1997

Importance and Fulfillment of Family Needs in the ICU

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IMPORTANCE AND FULFILLMENT OF FAMILY NEEDS IN THE ICU

By

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A THESIS

Submitted to
Grand Valley State University
in partial fulfillment of the requirements for the
degree of

MASTER OF SCIENCE IN NURSING

Kirkhof School of Nursing

1997

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ABSTRACT

IMPORTANCE AND FULFILLMENT OF FAMILY NEEDS IN THE ICU

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The family is a major source of support for the intensive care patient. To provide optimal support to the patient, the family's needs must be met. A convenience sample of thirty family members of intensive care patients were interviewed. The continuing importance of primary needs established in previous studies was demonstrated. None of the needs were universally perceived as being fulfilled. The nurse was most often cited as the best person to meet needs. Many respondents couldn't choose a single best person emphasizing the need for a multi disciplinary approach to meeting needs. Seven additional needs were identified (a) to know their right to question patient care, (b) to have a secure place to store belongings, (c) to have a place to sleep, (d) to have a member of the clergy available, (d) to be assured the patient is comfortable (e) to have a place for emotional outlets, and (f) to be assured patient confidentiality is maintained.

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CHAPTER1

INTRODUCTION

"Families hold the primary responsibility for the nurturance and development of their members. During stressful times, families have the potential to support, comfort, and give their members a sense of belonging" (McClowry, 1992, p. 559). A critical illness causes a significant amount of physiologic stress for the patient. The patient may also experience psychological stressors like fear, loneliness, confusion, and dehumanization (Kupferschmid, Briones, Dawson & Drongowski, 1991). The unexpected nature of critical illness, with the threat of an unfavorable outcome, can cause a significant amount of stress and has the potential to disrupt normal family coping mechanisms (Leske, 1991c; Hickey & Leske, 1992).

Recognizing that the family is the focus of care (American Nurses Association, 1980), nurses have a responsibility to both the patient and their family to provide interventions to maintain or restore family functioning (Smith, Kupferschmid, Dawson & Briones, 1991). Nurses interact with the patient's family from admission to discharge which places them in an optimal position to have a positive impact on family functioning (Reeder, 1991). Nurses can do this by identifying and meeting the needs of family members so that the family can provide necessary support to the patient (Kupferschmid et al., 1991; Hickey & Leske, 1992).

Molter's (1979) landmark study identifying the needs of family members of critically ill patients led to increased awareness of the role of the family in critical care

units across the nation. This increased awareness brought about changes in the delivery of care. Support groups for family members, changes in visiting hours and improved educational materials are only a few of these changes. The current health care climate with its focus on cost containment and outcomes management combined with a more informed and articulate health care consumer mean that the role of the critical care nurse in meeting family needs is more important than ever. Molter believes, however, that the nurse is "not expected to meet all the family needs" (Leske, 1991a, p. 186). Therefore, it is important for the nurse to assess not only the priority family needs but also, which needs nurses are best able to meet.

Problem Statement

This study combined aspects of previous studies assessing the needs of family members of patients in the intensive care. The study evaluated the importance of family needs. It also sought to identify need fulfillment by examining who the family perceived as the person(s) best able to meet each need, the degree to which each need was met, and if there was a relationship between the importance of a need and the degree to which the need was met. Most of the existing research on family needs took place in large medical and teaching centers. This study took place in a 350 bed, not for profit, community hospital.

Purpose

In view of the many changes in the health care delivery system since the original research on the needs of families of critically ill patients (Molter, 1979), this study began by assessing the continuing importance of family needs to ascertain if changes in recent

years had caused a shift in the importance of any of the needs. This study also assessed need fulfillment or who the family perceived as the person best able to meet identified needs and if the needs had been met. It then evaluated if there was a relationship between the importance of a need and the degree to which it was met. Dracup (1993) suggested that nurses interested in meeting the needs of family members of critically ill patients take research to its next step and look at how those needs can be met. Hopefully, the information from this study will enable nurses to focus their interventions on the needs that the nurse is best able to meet and consult other members of the health care team for help meeting the family's other needs, thereby, moving on to the next step suggested by Dracup.

CHAPTER 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Conceptual Framework

The Neuman systems model (Neuman, 1995) was the framework selected for this study. The client, in the Neuman systems model, may be an individual, a family, a community, or other group. For this study the client was the family of a patient in the intensive care unit. The Neuman systems model looks at the client wholistically in relation to their environment and how various stressors affect the client's health and well-being. It identifies stability, or health, as a "state of balance requiring energy exchange between the system and environment to cope adequately with imposing stressors" (Neuman, p. 13). A stressor may be defined as an environmental factor that has the "potential for disrupting system stability" (Neuman, p. 47). The admission of a family member to the intensive care unit was assumed to be a stressor for the family members participating in this study.

Neuman (1995) looks at the client as a basic structure "consisting of basic survival factors common to the species" (p. 26). The basic structure is surrounded by concentric circles called the lines of defense and resistance (see figure 1). The lines of resistance surround the basic structure. They in turn are surrounded by the normal line of defense and the flexible line of defense. There are similarities between all the lines of defense and resistance. Together, they are an interrelated group of protective and adaptive mechanisms which attempt to maintain client stability or wellness. The

