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Family needs of patients in the intensive care unit

Mary Kramer
San Jose State University

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Kramer, Mary Margaret, M.S.

San Jose State University, 1989

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FAMILY NEEDS OF PATIENTS IN THE INTENSIVE CARE UNIT

A Thesis

Presented to

The Faculty of the Department of Nursing
San Jose University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By

Mary Kramer

December, 1989

APPROVED FOR THE DEPARTMENT
OF NURSING

Susan O. Murphy
Susan O. Murphy, R.N., D.N.S.

Ann Doordan
Ann Doordan, R.N., M.S.

Sharon Wahl
Sharon Wahl, R.N., M.S.

APPROVED FOR THE UNIVERSITY

M. Lou Lewandowski

Abstract

This exploratory, descriptive study was a replication of Molter's 1979 study. It focused on the needs of family members of patients in an intensive care unit at a local community hospital. The sample consisted of 14 family members of patients who had been in the unit. Interviews were conducted with the family members using Molter's Critical Care Family Needs Inventory. Family members perceived their greatest needs as knowing patient prognosis, feeling there was hope, visiting at any time, receiving information about the patient once a day, and having questions answered honestly. Nursing staff was seen by the family members as most frequently assisting in meeting their needs. The need most often left unmet was to have someone assist with financial problems. Included in the paper are specific recommendations for the hospital as well as recommendations for continued research.

Acknowledgment

Assistance in completing this thesis and my education has come from many people. The nursing administration and staff of the of the intensive care unit at Community Hospital of the Monterey Peninsula have provided support and assistance throughout my education and this study. The family members who participated in the study have my thanks and respect for sharing their experiences while in the unit. A special thank you to the faculty who worked with me in completing this thesis. For their continued support, understanding, and diligent work, I express my thanks to my family.

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Chapter 1

INTRODUCTION

An admission to a hospital's intensive care unit is a crisis situation for the patient and his family. The admission is usually accomplished in a flurry of activity and concern for the patient's life or future abilities. When the patient is admitted, he becomes dependent on strangers in varying degrees for physical and psychological support. The usual support available from his family is altered due to the restrictions placed upon the patient and his family by the illness or the hospital, or by his family's ability or inability to cope with the illness and hospitalization.

Family systems theory (Miller & Winstead-Fry, 1982) describes the family as a system with interacting parts. Each member of the family continually interacts with other family members and the events in their lives. The illness of a member of a family, whether acute or chronic, will affect the patient's attitudes about his illness and recovery. Utilizing the family to support the patient can be important in helping the patient to recover.

Problem Statement

A family member can better support the patient throughout his hospitalization if the stresses of the family member are decreased (Spratt, Ganas, Hying, Kirsch, & Koch, 1986, p. 16). It becomes of the utmost importance to be able to identify and decrease the stresses experienced by family

members to enable them to better support the patient.

During the past decade, there has been an increasing awareness of the effects that family interactions have on patients and the identification and meeting of the needs of the families. Some research studies have looked at physiological effects seen in patients during interactions with families or hospital staff. Other studies have looked at what family needs are and how those needs are met. Molter conducted a study in 1979 that asked family members of intensive care patients to rate 45 different needs in order of their importance. The two needs most highly rated by the participants in the study were the need for hope and the need to feel the hospital staff cared about the patient (Molter, 1979).

Along with Molter, Norris and Grove (1986) and Mathis (1984) reported what families of critically ill patients have perceived as their needs during a hospitalization and who helped them to meet their needs. Heater (1985) proposed that family members at the bedside in an intensive care unit can promote rest for the patient, decrease patient anxiety, and provide psychological support and reassurance for the patient. A study conducted by Fuller and Foster (1982) reported that task-oriented nurse interactions with patients resulted in increases in the patient's heart rate, while interpersonal nurse or family interactions with the patient resulted in stable heart rate. Because so many of the

nurse's interactions with a patient are task oriented, the availability of the family can decrease patient anxiety. Despite the evidence that a family may have a positive effect on the patient and his recovery, the family is often not included in the patient's care. The exclusion can result from restricted visiting hours, inconsistent or inadequate information from physicians and nursing staff, or varying approaches from the hospital staff to the family and their interactions with the patient.

The complete care of a patient includes assessing and caring for his physical and psychological needs. Included in those needs are the needs of his family. Daley (1984) states that an assessment of a patient and his family is complete only if it includes the family's perceptions of the patient's illness and their own needs during the patient's hospitalization.

Identifying the physical needs of the patient is usually easily accomplished. Identifying the family's needs is more difficult. Assessing these needs requires a knowledge of the family structure and roles, cultural background, and coping mechanisms used by the family. The assessment and fulfillment of these needs requires action by the nurse. How well family needs are met by the nurse depends on an accurate assessment of the family's perception of their needs (Daley, 1984).

Purpose and Need

The value of family interaction with patients in intensive care units has been established by previous research. How a family interacts with an ill family member is very individual. Each family has specific needs. To better assist the family in helping the patient during the hospitalization, nursing staff first needs to identify the needs of the family.

The purpose of this study was to identify the family needs of families in a particular intensive care unit and compare those needs with needs identified in Molter's 1979 study. In addition, the study determined if the specific needs of the families were met and who assisted in meeting the needs.

Definition of Terms

For the purpose of the study, the following terms were defined:

1. Patient is anyone admitted to the intensive care unit who spent at least 72 hours in the unit.
2. Family member is any spouse, child, parent, or live-in partner or companion of the patient who is over the age of 18 and visited the patient more than once.

Research Design

This study was a replication of Molter's exploratory, descriptive study. Its focus was to identify the needs of families of critically ill patients in the intensive care

unit at a local hospital.

