowledge, identify the evidence gaps, and propose directions for future studies. **Methods**: In accordance with the PRISMA-ScR protocols, a systematic search for the period between 2016 and 2025 was carried out in the PubMed, CINAHL, and Scopus databases. The search focused on peer-reviewed studies for the inclusion of family participation in the ICU care and family participation on health outcomes. Key themes, methodological approaches and gaps in the literature were identified through data charting and synthesis. **Results**: The strategies of family involvement in African ICUs were dominated by information sharing, involvement in decision making, emotional and psychosocial support, and closeness to the patients. Organised family practice was related to less anxiety, enhanced emotional stability, and enhanced care experiences. Implementation was, however, mainly informal and inconsistent, and there was little evidence to indicate how family involvement supported direct clinical outcomes. **Conclusion**: These results suggest that family engagement is useful to seriously ill patients largely via psychosocial mechanisms, yet its applicability in African ICUs is restricted by the presence of dysfunctional communication, subordinate care societal cultures, staffing issues, and formal frameworks of family-centred care. More studies are required to come up with context-

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appropriate models, as well as to evaluate their effects on psychosocial and clinical outcomes

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INTRODUCTION

Critical illness is one of the greatest health system burdens in the world, and intensive care units (ICUs) are meant to offer life-sustaining care to patients with severe and in many cases life-threatening conditions like respiratory failure, cardiovascular collapse, and multi-organ dysfunction (Marshall et al., 2017). Critical care medicine has advanced, which means that patients can now survive, but such treatments often leave patients incapable of making decisions, communicating, or sharing their values and preferences owing to sedation, mechanical ventilation, and the high incidence of delirium (Schwartz, 2022). In turn, the issue of critical care is becoming more and more multidimensional, with the addition of ethical, emotional, and relationship aspects associated with decision-making and patient autonomy (Gunnlaugsdóttir, 2024).

Globally, the awareness of patient-centred care in the ICU is increasingly spreading beyond the context of the single patient to include the family members, in cases when the decision-making capacity of the latter is lacking (Olding et al., 2016). The family members tend to be surrogate decision-makers, offering important data about the medical history of the patients, their values, and end-of-life preferences (Schwartz, 2022). As a response to these realities, Family-Centred Care (FCC) has become one of the influential models in the practice of critical care. FCC focuses on the cooperation between the healthcare professionals and family members, including relatives, in planning, communication, and making decisions in care so that the provided care would be as close to the values and best interests of patients as possible (Schmollgruber, 2019; Schwartz, 2022). The high-income settings evidence reveals that effective family engagement in the ICU care has been linked to improved patient outcomes, such as a decrease in anxiety, improved recovery, and general care experience of the patients and their families(Dijkstra, 2023; Dijk, 2023).

In the low- and middle-income countries (LMICs) and on the regional level, the adoption of FCC in the ICUs is uneven and context-specific (de Beer & Brysiewicz, 2017; Gunnlaugsdóttir, 2024). The issues in healthcare systems of such settings are usually the shortage of personnel, insufficient

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training on the family-centred approach, excessive patient-to-provider ratios, and the restrictive institutional policies denying the family presence and involvement (Gunnlaugsdóttir, 2024). Further, sociocultural expectations have a great impact on family-related expectations regarding healthcare decisions. Families in most African settings are at the centre stage in health-related decision-making processes, in some instances taking the mandate in the selection of treatment, whereas in other situations, leaving all the decision-making to healthcare personnel (de Beer & Brysiewicz, 2017; Kehali et al., 2020). The dynamics may complicate the communication process, lengthen the decision-making process, and cause emotional distress among family members and care teams when there are no specific guidelines on how to engage with each other (Noman, 2025).

In the local settings, family involvement in ICU units in resource-strained hospitals is often informal and inconsistent and not well documented (de Beer & Brysiewicz, 2017; Kehali et al., 2020). Although the family members are usually supposed to offer emotional support, information, and surrogate decision-making, little is structured as to how families ought to be approached, assisted, or involved in the process of care (Schmollgruber, 2019). Consequently, family members might become confused, anxious and psychologically distressed, whereas healthcare providers might be affected by ethical dilemmas, conflicts and delays in making critical decisions, especially when it comes to life-sustaining treatment and end-of-life care (Dijk, 2023; Noman, 2025). Although the significance of FCC is not disputed, local evidence outlining the way family involvement is implemented in the ICUs and the way it affects quantifiable patient outcomes is lacking (Dijkstra, 2023; Olding et al., 2016).