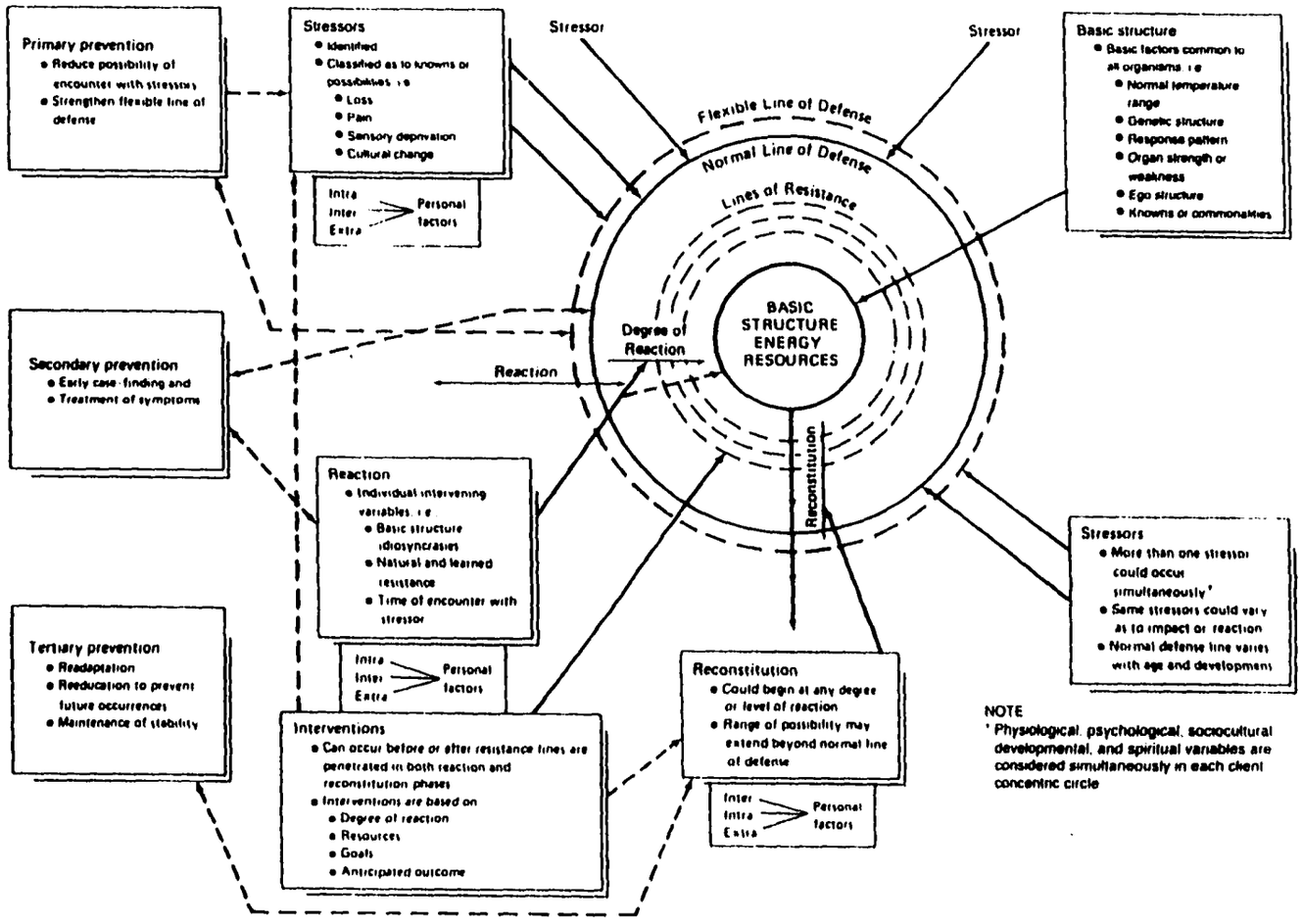

Figure 1. The Neuman Systems Model: Neuman, B. (1995). The Neuman Systems Model (3rd ed.). Norwalk, CT: Appleton & Lange. Reprinted with permission (see Appendix A).

Neuman systems model considers five client variables when assessing the core structure and the lines of defense and resistance. They are the physiological, psychological, sociocultural, developmental, and spiritual variables.

When a stressor succeeds in penetrating the flexible line of defense, signs and symptoms of illness are seen. Ideally, nursing interventions are geared toward strengthening the flexible line of defense and preventing illness. The flexible line of defense surrounds and protects the normal line of defense. It is an ever changing composite of defense mechanisms. It prevents stressors from invading the basic structure/client. The normal line of defense, or usual wellness/stability state, is "a *standard* against which deviancy from the usual wellness state can be determined" (Neuman, 1995, p. 30). The client demonstrates symptoms of illness or instability when the normal line of defense has been penetrated. The lines of resistance "are activated following invasion of the normal line of defense by environmental stressors" (Neuman, p. 30). The lines of resistance contain internal and external resources that protect and support the basic structure and normal line of defense.

Neuman (1995) sees nursing as the link between client, health, and the environment. Nursing interventions are broken down into primary, secondary, and tertiary prevention depending on where in the continuum of health the client is encountered. Primary prevention occurs when a stressor has been identified but has not caused a reaction in the client yet. Its goal is to "strengthen the client's flexible line of defense to decrease the possibility of a reaction" (p. 33). Secondary prevention occurs when symptoms occur, it is intended to strengthen the lines of resistance thereby

protecting the basic structure. Its goal is to return the client to a state of wellness or stability. Tertiary prevention is concerned with wellness maintenance once the client has achieved wellness or stability. It leads back to primary prevention.

For the purposes of this study, the client was the family of a patient in the intensive care unit. The patient's admission to the intensive care unit was a major stressor imposing on the family system in this study. It was not necessarily the only stressor the family was handling. The basic structure was the composition of the family including who its members were and the relationships between them. The family's normal level of functioning and coping mechanisms corresponded with the lines of resistance and defense. The physiologic variable entailed the family's basic needs such as food, rest, and shelter. The psychologic variable included the family's mental and emotional health and factors such as the support systems within the family. The spiritual variable encompassed the family's spiritual beliefs and values. The developmental variable related to the developmental stage of the family, the age, cognitive abilities, and life experiences of each individual family member including any previous experience with intensive care. Finally, the sociocultural variable consisted of the relationships within the family and with friends and others in the community as well as the family's cultural and socioeconomic background. The forty-seven identified family needs evaluated in this study may also be considered in terms of the five client variables. See Appendix B for a list of the needs statements which fall under each client variable.