Participants in the study were interviewed by the nurse researcher within 48 hours after the patient was transferred from the intensive care unit. During the interview, participants were asked to give demographic data on a general information form. Participants were also asked to rate the specific needs of the Critical Care Family Needs Inventory as: not important, slightly important, important, or very important. For each identified need, participants were asked if the need had been met and who had assisted them in meeting the need.

Scope and Limitations

The study was limited to one particular hospital and a specific group of family members seen in its intensive care unit. By limiting the participants to family members of patients who had been in the unit at least 72 hours, another larger group of families was excluded from the study. This group included those families of patients in the unit for less than 72 hours as well as families of patients who died in the unit. The needs of these families may have differed from the participants in the study.

Further specifics of the study's methodology and results can be found in subsequent chapters. A review of the literature found a number of studies that provided a diverse look at family needs during the hospitalization of a family member.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

Conceptual Framework

Family systems theory is the conceptual framework used for this study. The theory describes the family as having individual parts that combine to form a whole entity that we know as the family. The theory also considers the patterns of behavior seen in the family.

The premise of the family systems theory is that the whole entity of the family cannot be understood without looking at the parts of the family and how they interact (Miller & Winstead-Fry, 1982). A family includes not only the spouse and children of the nuclear family, it also includes the extended family of different generations and unrelated friends who interact with the nuclear family.

Bowen's family system theory (Miller & Winstead-Fry, 1982, p. 7) identifies the differentiation of self as the factor that governs individual behavior. Differentiation of self is also referred to as emotional maturity. This differentiation of self is a continuum. An individual who is less differentiated will react more dramatically to feelings of anxiety which can limit his ability to successfully deal with that anxiety. An individual who is more differentiated is affected by anxiety but is not controlled by that anxiety. This person is better able to separate himself from the event that has occurred.

The level of differentiation can be expanded to the family as a whole to provide a framework for an understanding of how the family functions. Similar to the individual who is less differentiated, a family who is less differentiated or less mature emotionally, will have more intense reactions to an anxiety producing situation. They will deal with that anxiety with less success than a family with a higher level of differentiation.

The functioning within a family occurs within a behavioral system known as a triangle (Miller & Winstead-Fry, 1982, p. 26). A triangle involves any two family members and a third party which could be any other person or an event. The triangle triggers an automatic response that has been learned by past experiences. If a family is less differentiated, the triangles or responses of the family are more rigid than those of a more differentiated family.

The routine needs of the family and the methods of communication in dealing with anxiety can be altered by a family member's illness and hospitalization. Understanding how a family functions, its level of differentiation and the connections between members can help the nurse assist the family in meeting their needs associated with the hospitalization. This understanding has been increased by several research studies which have focused on identifying family needs, how patients react to a family support, and who

helps the family in meeting their needs. These studies will be discussed in the review of literature.

Review of Related Literature

The research on which this study is based is Molter's 1979 study of the needs of relatives of critically ill patients. Molter developed the Critical Care Family Needs Inventory. This tool identifies 45 needs of families that include informational needs, comfort needs, visitation needs, emotional and social service needs. The tool has been used in other studies and a testing of its validity and reliability was conducted by Leske (1988). This tool was found to measure distinct areas of need that related to the overall needs of families during critical illness.

In her study, Molter interviewed 40 family members of patients in intensive care units in two hospitals. Participants in the study were asked to rank the 45 needs listed on the tool according to their importance. They were also asked to identify which individuals were of assistance in meeting these needs.

The need for hope was most often listed as having the highest priority for families. All 45 needs were listed by at least one family member as being very important. In Molter's study, families stated that the majority of their needs were met by nurses (Molter, 1979). The study demonstrated the variety of needs of family members and the importance nursing had in meeting those needs.

O'Keefe and Gilliss (1988) proposed that families can buffer a patient's stress and be a supportive resource to the patient. They reported a case study in which a patient and her family were closely followed by a clinical nurse specialist in a critical care unit. The family was followed from the time of admission through to discharge. The family's concerns and interactions with the patient were monitored by the nurse. The report of the case study indicated that when a family is supported by a nurse, the family can provide better support to the patient and strengthen the patient's and family's health.

The importance of support by the nurse or other health care professionals was also reported in a study conducted by Cozac (1988). This study involved spouses of patients who had coronary artery bypass surgery. Seven spouses were interviewed two times after the patient's admission to the intensive care unit after surgery. Spouses were asked about their feelings and reactions during the perioperative and postoperative periods. The participants in the study reported the need for support from health care professionals in the form of kindness, consideration, understanding, and reassurance. Support was most needed when the spouse first visited the patient.

Caplin and Sexton (1988) asked spouses of patients in a coronary care unit about stresses that they experienced. The spouses were asked to identify their stresses. Subsequently

the spouses and the nurses in the coronary care unit were asked to rate the identified stresses in terms of their perceptions of the level of stress generated for the spouse as high, medium, or low. The stress that ranked highest for both spouses and nurses was that of dealing with the patient's reaction to his having had a heart attack. Other stresses identified included not trying to upset the patient, not being informed about changes in the patient's condition, and being asked to wait to visit the patient. Spouses were also stressed by the deaths of other patients in the unit and by the prospect of difficulties when their family member came home.

Keeling (1988) conducted a study which gathered information from wives of patients with acute myocardial infarctions. Fifteen wives were interviewed during the convalescent period of their husband's hospitalization. Wives were asked to describe their own personality type and how they usually coped with stress. They were also asked about their perception of their husband's illness, their knowledge of cardiac risk factors, and what their own stressors were during this time. The study revealed that the wives had a fairly accurate understanding of their husbands' illnesses and feared the possibility of death. The majority of the participants wanted more information about risk factors. Their own personal stresses included concerns with being away from home, problems with sleep, appetite,

nervousness, and tendencies to be upset.