The overall aim in conducting the scoping review is to map and synthesise the available evidence on family involvement practice in intensive care units and analyse the impacts on patient outcomes (intensive care unit length of stay, intensive care unit related infections and overall recovery) in order to inform and enhance the family-centred care models in critical care units (Dijk, 2023).

Study Problem and Research Gaps

Despite the fact that family-centred care is highly promoted in critical care, the amount of systematically synthesised evidence regarding the impact of particular practices of family involvement in intensive care units on patient health outcomes is lacking. The literature on the topic is currently disjointed, uses inconsistent definitions of family engagement, and is primarily done in high-income countries, which restricts its applicability to resource-constrained and culturally diverse contexts. Moreover, most of the literature focuses on psychosocial and satisfaction-related patient and family outcomes, whereas more objective clinical outcomes, including ICU length of stay, ICU-acquired infections, patient recovery patterns, and mortality, are inconsistently studied.

Such disparity in the evidence base limits the capacity to build contextually relevant and evidence-based family-centred care plans in the ICU facilities. It is evident that there is a general gap in the synthesis of research that can assess the connection between family involvement in care and decision-making with specific patient health outcomes. Filling this gap will help healthcare professionals and policymakers comprehend the practical significance of family-centred care and how it can be utilised to improve patient outcomes and the overall quality of care in intensive care units.

Research Question

What family involvement strategies are in place in an ICU, and how do these strategies affect outcomes for patients who are critically ill?

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METHODS

This particular scoping review is based on the **PRISMA-ScR framework** (Tricco et al., 2018) that provides a structured and transparent approach to evidence synthesis across a variety of study designs. This particular review is designed to be a scoping review in order to capture the wide range of literature related to family involvement in critical care and the related health outcomes.

Eligibility Criteria:

The inclusion criteria were based on the research of patients in the intensive care unit (ICU) and their relatives who are in a critical condition. The study population was researched about family members and the critically ill patients. The concept under consideration was family involvement into care process, such as surrogate decision-making, direct engagement in care, and emotional attachment. The setting was restricted to the articles that were undertaken in the ICUs, which provided patient outcome-related studies and investigated the connection between family involvement and patient outcome.

Inclusion Criteria:

To do the review, empirical research articles published in English since 2016 and relevant to the study were selected, i.e., studies that studied family-centred care models and their related outcomes in critically ill patients. Qualified studies had to report patient outcomes depending on the family involvement in ICU care.

Exclusion Criteria:

Articles were not considered in case they did not have a direct emphasis on the critical care environment or ICUs. Studies which examined only the emotional outcomes of families or their satisfaction without correlating these studies with the quantifiable patient health outcomes were also not included.

Search Strategy:

An extensive search was performed in various electronic databases on the grey literature, such as PubMed, CINAHL, Scopus and Google Scholar. The search involved a mix of keywords, Boolean operators that included family-centred care, ICU, involvement of families, patient outcomes, patient decisions and critical illness. Medical Subject Headings (MeSH) were included and reconfigured to every database. Grey literature sources, such as government reports and clinical guidelines, were also examined in order to cover the topic exhaustively.

The Screening and Selection Process

The process of study selection took place in three stages. The initial stage was the screening of titles and abstracts to eliminate irrelevant research. The second stage involved a full-text review to determine the eligibility in terms of the inclusion and exclusion criteria. The third step was data extraction and charting to determine the study design, family involvement plans and patient outcomes. By using a standardised table, data was extracted based on the main information that was essential (i.e., authors and year of publication, study design and methodology, family involvement strategies applied, and patient outcomes measured, e.g., physical recovery, psychological well-being, and mortality). This procedure allowed for evaluating the quality of family intervention strategies and their influence on patient health outcomes in ICU units.

PRISMA-ScR FRAMEWORK

Identification: 68 records identified through database searching on the grey literature.

Screening: After removing 28 duplicates, 40 records were screened by title and abstract.

Eligibility: 18 full-text articles assessed; 12 met inclusion criteria.

Inclusion: Final synthesis included 12 studies.

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Figure 1: PRISMA Flow Diagram