The study questions related to Neuman's (1995) modes of prevention. The goal of primary prevention in this study was to identify the importance of identified needs of

family members of patients in intensive care. By identifying these needs interventions can be formulated to support the family, strengthen their existing coping mechanisms, and enhance family functioning so that the family may, in turn, support their ill family member. The family that is already showing signs of stress requires secondary prevention. Once stability has been achieved the family requires tertiary prevention to maintain stability. Identifying the person(s) best able to meet their needs as perceived by the family members guides the nurse in differentiating between interventions within the realm of nursing and those requiring consultation. Assessing the degree to which the needs were met enables the nurse to evaluate existing interventions and the need for further interventions. The relationship between the importance of needs and the degree to which they were met may also help nurses gauge the effectiveness of existing interventions. With its wholistic approach and focus on prevention, the Neuman systems model fits well with the concept of the family as the focus of care. The relationship between having a family member in intensive care, family needs, and the concepts of the Neuman systems model (1995) pertinent to this study are illustrated in Figure 2.

Review of Literature

There were a number of basic concepts integral to this study specifically family, the role family plays in patient care, and family needs. These concepts were defined through a review of pertinent literature. A brief summary of existing research on the needs of family members of patients in the intensive care setting follows.

Family. The traditional definition of a family as "a group of people related by blood or marriage " (Webster's New Twentieth Century Dictionary, 1979) does not fit all

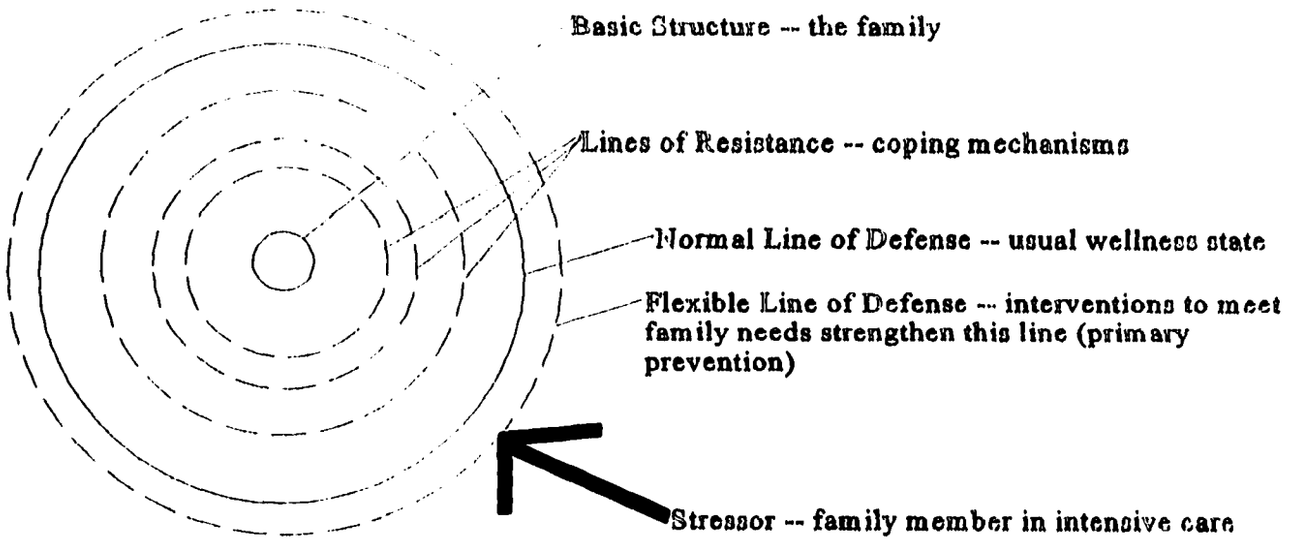

Figure 2. The concepts of the Neuman Systems Model related to family needs in the intensive care unit

situations. According to the 1990 Census Bureau (as cited in McCool, Tuttle, & Crowley, 1992) almost one third of the population lives in a household which does not fit the traditional definition. McCool, Tuttle, and Crowley (1992) present a number of reasons for the changing composition of families. They cite the fact that both men and women are marrying later or choosing options other than marriage, an increase in the divorce rate, and a decline in the number of children families are choosing to have as important factors. Other factors include an increase in the number of women in the workforce and increased life expectancy. These demographic changes have resulted in the formation of single person households, same or opposite sex couples, single parent families, and blended families among others.

In light of the changing composition of families, it is necessary to re-define what constitutes a family. Whall (as cited in McCool, Tuttle, & Crowley, 1992) defines a family as a self-identified group, not necessarily related legally or by blood, who function and identify themselves as a family. Definitions of family may also include mention of the emotional bond shared by family members (Friedman, 1986). Therefore, it is necessary for nurses to individually assess each family situation and identify who the patient and family consider part of the family. It is also important to remember that the family has a long-term relationship with the patient (Cope and Wolfson, 1994) as opposed to the short term relationship the nurse has with the patient.

Role Family Plays in Patient Care. Despite the many forms a family can take, all families can be viewed as a system and each individual within the family contributes to its functioning. Therefore, the illness of any one member within the family will have an

affect on overall family function (McCubbin, 1993). This is especially true in the intensive care setting. King & Gregor (as cited in Chartier & Coutu-Wakulczyk, 1989) relate that families experiencing anxiety and stress may exhibit depression, loss of appetite, weight loss, decreased ability to concentrate and insomnia.