Curly (1988) explored parental stress in a pediatric intensive care unit. Two groups of parents were involved in the study. The control group received routine nursing care while in the unit. The experimental group was enrolled in an intervention strategy known as the nursing mutual participation model by care. This model assumes that the health care provider cannot know what is best for another individual. The health care provider can assist an individual to help himself by learning about the individual's past experiences and beliefs. For this care model to be effective, a partnership and interdependence must be established between the health care provider and the individual. Results of the study showed a higher level of stress for the control group. Parents involved in the care model were better able to deal with the stresses of their child's hospitalization. These parents were able to recognize some normalcy in their child and in their relationship to the child.

Nyamathi (1987) assessed the coping responses observed in spouses of patients who had suffered myocardial infarctions. Based on the Lazarus stress and coping paradigm, the study assessed the spouses' coping responses during the acute and convalescent periods. Spouses of the patients were interviewed three to five times after the patient's discharge over a period of three months. The

interviews were conducted in the home of the patients. Interviewers sought the spouse's perceptions of their own coping abilities. During the hospitalization, the coping mechanisms used were both behavioral and cognitive. The coping behaviors used most often were to seek help and support from others and to be near the patient during the acute period of the illness.

A replication of Molter's study completed by Leske (1986) showed a variation in the needs identified by family members. Like Molter's study, the need for hope was demonstrated in this study dealing with families of patients who were victims of trauma or violence. Other needs relating to the expression of feelings, financial support or help with family problems and visitor accommodations were listed as being very important.

Focusing on families of patients with acute brain injury, Mathis (1984) demonstrated differences in the needs between these families and those seen in general critical care units as studied by Molter. Using Molter's Critical Care Family Needs Inventory, Mathis interviewed 26 family members or patients with acute brain injury or life threatening medical or surgical illnesses. The study found that families of patients with acute brain injury perceived their needs differently than families of medical or surgical patients in the intensive care unit. Needs that surfaced frequently for families of brain injured patients were the

need to relive the incident that resulted in the injury and the need to receive medical information. The families in the study also identified that they experienced a fear of criticizing hospital staff.

Rodgers' study also demonstrated variations in the needs of families (1983). This study involved family members of cardiac surgery patients. Family members were given a questionnaire based on Molter's Critical Care Family Needs Inventory. The most important need found by Rodgers' study was the need to be assured that the family would be notified of a change in the patient's condition.

Research completed by Norris and Grove studied the families' perceptions of their most important needs and the nurses' perceptions of those same needs. Family members and nurses were given a questionnaire comprised of 30 of Molter's 45 needs. Family needs found to be most important were similar to those found in Molter's study. The needs were to feel hope, to feel that hospital personnel cared about the patient, to know that the patient was receiving the best possible care, and the have questions honestly answered. Nurses perceived the most important needs of families were to have information about the patient and to feel that the hospital staff cared about the patient. Both families and nurses ranked the need to talk about the possibility of the patient's death as a low priority (Norris & Grove, 1986).

This Norris and Grove study demonstrated some of the inconsistencies in family and nurse perceptions of family needs. In contrast to nurses' perceptions, needs that were perceived as more important by the families included the need for the nurse's acceptance of the family, the need to be called at home regarding changes in the patient's condition, the need to know about the types of staff caring for the patient, the need for hope and the need to have honest answers to questions.

Another study that explored the similarity of the perceptions of spouse's needs by nurse and spouses was conducted by Hill (1988). Spouses of patients who had coronary artery bypass graft surgery and the nurses caring for the patients were given a modified version of the Critical Care Family Needs Inventory. The spouses listed their primary need as having questions answered honestly. Nurses perceived the spouses' primary need as having understandable explanations about the care of the patient. Both spouses and nurses listed the nurse as the health care provider who most frequently met the needs of the spouses.

Hickey and Lewandowski (1988) asked critical care nurses about visiting practices in their units, the role of the family in the care of the patient, and the nurse's role with the family. Actual visiting practices were found to be different from the official policies in the units. The 226 nurses participating in the study suggested 93 different

visiting policies describing who could visit, how long visits should be, and how often visitors could visit. Nurses identified the role for families to be one of offering support and encouragement to the patient and participating in the decision making process regarding the direction of patient care. Helping patients with meals was a role assigned to families by the nurses. Nurses did not agree that families should provide emotional support to patients during a crisis situation or be involved with physical care of patients. The study also identified factors that would influence the nurse's involvement with the families. These factors were related to the possibility of the patient's death and the nurse's subjective feelings about the patient and family.

Another replication of Molter's study focused on the unmet needs of families (Spratt, Ganas, Hying, Kirsch, & Koch, 1986). Molter's Critical Care Family Needs Inventory was given to 25 family members. They were asked to rate the needs and identify those needs that were unmet for them. Twenty-six of Molter's 45 needs were found to be unmet. These needs included: (a) having daily contact with the physician and the same nurse, (b) being able to differentiate between types of hospital staff, (c) being prepared to visit the patient for the first time, (d) having information about hospital support services, (e) having flexible visiting, (f) being able to discuss the possibility of the patient's death,

(g) having facilities available where visitors can be alone, and (h) having the opportunity to express feelings.

A 1984 study conducted by Daley showed that the personal needs of family members were not a priority to families during the initial 72 hours of hospitalization. Forty family members of patients in a general intensive care unit were interviewed. These family members identified six need categories: personal needs, the need to decrease anxiety, the need for support and ventilation, the need to be helpful, the need for information, and the need to be with the patient. The most important need of families was to have information about the patient. The study also demonstrated that physicians and nurses primarily met the families' needs. Families identified physicians as meeting the more significant needs (Daley, 1984).