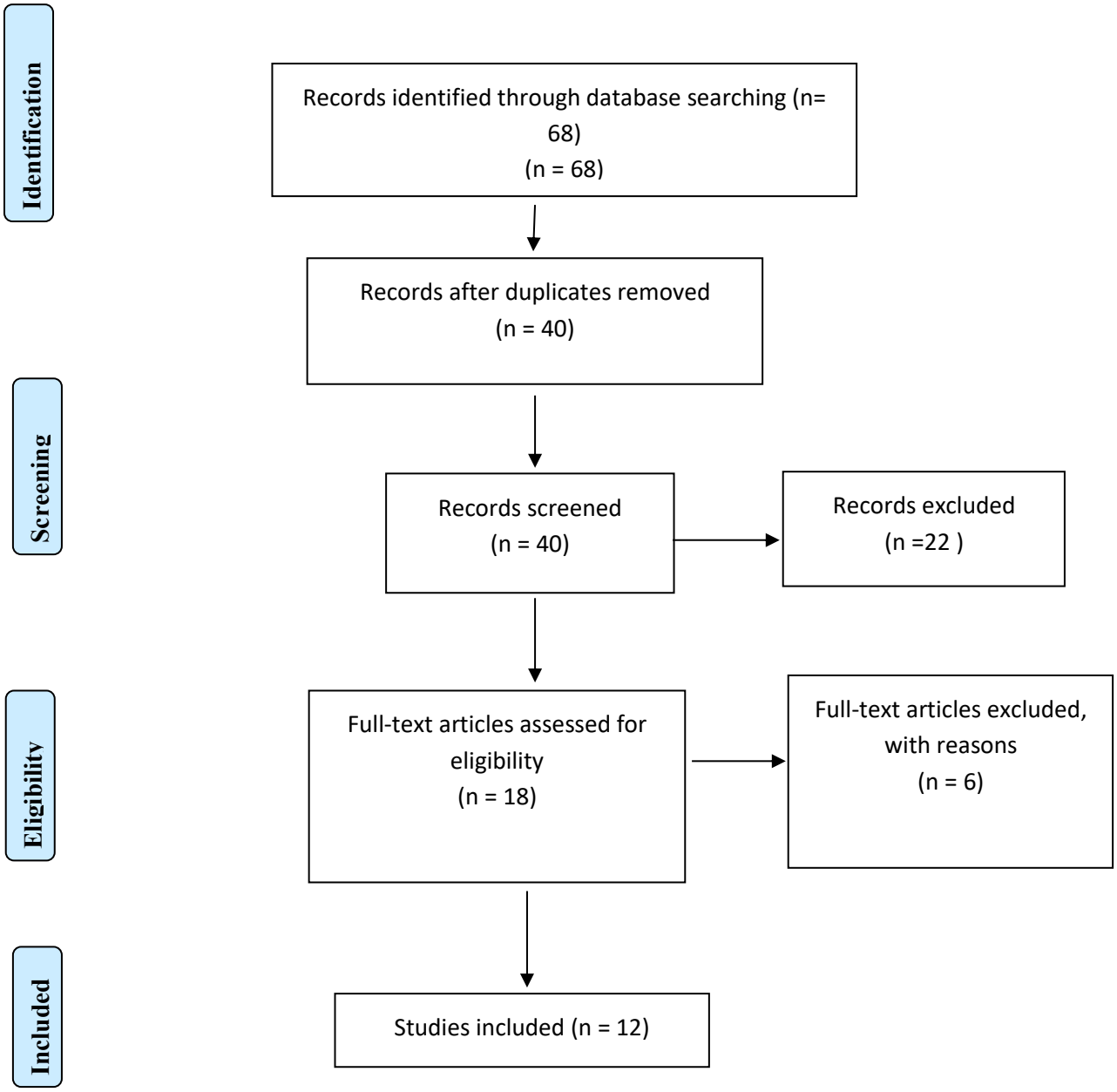

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Figure 2: Data Extraction Table

Citation	Context	Title	Aim/purpose of study	Methodology	Data analysis	Findings	Conclusion
(A.C. Schwartz, 2022)	Implemented in the general ICU context, not only within Africa.	Toward the realisation of family-centred care for adults in the ICU	To assess how Family-cantered care influences the advocacy of Patient autonomy in the ICU.	Descriptive study	The Study employed conceptual analysis of available ICU care models and Family Engagement models.	Concerning Family Participation, the Patient's Anxiety was reduced, enhanced involvement in the decision-making process, and overall satisfaction was achieved.	Implementing integrated structured family-centred care models into ICU practice will greatly foster the autonomy and emotional well-being of patients.
(B.M. Dijkstra, 2023)	Reports of research from various nations are collated as follows.	One of the studies is 'Family involvement in fundamental caring activities: the needs, views, preferences, and abilities of ICU patients, their relatives and health care workers' in an ICU.	The objectives of the research were to ascertain the needs, views, preferences and abilities related to family involvement in fundamental care in the ICU. The hospitals and the family engagements were thematically analysed, and the patterns in family engagement and the resultant patient outcomes were compared.	Integrated review	The studies included were synthesised thematically, comparing patterns in family engagement and patient outcomes.	Family engagement led to improved emotional stability, reduced length of stay in ICUs, improved patient cooperation and quicker recovery.	It is essential to implement planned family involvement in an ICU setting to facilitate the psychological and physical recovery of the patients in a safe and holistic manner.