Chartier & Coutu-Wakulczyk (1989) measured family needs and anxiety in family members visiting patients in the ICU using a French version of the Critical Care Family Needs Inventory (CCFNI) and the A-STATE anxiety scale of the State-Trait-Anxiety Inventory (STAI). Their research showed a significant relationship ($p<0.001$) between anxiety level and family needs. Rukholm, Bailey, Coutu-Wakulczyk, and Bailey (1991) also evaluated family needs and anxiety levels in the intensive care using the CCFNI and the situational and trait anxiety scales of the STAI. Their research demonstrated a significant relationship ($p < 0.0002$) between family needs and situational anxiety.

Halm et al. (1993) examined the behavioral responses of family members of intensive care patients over time using the Iowa ICU Family Scale (IIFS). The IIFS asks family members to report behavioral changes in five areas: sleep behaviors, eating behaviors, activity behaviors, family roles, and support systems. A daily stress response score (SRS) was calculated for participants each day they participated in the study which allowed the researchers to show variations in stress as well as a family member's average stress response to visiting the ICU. Mean SRS scores peaked with the patient's admission and gradually decreased. The highest mean SRS scores occurred during the first three days in the ICU. Halm et al. thus concluded that "all family members should

be considered "at risk" during the first three days" (p. 432).

The stress of a family member's admission to an intensive care unit can impact family function in many ways. In addition to the physiologic threat to the ill member, other members may be faced with role changes, isolation, financial concerns, transportation problems, fear of loss of their loved one, and emotional trauma (Hodovanic, Reardon, Reese, and Hedges, 1984). Families have varying abilities to deal with the stress of a critical illness. Just as the illness of one member affects the entire family, the family affects the patient's response to the illness (Hodovanic, Reardon, Reese, and Hedges).

"The emotional health of the family is essential to rebuilding the health of the patient" (Holmes-Garrett, 1990). The family is an important source of support for the ill patient. Simpson (1991) interviewed 100 patients within three days of their transfer from an intensive care setting to evaluate the ways family members provide support for the patient. Simpson found that just the family's presence was comforting to the patient. The family shows concern and caring for the patient, provides moral support, and serves as a patient advocate. The family also helps with responsibilities and shares news from home with the patient. Finally, Simpson found that patient visits provided reassurance to the family. The family, when its members are themselves sick or stressed, is unable to provide necessary support to the patient (Molter, 1994).

Family Needs. The nursing research on family needs in the intensive care setting assumes that by meeting family needs, nurses can enable family members to provide necessary support to the patient. Molter's (1979) research on the needs of families of

critically ill patients has served as a model for further research on the needs of families of critically ill patients. She identified 45 "needs" of families of critically ill patients by surveying the literature and a group of graduate nursing students. In her landmark study she interviewed a convenience sample of 40 relatives of critically ill patients, after the patient had been transferred to a general unit, to identify the needs of family members of critically ill patients and the importance of the needs. Each of the 45 needs identified by Molter was ranked by the relatives on a scale from not important at all to very important. Relatives were asked if they had any other needs not included on the list with no additional needs identified.

All of the needs were rated very important at least once. The ten most important needs identified were: (1) to feel there is hope (identified as very important by all 40 family members), (2) to feel that hospital personnel care about the patient, (3) to have the waiting room near the patient, (4) to be called at home about changes in the condition of the patient, (5) to know the prognosis, (6) to have questions answered honestly, (7) to know specific facts concerning the patient's progress, (8) to receive information about the patient once a day, (9) to have explanations given in terms that are understandable, and (10) to see the patient frequently

Molter (1979) also asked who had met the need and whether or not the need had been met. Choices for who had met the need included: doctor, nurse, chaplain, other relatives, friend, other visitor, and other. Nurses were cited the majority of time for 20 of the needs. An additional 7 needs were met most often by physicians. Leske (personal communication, February 6, 1995) states that the family members in Molter's study had

difficulty identifying who specifically had met a particular need. Molter found that only four of the needs identified as important or very important were met less than half the time. These were: the need to talk to the doctor at least once a day, the need to be told about chaplain services, the need to have a place to be alone while in the hospital, and the need to have someone help with financial problems.

Daley (1984) used a convenience sample of 40 family members with relatives in the intensive care setting to assess family needs. Like Molter (1979), Daley was interested in who was meeting the needs. Whereas Molter asked "who met the need?", Daley asked who the family perceived as the person(s) most likely to meet the need given the following choices: doctor, nurse, minister, family member, self, or other. Unlike Molter's study, Daley found that the doctor was the person perceived by the family as most likely to meet the majority of the needs.

Leske (1986) assessed the needs of 55 family members using the Critical Care Family Needs Inventory (CCFNI) and compared her findings to those of Molter (1979). Instead of speaking to individual family members, like Molter, Leske spoke to family members as a group and recorded their consensus response. She also conducted the interviews while the patient was still in the intensive care setting. The three most important needs identified by Leske were rated as very important by all the respondents. they were the need (a) to feel there is hope, (b) to have questions answered honestly, and (c) to know the prognosis. These three needs were also in the top ten needs identified in Molter's (1979) study.

In another study Leske (1991c) gathered data from 27 researchers who had used

the CCFNI in their research to do an empirical analysis of the results. The research was conducted between 1980 and 1989 in 15 states. The combined data gave Leske a sample of 905 family members. Leske found that 15 needs were consistently ranked as important, therefore, she identified these as primary needs. The needs, in order of importance were the need: (a) to have questions answered honestly, (b) to be assured the best care possible is being given to the patient, (c) to know the prognosis, (d) to feel there is hope, (e) to know specific facts about the patient's progress, (f) to be called at home about changes in the patient's condition, (g) to know how the patient is being treated medically, (h) to feel hospital personnel care about the patient, (I) to receive information about the patient daily, (j) to have understandable explanations, (k) to know exactly what is being done for the patient, (l) to know why things were done for the patient, (m) to see the patient frequently, (n) to talk to the doctor every day, and (o) to be told about transfer plans while they are being made.