Research done by Boykoff (1986) focused on the family visitation needs as perceived by patients and families. The premise of the study was that individuals do not function in isolation and need to be viewed in conjunction with their families. Both patients and families in a medical intensive care unit were asked about visitation needs. Results of the study demonstrated that families and patients wanted nursing to direct who was to visit, how long the visits should be, and how often to visit. Families also expressed a need to know about the patient's condition. Boykoff described the family as wanting the nurse to be a communicator, gatekeeper,

and the absolute care giver.

Stillwell (1984) also conducted a study dealing specifically with visiting needs. Results of this study directly opposed the results of Boykoff's study. While participants in Boykoff's study wanted nursing to direct visiting, participants in Stillwell's study did not. Participants in the Stillwell study were family members of patients in an intensive care unit. The participants were asked to rank nine needs regarding visitation according to their importance. The needs deemed to be the most important were to see the patient frequently and whenever the family member desired. Other needs listed by families were similar to those identified in Molter's study including the need for explanations of the patient's condition and physical appearance prior to the family's first visit.

Summary

Each of these studies has explored the family concerns and needs during a loved one's hospitalization in a critical care unit. The studies demonstrate a similarity of family needs among those families in which patients had similar illnesses. Families seen in coronary care units and post cardiac surgery units expressed needs to feel there was hope for the patient's recovery and to have honest answers to questions. Leske's study (1986) of families of trauma victims identified needs such as expressing feelings and receiving help with financial or family problems. Families

of patients with acute brain injuries needed to relieve the incident that resulted in the patient's admission. These families were the only ones in the reviewed studies who expressed a fear of criticizing hospital staff. This fear of criticizing the hospital staff is incongruent with the findings of other studies in which nursing staff was looked to for meeting family needs during hospitalization.

A consistent theme in studies that examined nurses' perceptions of family needs is that nurses perceive family needs differently than the families themselves. The reviewed studies identified nurses as perceiving the families' most important needs to be that of information about the patient. Families were more likely to identify a need for hope and honesty in answering questions.

While these studies have increased the knowledge base about family needs, each one has recommended further research. The goal of this study was to validate that the needs previously identified by Molter were similar to those needs experienced by families in another institution. Furthermore, this researcher was interested in determining who in that institution was perceived by the family as helping to meet their needs.

Chapter 3

THE METHOD

This chapter explains the research design and procedures for data collection. The purpose of the study was to identify the needs of families of patients in a specific intensive care unit and to identify who assisted families in meeting their needs.

Research Design

This exploratory, descriptive study was a replication of Molter's 1979 study. Permission was received from Nancy Molter to use the Critical Care Family Needs Inventory as a basis for the study. The tool lists 45 need statements to be rated as to their importance on a 4 point scale.

Leske completed validity and internal consistency testing of the tool. An item analysis was completed to determine the items that contributed to the homogeneity of the tool. Correlation of 43 of the 45 items was found to be between .25 and .60. The items were determined to be relatively homogeneous. Five distinct dimensions of the tool were determined in a factor analysis. The dimensions were identified as needs for support, comfort, information, proximity, and assurance. While the tool measures these distinct dimensions of family needs, the tool as a whole was determined to relate to the needs of families in a critical care setting (Leske, 1988).

The participants were interviewed by the nurse researcher using the Critical Care Family Needs Inventory. During the interview, participants were asked to rate specific needs as to their importance, to identify which needs were met, and to identify who assisted them in meeting the needs.

Sample and Setting

The sample population for this study was selected from families of patients in the intensive care unit in a local community hospital. The unit is a ten bed combined intensive care and coronary care unit. The patient population includes medical, surgical, and trauma patients of all ages. Most of the patients are elderly with cardiac problems. The majority of the patients stay in the unit one to five days, but there are those who stay as long as six weeks. Those patients who require cardiac catheterization or cardiac surgery are transferred to other facilities.

Visiting practices vary from the official policy. Official policy states that only immediate family can visit, two people at a time during the hours of 10 a.m. to 9 p.m. Children who visit must be 14 years of age. Ministers and attorneys are allowed to visit. In practice, friends are permitted to visit at the patient's request and family is permitted to visit at any time. Visitors are limited to two at a time. There are no specific restrictions on the length of visits; this is determined by patient tolerance and

nursing procedures. Visitors are asked to check with nursing staff before entering the patient's room. An auxiliary volunteer assists with this during regular visiting hours. For family members of patients who are from out of town, a quiet room is available for sleeping. Cots are provided in the patient's room for parents of small children admitted to the unit.

Participants in the study were family members of patients who had been in the intensive care unit for at least 72 hours. Of the family members approached by the researcher to participate in the study, 14 were interviewed. One prospective participant refused to participate. The reason for the refusal was not made clear. Another family member agreed to participate, but did not because the patient died unexpectedly prior to transfer out of the unit. Family members of patients who died in the unit were not approached to participate in the study.

All participants were immediate family or significant others of the patients and had visited in the unit more than once. Only one family member from each family was interviewed. Participants in the study included two husbands, four wives, one father, one mother, three daughters, one grandmother, and two live-in partners or companions.

Data Collection

Data for this study were collected over a four month period. Potential participants were selected from the family members who met the criteria and with whom the researcher was able to make contact. The potential participants were approached by the nurse researcher at or near the time of the patient's transfer out of the intensive care unit. Family members were given an introductory letter and copy of a consent form along with a verbal explanation of the study. If the family member agreed to participate in the study, they were asked to sign the consent form and a time was arranged for the interview. All interviews took place within 48 hours of the patient's transfer out of the unit. Interviews were 30 to 45 minutes in length.