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Citation	Context	Title	Aim/purpose of study	Methodology	Data analysis	Findings	Conclusion
(Thora Gunnlaugsdóttir, 2024)		In what ways can family within the ICU be aided?	To summarise studies on family members' experiences and requirements during their loved one's ICU admission.	Systematic reviews of qualitative and mixed methods reviews.	Analysis of barriers and facilitators to family involvement across different healthcare systems.	Absence of communication, emotional overwhelm, and hierarchical medical cultures limited family participation; where involvement was encouraged, families felt more informed, and patients benefited emotionally.	It is suggested that nurses apply various flexible strategies to ease the burden ICU families experience. Support policies are required to create opportunities for families to participate in ICU decision-making.
(Dijk, 2023)	Global ICU settings across multiple countries	Reducing family anxiety through structured involvement in critical care: Evidence from a global study	To examine the effect of structured family involvement on family anxiety and care experiences in ICU settings	Quantitative multicentre study	Statistical analysis comparing anxiety levels before and after structured family involvement	Structured family engagement significantly reduced family anxiety and improved communication and trust in care teams.	Implementing structured family involvement models in ICUs reduces family anxiety and improves overall care experiences.
(Gray et al., 2022)	Large cohort study in high-income hospital settings (non-ICU specific to family care)	A human breast atlas integrating single-cell proteomics and transcriptomics.	To develop a comprehensive cellular atlas using single-cell proteomics and transcriptomics.	Laboratory-based quantitative experimental study	Advanced bioinformatics and integrative molecular analysis	Identified cellular heterogeneity and functional states within breast tissue	Although methodologically rigorous, the study is not directly applicable to family-centred ICU care or patient outcomes

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Citation	Context	Title	Aim/purpose of study	Methodology	Data analysis	Findings	Conclusion
(de Beer & Brysiewicz, 2017)	ICU settings in KwaZulu-Natal, South Africa	The conceptualisation of family care during critical illness in KwaZulu-Natal, South Africa	To explore how family care is conceptualised during critical illness in a South African ICU context	Qualitative descriptive study	Thematic analysis	Families experienced emotional distress, uncertainty, and limited involvement due to communication gaps.	Family-centred care frameworks must address the emotional, informational, and cultural needs of families in ICU settings.
(Kehali et al., 2020)	ICUs in Addis Ababa, Ethiopia	A phenomenological study on the lived experiences of families of ICU patients	To explore the lived experiences of families of critically ill patients	Qualitative phenomenological study	Interpretative phenomenological analysis	Families experienced psychological distress, financial burden, and inadequate communication.	Improved family engagement and communication strategies are needed to reduce family distress in ICU settings.
(Noman, 2025)	ICU settings in the United Arab Emirates	Communication gaps in ICU: Improving family and patient communication for better care outcomes	To assess communication gaps between healthcare providers, patients, and families in ICUs	Mixed-methods study	Thematic and descriptive statistical analysis	Information needs were prioritised by families, while reassurance and proximity were inadequately addressed.	Addressing communication gaps is essential to improving family involvement and patient care outcomes in ICUs
(Olding et al., 2016)	Adult ICU settings across multiple countries	Patient and family involvement in adult critical and intensive care settings: A scoping review	To map existing literature on patient and family involvement in adult ICUs	Scoping review	Narrative and thematic synthesis	Family involvement mainly focused on decision-making and information sharing; limited evidence on clinical outcomes.	Stronger empirical evidence is required to link family involvement with measurable patient health outcomes.
(Schmolgruber, 2019)	ICU settings in South Africa	Empowering family members in ICU settings: A study on	To develop a culturally appropriate	Qualitative theory-	Grounded theory analysis	Identified empowerment elements, including	Empowering families through structured FCC

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Citation	Context	Title	Aim/purpose of study	Methodology	Data analysis	Findings	Conclusion
		family-centred care models	family-centred care model for ICUs	generating study		information sharing, proximity, cultural sensitivity, and resource support	models enhances collaboration and care quality in culturally diverse ICUs
(Tricco et al., 2018)	Global evidence synthesis context	PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation	To provide reporting guidance for scoping reviews	Methodological guideline	Consensus-based methodological synthesis	Established standardised reporting criteria for scoping reviews	PRISMA-ScR improves transparency, rigour, and reproducibility of scoping reviews
Marshall et al. (2017)	Global ICU settings across high-, middle-, and low-income countries	What is an intensive care unit? A report of the Task Force of the World Federation of Societies of Intensive and Critical Care Medicine	To provide a standardised, internationally applicable definition of an intensive care unit and describe its essential functions, structures, and resource requirements	Expert consensus report by an international task force	Narrative synthesis and consensus-based analysis of existing ICU models and practices	ICUs are specialised hospital units providing continuous monitoring, advanced life-support therapies, and multidisciplinary care for patients with life-threatening conditions; ICU structure and resources vary widely across settings	Establishing a clear global definition of ICUs supports standardisation, planning, policy development, and equitable strengthening of critical care services worldwide