Using factor analysis the 45 needs on the CCFNI have been grouped into five categories (Leske, 1992b) which according to Leske (1991c) can serve as a "research-based framework to guide family-centered critical care nursing interventions and future research" (p. 222). They are (a) the need for assurance, (b) the need for proximity, (c) the need for information, (d) the need for comfort, and (e) the need for support. In Leske's (1991c) empirical analysis of research from 1980 to 1989, she identified the need categories of assurance, proximity and information as priority needs.

Wilkinson (1995) conducted a qualitative study to identify family needs. Wilkinson conducted interviews of six family members in a general intensive care unit at

least 72 hours after the patient was admitted. After analyzing the data Wilkinson found six categories of needs. The first need, which according to Wilkinson was a source of stress for the family, was the shock of admission to intensive care and coming to terms with critical illness. The need for access and close proximity, included not only visiting needs but also the family's need for physical comforts such as food. The need for a caring environment addressed issues of both the competency and caring of the staff as well as the appearance of the physical environment. The need for social support included support from the nursing staff. The need for information was found to enhance coping mechanisms by allowing family members to think ahead to what might happen next. The final need category identified was the need for hope. (See Appendix C for a comparison of Neuman's five client variables, the need categories of the CCFNI, and Wilkinson's six categories of needs as they relate to the 45 need statements on the CCFNI.)

Summary and Implications for Study

To provide wholistic care to the patient in the intensive care setting, the nurse must include the family in the plan of care. The first step in including the family is assessing the importance of family needs. Nurses must, however, recognize that they can not meet all of a family's needs (Leske, 1991a). Therefore, it is not only important for the intensive care nurse to identify family needs but also to recognize which needs the nurse is best able to meet. Then by identifying those needs which are not currently being met, the nurse can either formulate interventions or make referrals to meet those unmet needs.

Research Questions

What is the importance of identified needs of family members of patients in an intensive care setting?

Who is the person(s) best able to meet needs as perceived by the family members of patients in the intensive care setting?

To what degree have the perceived needs of family members been met?

Is there a relationship between the importance of a need and the degree to which it is met?

Definition of Terms

The following definitions were used in this study:

1. Family -- A group of persons, related by blood or not, joined by a bond of love and concern for one another over an extended period of time as identified by members of the family. The family defines who are its members.
2. Family needs -- A requirement that if met strengthens the family's flexible and normal lines of defense and protects the basic integrity of the family unit. Unmet needs may result in disruption of the family unit.

CHAPTER 3

METHODS

Research Design

A descriptive research design with a structured interview technique using a modified form of the Critical Care Family Needs Inventory (original CCFNI, Appendix D; modified CCFNI, Appendix E, response sheet for modified CCFNI, Appendix F) was used to gather data from family members of patients in the intensive and coronary care units of a non-profit, community hospital in the midwest. The interviews were conducted by the researcher in a private consultation room beside the waiting room for the intensive and coronary care units during regular visiting hours.

Threats to external validity included a number of personal and situational variables which might influence the study results. There are a number of family dynamics which it was not feasible to assess in the course of the study which could potentially affect the outcomes. First, while the demographic data gathered gave the family member's formal relationship to the patient, assessing the informal roles of the patient and family member was beyond the scope of this study. Next the interpersonal relationship between the patient and the family member, for example how close the relationship between them was and if there were any unresolved issues between them was not identified. There may have been hardships imposed on the family by the hospitalization such as child care, financial and job constraints, and transportation problems which affected responses and were not identified by the researcher. The degree of rapport developed between the researcher and the family member being interviewed

may have affected the family member's willingness to share information. The more comfortable the family was with the researcher, the more willing they may have been to share information. Finally, family members who were not able to visit due to distance, health, finances, and other constraints were not available for participation in the study.

Personal variables which might have influenced the study included researcher availability and technique. Data collection was limited by the researcher's availability. The researcher was available during the data collection period at a variety of different times to try to reach as many family members as possible. As the only data collector, the times the researcher was available were, of necessity, limited by the researcher's needs for food and rest, as well as the researcher's own work and family needs. Researcher technique while administering the questionnaire could have also affected responses. A script (Appendix G) was used during administration of the questionnaire to insure consistency in administering the questionnaire.

Sample and Setting

A convenience sample of 30 family members of patients in the 9 bed intensive care and 12 bed coronary care unit of a 350 bed, not for profit, community hospital in northwestern Indiana made up the subject pool. The surrounding community includes numerous Amish and Mennonite congregations. The intensive and coronary care units, from which subjects were drawn, had open visiting from 6:00 a.m. to 2:00 p.m. and again from 4:00 p.m. to 10:00 p.m. The afternoon break in visiting and the night time hours were designated as quiet time. During those hours, exceptions to visiting are made on an individual basis by the nurse caring for the patient. However, the purpose of

quiet time was to allow the patient a block of uninterrupted rest. Procedures, lab draws, x-rays, and transfers were also discouraged during quiet time. The average daily patient census for the two units is 10. Therefore, if each patient had just one family member present during regular visiting hours, the researcher would conceivably have a potential sample pool of at least ten family members for each day of data collection.