During the interview, participants were asked demographic information that included the age and sex of the participant and the patient, the patient's diagnosis, and the relationship between the family member and the patient. Demographic information also included the patient's and the family member's prior exposure to the hospital and the intensive care unit and exposure to other hospitals and intensive care units. Participants were also asked the distance from the hospital to their home and where they were staying during the hospitalization.

The demographic data collected in this study vary from the original Molter study. Molter's study asked the

participants to list their education level and occupation (Molter, 1979). This was omitted from the current study because the population of this setting is relatively small and homogeneous. Of greater interest to the researcher was the patients' and family members' prior exposure to hospitals and intensive care units. Prior exposure to hospitals to a specific hospital or intensive care unit may alter the needs of a family member as well as their perceptions of what is occurring during the hospitalization.

As in the Molter study, the need statements of the Critical Care Family Needs Inventory were read to the participants and they were asked to rank the need's importance. A 4 point scale that was used described the needs as being: (a) not important, (b) slightly important, (c) important, and (d) very important. If the particular need was present for the participants, they were asked to state if the need had been met or left unmet. For the needs that had been met, the participants were asked to identify who had assisted them in meeting their needs. The choices included: (a) physicians, (b) nursing staff, (c) immediate family, (d) extended family, (e) friends, (f) clergy, (g) other hospital staff, or (h) someone else not listed.

At the completion of the interview, participants were asked if there were other needs that they had experienced that had not been previously identified. Throughout the

interview, discussion about their experiences in the intensive care unit was encouraged.

Summary

This exploratory study asked family members of critically ill patients to identify their own needs during the time the patient was in the intensive care unit. The study also asked participants to identify needs that were met or unmet and people who assisted in meeting their needs. Demographic data were also obtained for the purpose of describing the population. The data obtained were analyzed with descriptive statistics.

Chapter 4

DATA ANALYSIS AND FINDINGS

The purpose of this study was threefold: (a) to identify the family needs of critically ill patients in a general intensive care unit, (b) to determine if those needs were met, and (c) to determine who was of assistance to the family members in meeting their needs. The needs identified in this study were expected to be similar to those identified in Molter's 1979 study.

Data Analysis

Descriptive statistics were used to analyze the data. A listing of the needs in the Critical Care Family Needs Inventory is presented in Table 1. The needs are listed according to their importance as identified by the participants. Each of the 45 needs was given one of the two highest ratings, important or very important, by the participants. Six of the needs were not identified by any participants as being very important.

Needs that were unmet for at least one participant in the study are listed in Table 2. Nineteen different needs were identified as being unmet. Table 3 identifies the frequency with which different groups assisted family members in meeting their needs. For 66% of the needs that were listed as being met, the participants identified persons in more than one group who helped to meet their needs.

Findings

As described in Chapter 3, the participants in the study included various family members and live-in companions of the patients. The average age of the participants was 52 with a range in ages from 38 to 76. Of the 14 participants, six were from out of town. These participants stayed in relatives' homes, a YWCA shelter, local hotels, a local campground, and at the hospital. The distances from the hospital to where the participants stayed during the hospitalization period ranged from 2 to 30 miles. The average distance was 8.5 miles.

Participant exposure to hospitals and intensive care units varied. A majority of the study's participants had exposure to hospitals in general as well as to the hospital where the study occurred. Eleven participants had previous experiences with hospitals and five had experience with intensive care units. Six of the participants had previous experiences with the local hospital and three of those had had relatives in the intensive care unit at that hospital.

Demographic data regarding the patients included age, diagnosis, and previous hospitalization. The range of patient ages was 14 to 87 with the average age being 56 and the median age being 64. Diagnoses included:

myocardial infarctions	4
respiratory failure	3
motor vehicle accidents	3

sepsis	2
gunshot wound	1
drug overdose	1

The number of patients who had been previously hospitalized was 11. Three of those had been hospitalized with the same illness. Eight patients had been in this particular hospital previously and three of those patients had been in the intensive care unit. Three patients had been in other intensive care units. For the majority of patients, this was their first admission to an intensive care unit.

A list of the needs ranked according to their importance is found in Table 1. The needs ranked as most important in this study were: to know the prognosis; to feel there is hope; to visit at any time; to receive information about the patient once a day; and to have questions answered honestly. These needs, as well as the next seven ranked by their importance, are concerned with information about the patient's condition, having access to the patient and being given reassurance about the patient's future health. Personal needs of the participants for facilities, support from others, and social service information complete the listing of needs. The needs that were listed as the least important were: to have explanations before going into the critical care unit for the first time and to have another person with the relative when visiting the unit.

Participants were asked to identify any other needs that had not been asked in the Critical Care Family Needs Inventory. One participant cited a need for a smoking area for visitors within the hospital. Visitor smoking is only allowed outside the building. A second participant felt that better accommodations should be available in the hospital for out-of-town family members.

While participants listed most needs as being met, there were 19 needs described as being unmet by at least one participant. The need that was not met for anyone who identified it as a need was to have someone to help with financial problems. Comments from the participants indicated that this would be a greater need once the patient was out of intensive care. The complete list of unmet needs can be seen in Table 2. Only one of the five top ranked needs was listed as being unmet by a participant. This was the need to know the prognosis.

For 64% of the needs described as being met, participants listed more than one group as assisting in meeting those needs. A total of 570 responses were given to the question "Who helped to meet that need?" Nurses were named as meeting needs in 32 of the need statements and were named in 44% of the total responses. Physicians were identified in 25 of the need statements and 26% of the total responses as meeting family needs. In nine of the needs, participants described the needs as being met by someone else

not previously listed. This accounted for 2.8% of the total responses. Participants primarily identified themselves as the one who met the need in this category.