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RESULTS

Characteristics of Included Studies

This scoping review incorporated twelve articles published in the period between 2016 and 2025, which investigated the role of family involvement in the treatment of critically ill patients. Various approaches were used in the studies, with such designs as the qualitative descriptive and phenomenological one, quantitative multicentre studies, mixed methods research, integrative reviews, scoping reviews, and conceptual analyses (de Beer and Brysiewicz, 2017; Kehali et al., 2020; Schmollgruber, 2019; Dijkstra, 2023; Dijk, 2023; Olding et al., 2016; Schwartz, 2022) Some of the studies were carried out in African ICUs, especially in South Africa and Ethiopia, others presented evidence on a global scale that could be applied in family involvement strategies in the African hospital setting (Noman, 2025; Gunnlaugsdóttir, 2024).

The majority of the research related to the adult intensive care units addressed the questions of family involvement based on the principles of communication, involvement in the decision-making process, emotional support, and the development of the strategies of engagement. They excluded a study that did not have a thematic analysis, given their irrelevance in family involvement in critical care (Gray et al., 2022). Taken together, the incorporated studies give a general picture of the conceptualisation, implementation, and association of family involvement strategies with patient and family outcomes.

Strategies of Family Involvement as Identified in ICUs.

In the twelve studies, family involvement strategies were mainly focused on information sharing, emotional support, closeness to the patient and involvement in decision making. Family members were frequently present but not actively incorporated in care processes in the case of African ICU settings. South African and Ethiopian studies indicated that the family involvement was informal and unstructured, and there was little guidance by medical workers (de Beer & Brysiewicz, 2017; Kehali et al., 2020). Such an unstructured state often led to confusion, anxiety, and uncertainty among the family members.

A number of studies also indicated the significance of structured family-centred care (FCC) models. Schmollgruber (2019) has identified some empowerment solutions, like culturally tailored communication, disclosure of information, and encouraging closeness to the patients, as the core of practical family involvement in South African ICUs. In the same manner, Schwartz (2022) emphasised the fact that the structured FCC models promote patient autonomy as it allows families to act on behalf of patients who are unable to express their wishes because of critical illness.

Family Involvement and Patient and Family Outcomes.

The evidence in the reviewed studies showed that the family involvement strategies were linked to emotional, psychological, as well as relational improvements in both the patients and the families. Integrative and quantitative research found that planned family involvement resulted in lower levels of anxiety, emotional stability, better cooperation with care, and, in certain instances, decreased ICU stays (Dijkstra, 2023; Dijk, 2023). These results imply that family presence and involvement may have a positive impact on ICU experience and may be included in the recovery procedures.

African qualitative research also found that in cases where families were not involved in care or were not well informed, patients and relatives were more affected and dissatisfied with care (de Beer and Brysiewicz, 2017; Kehali et al., 2020). On the other hand, in areas where families were informed and felt supported, they expressed improved coping as well as trust in the healthcare providers. Despite the

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primary focus on psychosocial benefits, for the most part, clinical health outcomes were not directly measured (Olding et al., 2016).

Communication as an Essential Element of Family Involvement.

The communication factor became one of the significant predictors of effective involvement of families included in the reviewed studies. It was shown in several studies that poor communication was a significant obstacle to family participation, especially when operated in hierarchical ICU settings, where families felt they were not included in the discussion and decision-making process (Gunnlaugsdóttir, 2024; de Beer and Brysiewicz, 2017). The lack of consistency in updates and clarity of information were also a factor that increased family anxiety and emotional burden in the African ICU settings.

Research carried out outside of Africa but applicable to comparable resource-constrained ICU settings established that structured communication interventions like scheduled family meetings and transparent information channels were strongly associated with sufficiently lowering family anxiety and enhancing trust in care groups (Dijk, 2023; Noman, 2025). These results indicate that communication practice can be a viable and effective strategy to increase family involvement in African hospitals.

Obstacles to Efficient Family Involvement in African ICUs.