The following inclusion criteria were used to select subjects:

1. Patient was admitted greater than 24 hours before the interview to allow the family member to have immediate concerns about the patient answered and enable the family member to become aware of their needs.
2. Family member was at least 18 years old.
3. Family member was a spouse, parent, child, sibling, significant other, or other individual identified by the family as a member of the family. The first 3 family members per patient, who agreed to participate, were be included in the study. Participation was limited to three family members per patient to prevent possible bias.
4. Family member was able to speak and understand English.
6. Family member was physically present at the hospital.

A minimum of 30 subjects were enrolled in the study.

Instruments

A modified version of the Critical Care Family Needs Inventory (CCFNI) was used in this study (Appendix E, the response key is listed in Appendix F). Leske (1986) developed the CCFNI cooperatively with Molter using the 45 need statements from

Molter's study. The CCFNI has served as the basis for studies exploring the needs of families of critically ill patients in a variety of settings.

The CCFNI is composed of 45 need statements randomly arranged which are rated on a 4-point scale from 1, not important, to 4, very important. An open ended question allowing family members to verbalize additional needs is added at the end. A Family Needs Questionnaire (FNQ) (cited in Kreutzer, Serio, & Bergquist, 1994) addressed three need statements which the researcher felt were relevant to the current study. Recognizing that there are several possible outcomes to any illness requiring intensive care up to and including death, the researcher chose to substitute the need "to talk about the possibility of the patient's death" (Molter & Leske, 1983) from the CCFNI for the need "to have help preparing for the worst" (as cited in Kreutzer, Serio, & Bergquist, p. 110) from the FNQ. The other two needs from the FNQ: question 46:"to get a break from my problems and responsibilities" (as cited in Kreutzer, Serio, & Bergquist, p. 110) and question 47 "to have help getting over my doubts and fears about the future" and were added to the end of the CCFNI questions.

Question number 24 of the original CCFNI relates to the need to have a pastor visit. The modified version asks the participant to rate the need to have a religious leader or layperson visit. This change was made in an attempt to appeal to a wider range of religious affiliations.

The CCFNI has also been modified by the researcher to encompass each of the study questions. For each of the 45 need statements, the family member was asked "who do you think is the person best able to meet this need?" The family member could

choose from eight choices: self, other family member, friend, doctor, nurse, social worker/case manager, religious leader or layperson, and other. If other is selected the family member was asked to specify who. For each need statement the family member was also asked to rate on a 4 - point scale the degree to which the need had been met from 1, not met at all, to 4, totally met.

Initial content validity for the CCFNI was established in Molter's (1979) study by 23 graduate nursing students, two ICU nurses, and a nurse with a family member in the ICU. An expert panel of 16 nurse managers and faculty formed by Macey and Bouman (1991) confirmed content validity for the CCFNI, despite the fact that one needs statement was judged by four panel members and three other needs statements were judged by three panel members as not being needs. Each of the four needs statements identified by panel members as not being a need were identified by family members in Macey and Bouman's study as being a need.

Using a Gunning Fog Index, Macey and Bouman (1991) found the readability of the CCFNI to be at the ninth grade level which they classify as easy to read. Test-retest reliability of the CCFNI was also established by Macey and Bouman. They found all but six of the 45 need statements on the CCFNI had at least 70% agreement. Leske (1991b) reports Cronbach's alpha for the CCFNI as 0.92. Evaluating the internal psychometric properties of the CCFNI, Leske (1991b) addressed: item analysis, factor analysis, reliability, and construct validity of the tool. Her conclusion follows:

> Construct validity and reliability from this study support continued use of the CCFNI. The CCFNI appears to have sufficient validity and reliability to be used

by researchers and clinicians who wish to describe family needs in various populations, explore correlates or determinants of specifics needs and their importance, and measure changes in need importance as a result of nursing interventions. (P. 242-243)

This study also consisted of demographic questions (Appendix I) to describe the participants and see if there was a correlation between different life experiences and the family member's reported needs. These questions address the participant's relationship to the patient, the participant's age, race, sex, occupation, and education. Since there is the possibility of having Amish and Mennonite participants, religious affiliation will also be asked. The term Anabaptist is a peace church tradition which includes the Amish, Mennonite, Quaker, and Mennonite Brethren since not all members of these congregations would identify themselves as Protestant. Other questions will attempt to identify the participants previous experience with the intensive care setting, satisfaction with that experience, and any concurrent stressors the family member is experiencing.

Procedure

The Grand Valley State University Human Research Review Committee accepted the research proposal. The research proposal was also submitted to the acute care clinical nurse specialist at the hospital where the research was conducted for approval. The researcher approached family members in the intensive and coronary care waiting room to recruit subjects. To insure confidentiality family members interested in the study were removed to a private office to help maintain anonymity. In private the researcher further explained the study, including its purpose, participant involvement

including risks and benefits of the study, and assurance of confidentiality and anonymity, and that participation was voluntary. Informed consent was obtained (see Appendix H) and participants were given a telephone number to contact the researcher with questions and a postcard allowing the participant to withdraw from the study. The researcher also provided envelopes for participants to self address if they wished to receive a summary of the study results.

The actual interviews were conducted privately with just the interviewer and the individual family member present. The researcher started with the demographic data. Next the researcher gave the subject a sheet which had the possible responses to the questions (see Appendix F). For each question the subject was asked to respond with the number corresponding to the appropriate response. The interviewer had a combination CCFNI questionnaire/data collection sheet on which the responses were recorded (see Appendix E).

CHAPTER 4

RESULTS

Techniques

Data analysis was done using the Statistical Package for the Social Sciences (SPSS). Cronbach's alpha was calculated for the revised CCFNI to be 0.89 demonstrating acceptable reliability for the revised tool. The family members participating in the study were described using the demographic data collected. Frequency distributions for each category were tabulated to aid evaluation of the data. Each of the research questions was answered following evaluation of the data gathered.