Throughout the study, the participants expressed a need for visiting the patient. All responses to the need statement "to see the patient frequently" were identified as either important or very important. The majority of participants identified the need to have visiting hours changed for special conditions as important or very important. All needs were described as being met. Nine participants identified that there was no need to have visiting hours start on time. Comments during the interviews indicated that participants felt able to visit when they wanted. Comments included: "The visiting was much better than I thought it would be," "I was always there," "I didn't pay any attention to the visiting rules," and "I felt at liberty to come when I wanted."

The needs to feel the best possible care was being given to the patient and to feel that the hospital personnel care about the patient were ranked high by participants. Physicians, nurses, and other hospital personnel were identified as assisting the families in meeting those needs. Other comments regarding these needs indicated that past experience with the hospital and its reputation in the community gave participants the assurance that their family

member would receive the best possible care and concern from the staff.

Findings from the study identified the greatest needs of the participants as knowing the prognosis of the patient and feeling that there was hope for the patient's recovery. One participant described the positive attitude of the physicians and nurses as "a real morale booster." The needs identified in the study were met by many sources and often were met by more than one group of people. Families did identify nurses as the primary group assisting in meeting their needs. The unmet need included the needs for information and the comfort and support of the participants.

Table 1

Family Needs Ranked by Importance

(N = 14)

Need	Not Important	Slightly Important	Important	Very Important
1. To know the prognosis	0	0	1	13
2. To feel there is hope	0	0	2	12
3. To visit at any time	0	0	2	11
4. To receive information about the patient once a day	0	0	3	11
5. To have questioned answered honestly	0	0	3	11
6. To feel that hospital personnel care about the patient	0	0	3	11
7. To know specific facts concerning patient progress	0	0	4	10
8. To be assured the best care possible is being given to the patient	0	1	3	10
9. To see patient frequently	0	0	5	9

Table 1 continued

Need	Not Important	Slightly Important	Important	Very Important
10. To have explanations given that are understandable	0	1	4	9
11. To know exactly what is being done for the patient	0	3	2	9
12. To be called at home about changes in patient's condition	1	1	3	9
13. To feel a accepted by hospital staff	0	2	4	8
14. To have a telephone near the waiting room	1	3	2	8
15. To have friends nearby for support	2	2	2	8
16. To know why things were done for the patient	0	1	6	7
17. To have someone be concerned with the relative's health	0	2	5	7

Table 1 continued

Need	Not Important	Slightly Important	Important	Very Important
18. To have a bathroom near the waiting room	0	5	2	7
19. To have a waiting room near the patient	0	2	7	5
20. To know how the patient is being treated medically	0	2	7	5
21. To talk to the doctor every day	2	0	7	5
22. To have visiting hours changed for special conditions	6	0	3	5
23. To have directions as to what do at the bedside	5	2	3	4
24. To have comfortable furniture in the waiting room	1	4	6	3
25. To have the pastor call	7	0	4	3
26. To be told about transfer plans while they are being made	0	4	8	2

Table 1 continued

Need	Not Important	Slightly Important	Important	Very Important
27. To talk about the possibility of the patient's death	6	1	5	2
28. To have a specific person to call at the hospital when unable to visit	6	2	4	2
29. To be told about someone to help with family problems	5	4	3	2
30. To have someone to help with financial problems	7	3	2	2
31. To help with the patient's physical are	2	4	8	1
32. To know which staff members could give what type of information	3	2	8	1
33. To have a place to be alone while in the hospital	3	4	6	1
34. To have good food available while in the hospital	6	3	4	1

Table 1 continued

Need	Not Important	Slightly Important	Important	Very Important
35. To be assured it is alright to leave the hospital for awhile	6	3	4	1
36. To be told about other people that that could help with problems	5	4	4	1
37. To talk about negative feelings such as anger or guilt	8	1	4	1
38. To have explanations of the environment before going into the critical care unit for the first time	11	0	2	1
39. To be encouraged to cry	7	5	1	1
40. To be alone at any time	2	2	10	0
41. To know about the types of staff members taking care of the patient	6	3	5	0
42. To have visiting hours start on time	9	0	5	0

Table 1 continued

Need	Not Important	Slightly Important	Important	Very Important
43. To be told about chaplain services	9	3	2	0
44. To talk to the same nurse every day	8	3	3	0
45. To have another person with the relative when visiting the critical care unit	10	4	2	0

Table 2

Participants' Unmet Needs

Need	Met	Unmet
1. To have someone to help with financial problems	0	7
2. To be called at home about changes in the patient's condition	1	5
3. To be told about other people that could help with problems	4	4
4. To have the pastor visit	3	4
5. To talk to the same nurse every day	2	4
6. To be told about chaplain services	1	4
7. To have directions as to what to do at the bedside		
8. To be told about someone to help with family problems	4	3
9. To be encouraged to cry	3	3
10. To help with the patient's physical care	10	2
11. To have friends nearby for support	10	2
12. To have good food available in the hospital	6	2
13. To talk about the possibility of the patient's death	6	2
14. To have another person with the relative when visiting the critical care unit	2	2
15. To know the prognosis	13	1
16. To talk to the doctor every day	11	1
17. To have a specific person to call at the hospital when unable to visit	7	1

Table 2 continued

Need	Met	Unmet
18. To talk about negative feelings such as guilt or anger	5	1
19. To have explanations of the environment before going into the critical care unit for the first time	2	1

Note. Total numbers vary for each need depending on the number of participants who ranked the needs as being important.