Although the advantages were acknowledged, it was found that there were a number of obstacles to family involvement that were constantly cited. These were a small staff capacity, institutional policies that prevented the presence of the family and the absence of official FCC guidelines and cultural norms to support clinician authority (Kehali et al., 2020; de Beer and Brysiewicz, 2017). Emotional burnout and financial burden further restricted the capacity of the family to be active when the ICU stay is prolonged.

As Olding et al. (2016) identified, there is no adequate empirical evidence correlating family involvement with specific patient health outcomes, despite the vast support of this approach. This was especially true in African contexts with a lack of quantitative measures of clinical outcome (morbidity, mortality or functional recovery).

Summary of Key Findings

Altogether, the twelve studies indicate that the family involvement strategies, in particular, structured, communicative and culturally sensitive ones are linked with positive emotional wellbeing, lower anxiety, and better care experiences of critically ill patients and their families. Nevertheless, the evidence base in Africa is still very qualitative and experience-based, with little outcome based studies.

The results suggest that both psychosocial and clinical health outcomes indicate the need to have a context-appropriate family involvement framework in the African ICUs that is backed by the institutional policy and future study.

DISCUSSION

This scoping review examined what evidence has been found on the topic of family involvement strategies and how they affect the improvement of the health of critically ill patients in African hospital settings. The results show that family engagement, especially when organization support, has a positive effect on patient and family outcomes, primarily using psychosocial, emotional, and relational channels. Nevertheless, there are also some enduring systemic and contextual challenges that are identified in the review that restrict the complete incorporation of families into the ICU care structures in African contexts.

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Patient and Family Wellbeing as a Contribution of Family Involvement.

The results of this review indicate that the family involvement strategies are always related to lower anxiety, emotional stability, and coping among the families of critically ill patients (de Beer & Brysiewicz, 2017; Kehali et al., 2020; Dijk, 2023). These findings are consistent with the evidence around the world showing that the presence of family members and their involvement in the process can alleviate stress-induced psychological distress related to ICU hospitalisation. Dijkstra (2023) also reported similar results, discovering that family involvement enhanced emotional stability and cooperation of a patient with indirect promotional effects on a patient's recovery.

The similarity of studies can be explained by the universally stressful character of a critical illness, irrespective of the geographical area. Exclusion in the care processes worsens anxiety and distress in the African ICUs, where patients usually experience sudden deterioration, and families have high social, as well as caregiving roles. Inclusion of families in the form of communication, proximity and participation makes them more likely to cope, and this facilitates patient wellbeing. That is why the reviewed African and non-African studies found similar psychosocial advantages of family involvement (Schwartz, 2022; Dijk, 2023).

Communication as a Focal Process to Successful Family Involvement.

Effective family involvement was based on the application of communication as a major strategy in the studies reviewed. Ineffective communication was also named as one of the most significant obstacles in African ICUs, which led to emotional distress, uncertainty, and dissatisfaction with care (de Beer and Brysiewicz, 2017; Kehali et al., 2020). These results align with Gunnlaugsdóttir (2024), who found that meaningful participation by the family was constrained due to hierarchical medical cultures and deficient in clarity in communication.

The consistency of these results in a variety of contexts indicates that communication is one of the core mechanisms through which family involvement can work. Research employing structured forms of communication, including regular updates and intentional interaction, documented less family anxiety and enhanced confidence in healthcare teams (Dijk, 2023; Noman, 2025). Consistency of these studies can be attributed to the fact that the communication directly responds to the main needs of families, which are information, reassurance and inclusion, which is particularly acute in the high-stress ICU setting.

Empowerment and Structured Family-Centred Care Models.

This review suggests evidence that structured family-centred care (FCC) models are more effective than informal involvement or ad hoc involvement. In South African ICUs, Schmollgruber (2019) showed that information sharing, cultural sensitivity and facilitated proximity (enhanced collaboration among families and healthcare professionals) strategies empowered these facilities. Equally important, Schwartz (2022) emphasised that the structured FCC models lead to patient autonomy because they allow the families to become advocates of incapacitated patients.

The consensus between these studies must have indicated the significance of the role and expectations of transparency. In informal environments where family participation is not regulated, families can be at a loss as to where they fit in the care process, and the healthcare providers might view family presence as a nuisance. Organised models will minimise ambiguity, rightfulise family involvement, and synchronise involvement with clinical objectives, which enhances both acceptability by healthcare professionals and practice efficacy.

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Little Direct Clinical Health Outcomes Evidence.

Even though most studies showed positive psychosocial outcomes, little of the evidence directly related the family involvement strategies to quantifiable clinical health outcomes, including mortality or morbidity. The same was observed by Olding et al. (2016), who suggested that even though family involvement is also widely promoted, there is still a lack of empirical evidence linking it to the tangible patient health indicators. This was discovered both in Africa and in the whole world.