The research question, what is the importance of identified needs of family members of patients in an intensive care setting, was answered by tabulating the frequency of responses to each statement. Next a mean and standard deviation was calculated for each need. The 47 needs statements were then rank ordered based on the mean score. The same process was used to answer the research question, to what degree have the perceived needs of family members been met. A Frequency table was generated to answer the question of who the family perceived as the best person(s) to meet each of the 47 needs.

The questions of need importance and degree to which the need was met both yielded ordinal level data which allowed the two sets of data to be compared item by item using a Kendall's Tau to determine if there was a relationship between the two variables. An overall need score and an overall fulfillment score was calculated by adding the mean scores for the need importance and degree to which the need was met

respectively. These scores were then considered to be interval level data and analyzed with the interval level demographic data using Pearson's correlation coefficient.

Characteristics of Subjects

Demographic information collected on the subjects included their relationship to the patient, age, sex, ethnic and religious background, level of education, and occupation. In keeping with the theoretical framework which looks at the effect of stressors on the system, the respondents concurrent stressors, level of perceived stress and coping mechanisms were also investigated. The patient's age, diagnosis, condition, and time since admission to the critical care unit was also collected.

The sample was composed of a total of 30 family members of patients in the intensive and coronary care units. Most of the sample (50%) was made up of children of the patients. Parents (16.7%) and spouses (13.3%) made up the next largest group of relatives interviewed. Other family members included were siblings (6.7%), grandchildren (6.7%), and friends (6.7%). A majority of the sample were female (70%) and white (83.3%). Blacks made up 10% of the sample, the remainder of the sample was composed of one Hispanic (3.3%) and one Asian-American (3.3%). The age of the subjects ranged from 18 to 68 with a mean age of 43.9 ± 16.0 years. Fifty-three percent of the sample were Protestant. Anabaptists were the second largest group with 16.7% of the subjects. Other religions represented by the sample included Catholic (10%), Buddhist (3.3%), and Non-Denominational (3.3%). Thirteen and one third percent of the respondents reported having no religious affiliation. There was a lot of variation in level of education amongst the respondents: 23.3% did not complete high school, 20.0%

graduated high school, 6.7% had vocational or trade training, 43.3% had some college and only 6.7% were college graduates. Homemakers made up the largest group of respondents (20%). The next largest group consisted of unskilled labor (16.7%) and those employed in a trade (16.7%). Thirteen and one third percent of the respondents were retired. Office positions were held by 10% and another 10% were in managerial positions. Students accounted for 6.7% of the subjects. One subject (3.3%) was a minister and one subject (3.3%) worked in a health-care related position.

Only 10% of the subjects had any prior experience with intensive care as a patient, however, 53.3% had prior experience as a family member and 33.3% had prior experience visiting someone other than a family member. None of the subjects had ever been employed in a critical care unit. The subjects with prior intensive care experience rated their overall satisfaction with that experience on a scale from 0 (low) to 10 (High). Satisfaction with the previous critical care experience ranged from 3 to 10 (mean 7.47).

Half of the subjects reported having experienced recent stressful events in their lives other than the patient's hospitalization. The stressful events experienced by the subjects included: respondent illness (20%), other family member illness (13.3%), death of a family member (13.3%), caregiver responsibilities (13.3%), job stress (13.3%), school stress (13.3%), financial problems (6.0%), and unemployment (6.0%). Subjects coped with the various stressors they experienced in a variety of ways. Twenty percent reported that their spiritual beliefs helped them manage when they felt stressed. Another 20% dealt with their stress by ventilating. Forms of ventilation reported included crying, swearing, and talking about the stressor. Diversionary activities provided stress relief for

13.3% of the subjects. Diversionary activities employed by the subjects ranged from singing or listening to music to reading and watching a fish tank. Physical activity accounted for 10% of the respondents coping mechanisms. Another 10% reported not being aware of any particular coping or stress relief mechanisms they used. Mental strategies, sleep and family support each were cited by subjects 6.7% of the time as helping them manage with stress. One subject (3.3%) cited being left alone as a way of dealing with stress. Another subject (3.3%) related that smoking helped with the stress. Subjects rated their current level of stress on a scale of 0 (low) to 10 (high) with a mean stress level of 6.733 ±2.18. Two subjects (6.7%) reported experiencing the maximal (10) level of stress at the time of the interview.

The age of the patients ranged from 16 to 88 with a mean age of 56.9 ± 23.4 years. All but one of the hospitalizations (96.7%) were unplanned. The majority of the patients (46.7%) had neurological diagnoses: stroke, traumatic head injury, and cerebral hemorrhage. Other patient diagnoses were cardiac (20%), respiratory (13.3%), gastrointestinal (6.7%), trauma (6.7%), and cancer (6.7%). At the time of the interviews, the patients had been in the intensive or coronary care units from 1.2 to 30.2 days. The mean length of stay at the time of the interviews was 8.87 ± 8.31 days. The subjects rated their perception of the seriousness of the patient's condition on a scale of 0 (not serious) to 10 (very serious or critical). The mean perceived seriousness of the patient's condition was 9.067 ± 1.413.

Research Questions

The first question asked in this study was what is the importance of identified

needs of family members of patients in an intensive care setting. Subjects rated the importance of each need statement on a scale from 1 (not important) to 4 (very important). The mean importance of needs ranged from 4.00 to 2.47 for the most and least important needs respectively. Only one need, the need to be assured that the best care possible is being given to the patient, was rated very important by all of the respondents. All of the needs were rated very important by at least one of the respondents. The fifteen most important needs in rank order were (a) to be assured that the best care possible is being given to the patient, (b) to be called at home about changes in the patient's condition, (c) to have questions answered honestly, (d) to feel there is hope, (e) to see the patient frequently, (f) to know specific facts concerning the patient's progress, (g) to feel that the hospital personnel care about the patient, (h) to know how the patient is being treated medically, (i) to be told about transfer plans while they are being made, (j) to have explanations given that are understandable, (k) to receive information about the patient at least once a day, (l) to know exactly what is being done for the patient, (m) to have help preparing for the worst, (n) to know why things were done for the patient, and (o) to know the expected outcome. All 47 need statements in rank order of importance is listed in Appendix J. Appendix K lists a rank order of the importance of needs within each of Neuman's variables.