Table 3

Groups Assisting in Meeting Family NeedsN = 570

Group	Number of Responses	Percentage of Responses
Physicians	150	26.3%
Nursing Staff	251	44.0%
Immediate Family	23	4.0%
Extended Family	9	1.5%
Friends	15	2.6%
Clergy	7	1.2%
Other Hospital Staff	99	17.0%
Someone Else Not Listed	16	2.8%

Note. Participants could list more than one group as meeting a specific need.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The study consisted of interviews with 14 family members of patients in an intensive care unit. Using the Critical Care Family Needs Inventory as a guide, participants were asked to rank needs as to their importance and whether or not each need had been met. Participants were also asked to identify who was of assistance in meeting their needs.

Limitations of this study are related primarily to the sample. These limitations include: (a) the definitions of patient and family member, (b) those family members with whom the researcher was able to make contact, and (c) English speaking family members. Because patients were required to be in the unit for 72 hours, those families whose family member was there a shorter period of time were not included. Families of patients who died while in the unit were also not included in the study. These families as well as those in the unit less than 72 hours may have different needs that were not addressed. Also, the economic or educational status of the family members were not addressed in this study.

The priority needs identified in this study differed from those identified in Molter's study. The five highest ranked needs in Molter's study were: to feel there is hope, to feel that hospital personnel care about the patient, to

have the waiting room near the patient, to be called at home about changes in the patient's condition, and to know the prognosis (Molter, 1979, p. 334). The five highest ranked needs in this study were: to know the prognosis, to feel there is hope, to visit any time, to receive information about the patient once a day, and to have questions answered honestly. While these specific needs vary from those identified by Molter, they are all directed toward the patient, knowing about his condition, and being able to be near the patient.

Personal needs of the participants were of lower priority in both studies. In the hospital in which this study was conducted, many of the comfort and visiting needs were provided for by the physical layout of the unit and the flexible visiting policies. Needs for support went unfilled for some participants. These needs included information about outside resources for help with financial or family problems and emotional support for the participants. These are areas where nursing is not always well prepared to be of assistance to the family. In the hospital where the study was conducted, there is not one department or individual who serves as a social worker in helping to coordinate outside support for families during the hospitalization. A crisis intervention team is available for immediate intervention for the patient or family, but a physician order is required for ongoing psychosocial service.

As in Molter's study, nursing staff was identified as the primary group assisting families in meeting their needs. Family members as well as patients become dependent upon nursing staff for information, reassurance, and support. The families in this study also relied heavily on physicians and other hospital staff in meeting their needs. Physicians were named in 26% of the responses as assisting with meeting family needs. Other hospital staff was named in 17% of the responses.

For participants in this study, the greatest needs dealt with knowing the patient's condition and being near the patient. The majority of identified needs were met for the participants and the nursing staff was of the greatest assistance in meeting those needs.

Recommendations

This study identified a difference in the importance of needs of families to those identified in Molter's 1979 study. Despite the differences, the needs of knowing the prognosis and feeling there is hope for the patient were primary ones in both studies. This study demonstrates the importance of identifying the needs for families in a particular setting as they will vary from area to area. The study also demonstrated the differences in needs among different families. Continued investigation of the needs of families in different settings will enhance the base of knowledge of family needs during a critical care admission.

More specifically, the study demonstrated some areas of need in the institution in which it was conducted. Nursing staff was identified as the primary group who was of assistance in meeting family needs. In all probability, this will not change in the future; however, in order to better meet the needs of the family, the nurses in this hospital need to be able to offer information on outside resources to the family.

Beyond the specific recommendations for the hospital, this study suggests that continued research be conducted regarding family needs during a hospitalization. Nursing, as the primary health care provider in a hospital setting, is in the best position to identify the needs of families and to continue to assist in meeting the needs. This researcher would suggest that further study is also needed to ascertain the differences in perceptions of family needs between family members and nursing staff. As nurses continue to investigate the needs of families during hospitalization, their perceptions of those needs will come closer to the family's perceptions. As this occurs, nurses will be better able to serve their patients and their families.

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Appendix A
Letters of Permission

Nancy C. Molter, RN, MN, CCRN
9526 Millers Ridge
San Antonio, TX 78239
25 October, 1988

Mary Kramer RN
1595-B Josselyn Canyon Road
Monterey, CA 93940

Dear Mary,

Please feel free to use and adapt the Critical Care Family Needs Inventory tool for your research project. Reliability data related to the tool is published in the March, 1986 issue of Heart & Lung by Jane Leske.

Jane has also done construct validity on the tool. She can be contacted at 5333 W. River Trail, Mequon WI 53092. Phone (414) 241-4316. I've enclosed a copy of the tool and wish you success in your program.

Sincerely,

Nancy Molter

Community Hospital of the Monterey Peninsula

February 14, 1989

Human Subjects Committee
San Jose State University
San Jose, CA

This note confirms that Mary Kramer, R.N., has received permission to complete her thesis research project entitled "Family Needs of Patients in ICU" at Community Hospital of the Monterey Peninsula. It is our understanding that the study will proceed as outlined in her thesis proposal, which I have read, and with the revision of the Patient Agreement/Consent form, which has been instituted.

The change in the guidelines and consent form to indicate Community Hospital as the contact agency is the result of Community Hospital's need to maintain a non-research, non-teaching philosophy and in view of the fact that we have no contractual relationship with San Jose State University.

I hope that this modification does not limit Mary Kramer's ability to complete her thesis work, as we do support this as a valuable project for her and for our patients. Please call me if you have questions or concerns.