This is a compromise that can be attributed to the methodological limitations. African studies had a great number of qualitative or descriptive designs which aimed at comprehension of experiences as opposed to quantifying outcomes. Also, in the African ICUs, the resources might be limited to undertake massive quantitative research. As a result, health-related increases related to family participation are increasingly explained by psychosocial mediating variables (e.g. less anxiety and enhanced cooperation) as opposed to clinical outcomes.

The Contextual Barriers within the African ICU.

In the review, various obstacles to successful family engagement in African hospitals are identified, such as a shortage of personnel, ICU-related policies, hierarchical care model, cultural values, and financial resources (de Beer and Brysiewicz, 2017; Kehali et al., 2020). These obstacles align with the larger literature on the provision of critical care in low and middle-income nations, indicating that systemic issues are an important factor in restricting family involvement.

Consistency in the literature shows that in the absence of institutional interventions in place, like definite FCC guidelines, staff training, and supportive policies, family involvement will always be inconsistent and reliant on the attitude of individual clinicians. This demonstrates the necessity of health system-level interventions instead of individual practice change.

Research Implications on Practice, Policy and Research.

The results of the presented scoping review imply that family involvement practices must be strategically incorporated in the ICU care in Africa; however, special attention should be paid to communication, cultural sensitivity and structured interaction. Policy makers and hospital directors ought to look at coming up with context-related FCC models, which look at families as full-fledged caregivers and not visitors.

From a research perspective, research outcome-related studies in the field of African ICUs are evident in examining the family involvement and effects on psychosocial and clinical health outcomes. Possible research in the future is also to investigate the plausible models of structured family involvement that can be adaptable in a resource-constrained environment.

Summary

Overall, this scoping review indicates that there is a high level of agreement among the studies that family involvement strategies have a positive impact on care experience and emotional wellbeing of critically ill patients and their relatives in African hospitals. The similarity in the psychosocial needs, the importance of communication, and the advantages of organised participation can be identified as the main factors that precondition this agreement. Nevertheless, there are still gaps in the evidence on the connection between family involvement and direct clinical outcomes, which highlights the necessity to conduct additional research and design the policy depending on African ICU settings.

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Recommendations for Implementation

For family involvement to be meaningful, the commitment of the institution is required. The key recommendations that arise from this review include:

- **Organised family involvement programmes**: Hospitals ought to develop policies to integrate family members in the rounds, updates, and decision-making, and, in a suitable case, care duties.
- **Create flexible visiting practices**: Visits that are longer and more frequent, and relaxed visitation, are likely to enhance family presence and can lead to more care engagement.
- **Educating and Training Families**: Educating family members about specific family roles and their decision-making responsibilities helps families become more confident and potentially enhances outcomes.
- **Training Healthcare Workers:** Education about family-centred care, communication, and incorporating cultural competence into care will be essential for nurses and physicians working in the ICU.
- **Facilitating Infrastructure**: Family waiting rooms, family rest areas, and family information resources are important resources to support families in limited-resource settings and alleviate stress, in addition to enhancing engagement (Kehali et al., 2020).
- **Adapting and Integration of Cultural Sensitivity:** In the African and multicultural environments, policies and approaches will need to incorporate and adapt for the consideration of beliefs of religions, positions of families, languages, and the socio-economic standing of families (Schmollgruber, 2019).

Impacts and Challenges

One can determine effects on family involvement, but there are still difficulties. Within institutions, limited hours for family visits, inadequate family latch and emotional resources, and slow or no family decision-making involvement from care providers are some of the barriers to implementation. Family participation in the care is another element in which cultural and religious forces are influential, and culturally sensitive family participation plans should be implemented (Gunnlaugsdóttir, 2024).

Impacts for Practice

Integrating family-centred care into ICU areas requires the provision of training for family members and preparing systems to ensure families' active roles in the care process. Healthcare providers need to direct efforts toward this model.

The family aspect that could be considered and included in the policy could be the adoption of flexible working hours and psychosocial support based on family in the ICU.

CONCLUSION

In the context of critical illness, the health outcomes of patients improve significantly when family members are involved in their care. The implementation of FCC in the ICU is vital as it directly affects the patient’s recovery and the family’s emotional health and well being. The evidence is overwhelming that appropriately implemented FCC models in this setting improve patient outcomes by reducing recovery time and improving overall satisfaction. This review clearly demonstrates the value of FCC.

Involvement of family members in decision-making and direct care activities fosters a sense of security and empowerment within family-centred care (FCC) in a way that patients feel less isolated and more supported, while families also feel supported, especially during emotionally strenuous situations.

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Additionally, involving families in the care activities fosters open lines of communication and collaboration between the healthcare providers and family members, while enhancing shared decision-making in relation to the best interest of the patient. It is a fact that families that are actively involved in the decision-making process have reduced emotional distress, acquire more adaptive coping mechanisms, and overall resilience in an ICU admission and post-discharge. The positive psychological impact of family care is unquestionable, as family members of patients who are cared for actively within the healthcare environment experience lower anxiety and depression, enhancing their ability to provide emotional and instrumental support to the patient.

In relation to the implementation of family-centred care, the benefits of family-centred care are clear, while many problems continue to exist. The scope of potential challenges is broad, and includes institutional issues such as visitor restrictions, family engagement training deficits in staff, and the absence of family support structures.

The family dynamics, culture, and the role of family members all vary across multiple geographies and communities, which makes culture equally important. Families might expect a member to be more subdued and passive in the decision-making, while in others, the expectation might be of complete participation in all dimensions of the care for the patient. Such cultural differences make the family-centred care model universal in some situations and confrontational in others. Also, family members experience unique and difficult emotional encounters in the ICU. They might grapple with uncertainty regarding the prognosis of the patient while also feeling the strain of decision-making helplessness. This highlights a gap in healthcare systems to close for families by designing tools for communication while providing emotional support in crises, frameworks for psychological assistance, and care frameworks for complicated families in critical situations.

The identified issues and emotional stress can be alleviated by designing active policies related to family-centred care and inclusive structures of integrated care systems based on the family and the family system. These can include improvement in active support and mechanisms for aid communication, family debriefing in times of critical care, and in the provision of counselling, inclusive of family systems dynamics and stress frameworks.

Additionally, fostering the ability of healthcare practitioners to work with families, appreciate their needs, and facilitate resource provision is vital in dealing with organisational challenges. The efforts to break the cultural or structural barriers that prevent relatives from taking part in the care of their loved ones should be given priority.

To refine the strategies of family-centred care and prepare evidence-based best practices adaptable to varied ICU environments, additional work in this domain is necessary. This review provides a valuable starting point in mapping the available literature, but the impacts of family involvement on patient outcomes, family well-being, and other associated outcomes over time remain grossly understudied. Family involvement also needs to be congruently examined in relation to specific health outcomes and metrics, including recovery, ICU length of stay, complexities, and other complications. It is also important to realise the different models of family engagement in care work across cultures and the resource settings in order to maintain family-centred care tenets. This will provide the necessary guidance to formulate approaches that the world can use to regulate and enhance families' participation in ICU practices.

Family-centred care will, without a doubt, transform patient outcomes and must be a priority in caring for the critically ill.

When healthcare systems recognise and appreciate the part families take in the caregiving process, they are in a better position to help families recover,

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enhance family health, and improve the overall care offered to patients in the ICU. However, for healthcare systems to realise such advantages, they must provide systems for emotional support and address cultural and institutional barriers. Strengthening research, addressing the issues raised in this study, and improving strategies for family integration in care will help family-centred practices to become the new norm and improve the experience for patients, their families, and health systems.

Research Implications

More work is required to design and evaluate standardised protocols for integrating families into ICU care routines and measure the impact on patient outcomes. Future work should evaluate the impact of family-centred care on particular patient populations and the weighted outcomes, for instance, patients with chronic illnesses and their families and patients psychologically.

Research Gaps and Future Opportunities

The review brought forward the following gaps:

- **Building quantitative links to hard patient outcomes:** We need more large-scale family involvement studies to evaluate the impact on ICU LOS, complications, mortality, and readmission.
- **Interventional studies in resource-limited environments:** Most of the existing work in Africa is descriptive and qualitative. We need to focus more on the family involvement framework in intervention studies.
- **Strategic Homogenization**: There is no unifying understanding of "family involvement" (participation, decision making, and direct care).
- **Impact and resource plan**: especially for resource poor settings, understanding the scope of family-centred care and the expected cost to the family will help in making the care more accessible.
- **Equity and access:** The research should investigate the impact of the varying degrees of socio-economic status, culture, and geography on family involvement and how equity in access can be attained.

Review Limitations

This study serves as a scoping review and did not evaluate the methodological quality of each study (as is usual for scoping reviews). The diversity of the family involvement dimensions, study designs, settings, and outcomes means that firm causal conclusions are more difficult to achieve. Moreover, there is a possibility that the decision to include studies that are published in English only may have overlooked other potentially useful literature that may be in other languages, especially in francophone Africa.

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