Sincerely yours,

Mary Ann Washington, R.N.
Vice President/Nursing Services

MGW:rr

Appendix B
Human Subjects Approval

SAN JOSE STATE UNIVERSITY FOUNDATION

April 19, 1989

Ms. Mary Kramer
1595-B Josselyn Canyon Road
Monterey, CA 93940

Dear Ms. Kramer:

Your human subjects protocol number #7454 has received final approval from the Human Subjects Institutional Review Board. Attached is a copy of the final approval form with the signatures of the Chairman of the Human Subjects Institutional Review Board, Dr. Toni Campbell, and the Associate Academic Vice President for Graduate Studies and Research, Dr. Serena Stanford.

The Human Subjects Institutional Review Board must be notified in writing of any proposed changes to this approved protocol, and approval must be granted in writing before any change is instituted.

If you have any questions, please contact Dr. Toni Campbell at (408) 924-3725 or myself at (408) 924-1438.

Congratulations and good luck with your research!

Sincerely,

Jerelyn Cockriel
Contracts and Grants Coordinator

Attachment

SAN JOSE STATE UNIVERSITY
GRADUATE STUDIES AND RESEARCH

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD
PROJECT PROPOSAL REVIEW

56

I, the undersigned member of the San Jose State University Human Subjects Institutional Review Board, have reviewed the following proposal submitted to the Committee on 2/23/89 by:

PRINCIPAL INVESTIGATOR: Mary Kramer
PROTOCOL #: 7454 DEPT.: Nursing
PROJECT TITLE: FAMILY NEEDS OF PATIENTS IN THE INTENSIVE CARE UNIT

I recommend the following action (indicate one):

1. Approved for clearance as involving minimal risk to Human Subjects. ☒
2. Approved for clearance with risk to Human Subjects. ☐
3. Approved for clearance when the following conditions are met: ☐

4. Not Approved (return to principal investigator for following reasons): ☐

5. Expedited Review (specify condition[s] that merit expedited review): ☐

Robert F. Latta, MD 2/23/89
Signature of IRB-HS member Date

OFFICIAL SIGNING FOR INSTITUTION

Jan Campbell 4/12/89
Chair, Human Subjects Institutional Review Board Date

Serena Stanford 4/18/89
Serena Stanford, Ph.D. Date
AAVP for Graduate Studies & Research

San Jose State University Foundation
One Washington Square
San Jose, CA 95192-0139 (408) 924-1435

FAMILY NEEDS OF PATIENTS IN THE INTENSIVE CARE UNITAGREEMENT TO PARTICIPATE IN STUDY

I have been asked to participate in a research study that is investigating the needs of families of patients in the intensive care unit. The results of the study will help nurses increase their knowledge and understanding of those family needs.

I understand that:

- 1) I will be asked to complete a general information form and to participate in an interview that addresses my needs during this hospitalization. The interview will be conducted with Mary Kramer.
- 2) A risk of this study is a possible loss of confidentiality for me or my family. To protect my privacy and that of my family, my name will not be used on the general information form or the questionnaire. All findings from this study will be reported only as group data.
- 3) The findings of this study are not expected to benefit me directly. However, it may be of value to me to discuss the experience of this hospitalization and the time in the intensive care unit with another person. Whether or not I participate in this study will not influence the care of my family member in any way.
- 4) Any questions about my participation in this study will be answered by Mary Kramer (625-4950). Questions or complaints regarding research procedures, my rights as a research subject, or problems that arise with the study will be answered by Mary Ann Washington, Vice President of Nursing at Community Hospital (624-5311 ext. 4711).
- 5) My consent is given voluntarily without being coerced; I may refuse to participate in the study or in any part of the study, and I may withdraw at any time without prejudice to my relations with Community Hospital of the Monterey Peninsula.
- 6) I have received a copy of this consent form for my files.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

DATE

PARTICIPANT'S SIGNATURE

MARY KRAMER NURSE RESEARCHER

Appendix C
Critical Care Family Needs Inventory
and General Information Form

FAMILY NEEDS OF PATIENTS
IN THE INTENSIVE CARE UNIT

59

Hello. You are being asked to participate in a research project that addresses the needs of family members of patients in the intensive care unit. Family members are an important part of a patient's recovery. You offer support and encouragement to your family member that can speed their recovery.

This research study will help to identify the needs of families and will enable nursing staff to identify and meet those needs more effectively. The study is being done as a thesis for my master's degree in nursing. The study has been approved by both Community Hospital and San Jose State University.

I will be the only person gathering the research information. I will be interviewing you about the intensive care unit and your needs while here. Responses shared in the interview will not be shared with anyone including staff members except as the completed thesis.

A consent form is attached. I greatly appreciate your participation in this study. If you have any questions, comments, or suggestions please feel free to make them to me.

Mary Kramer RN
Nurse Researcher

GENERAL INFORMATION FORM

My age _____ My sex _____

My relationship to my hospitalized family member _____

My family member's diagnosis _____

My family member's age _____ My family member's sex _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

My family member has been hospitalized before: YES NO

My family member has been hospitalized before for:

the same illness _____ YES NO

another illness or surgery _____ YES NO

please list that illness _____

My family member has been hospitalized before in:

this hospital _____ YES NO

another hospital _____ YES NO

this intensive care unit _____ YES NO

another intensive care unit _____ YES NO

Other family members have been hospitalized in:

this hospital _____ YES NO

another hospital _____ YES NO

this intensive care unit _____ YES NO

another intensive care unit _____ YES NO

The distance from my home to the hospital _____

Where I am staying while my family member is hospitalized _____

PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

These consist of pages:

61-66, GUIDE FOR CRITICAL CARE FAMILY NEEDS INVENTORY

U·M·I