The second research question asked who was the person(s) best able to meet needs as perceived by the family members of patients in the intensive care setting. The person(s) best able to meet the 15 most important needs as identified by the subjects was the doctor for 10 needs, the nurse for 6 needs, and a religious leader or layperson for 2

needs. (Total greater than 15 due to ties for person(s) best able to meet individual needs.) Overall, nurses were perceived as the person(s) best able to meet 18 needs. For 5 of the "comfort" needs (to have a telephone near the waiting room, to have a bathroom near the waiting room, to have the waiting room near the patient, to have good food available in the hospital, and to have comfortable furniture in the waiting room), subjects felt that the hospital held ultimate responsibility for meeting the need. Subjects were unable to choose one best person(s) to meet many of the needs and chose two or more individuals as best able to meet the need in those instances. For 21 of the needs at least 20% of the subjects felt that more than one person was best able to meet the need. Table 1 shows the percentage of times each choice was perceived as the best person(s) to meet each need.

The third question asked in this study was to what degree have the perceived needs of family members been met? Subjects rated the degree to which each need had been met on a scale from 1 (not met at all) to 4 (totally met). None of the needs was perceived by the subjects as totally met 100% of the time, although each need was perceived as totally met at least once. The highest mean score for the degree to which needs were met was 3.83 for the need to have the waiting room near the patient, to see the patient frequently, and to have a bathroom near the waiting room. Appendix I lists the mean degree to which each need was perceived to have been met or fulfilled.

The final question examined in this study asked if there was a relationship between the importance of a need and the degree to which it was met or fulfilled. There was a significant relationship between need importance and fulfillment for only three of

the needs. There was a positive relationship ($r = .3955$) between the need to have a telephone near the waiting room and the degree to which it was met ($p = .031$). There was also a positive relationship ($r = .4126$) between the need to have help preparing for the worst and the degree to which it was met ($p = .023$). The final need with a significant relationship between need importance and fulfillment was the need to feel it is alright to cry ($r = .3565$, $p = .034$).

Other Findings of Interest

An overall need score was calculated for the 47 items on the modified CCFNI and adding all the scores together. The mean overall need score was 166.759 ± 12.094 out of a total possible score of 188.0. One subject had an overall need score of 188.0 indicating that each of the 47 needs was very important to that individual. A corresponding overall degree to which needs were met score was calculated. The overall degree to which needs were met score was 161.455 ± 19.373 out of a total possible score of 188.0. There was a significant inverse relationship between age and the overall need score ($r = -.5211$, $p = .004$).

Six additional needs were identified by the subjects. They were the need: (a) to know about their right to question the care that is being given, (b) to have a place where they can get some sleep while at the hospital, (c) to have a secure place to store personal belongings while at the hospital, (d) to have a member of the clergy available to family members, (e) to have a room available for emotional outlet, (f) to be assured that the patient is not in pain. One subject voiced a need to be able to look into the patient's room frequently and the need to have special consideration for out of town visitors

regarding visiting. The researcher felt that these two needs were included in the 47 needs statements on the modified CCFNI (The need to see the patient frequently and the need to have visiting hours changed for special conditions respectively).

Table 1

Percentage of Time Individuals Perceived to be Best Person(s) to Meet Need

Need Statement	Self	Family	Friend	Doctor	Nurse	SW/CM	RL	Other
To be assured that the best care possible is being given to the patient.	3.3	3.3	0	43.3	26.7	3.3	0	20
To be called at home about changes in the patient's condition.	3.3	3.3	0	23.3	43.3	0	0	26.7
To have questions answered honestly.	0	3.3	0	60	13.3	0	0	23.3
To feel there is hope.	3.3	3.3	3.3	26.7	13.3	0	26.7	23.3
To see the patient frequently.	13.3	16.7	0	6.7	46.7	0	0	16.7
To know specific facts concerning the patient's progress.	3.3	3.3	0	40	33.3	0	0	20
To feel that the hospital personnel care about the patient.	3.3	0	0	0	60	6.7	0	30
To know how the patient is being treated medically.	3.3	3.3	0	60	20	0	0	13.3
To be told about transfer plans while they are being made.	3.3	0	0	50	23.3	6.7	0	16.7
To have explanations given that are understandable.	3.3	0	0	40	26.7	3.3	0	26.7

Table 1 continued

Need Statement	Self	Family	Friend	Doctor	Nurse	SW/CM	RL	Other
To receive information about the patient at least once a day.	3.3	0	0	20	53.5	0	0	23.3
To know exactly what is being done for the patient.	0	3.3	0	36.7	36.7	0	0	23.3
To have help preparing for the worst.	3.3	20	0	6.7	3.3	0	40	26.7
To know why things were done for the patient.	3.3	0	0	36.7	36.7	0	0	23.3
To know the expected outcome.	3.3	3.3	0	83.3	0	0	3.3	6.7
To have a telephone near the waiting room.	0	6.7	0	0	3.3	13.3	0	76.7
To have help getting over my doubts and fears about the future.	6.7	16.7	0	16.7	0	6.7	23.3	30
To visit at any time.	3.4	3.4	3.4	13.8	69	0	0	6.9
To talk to the doctor every day	10	3.3	0	70	6.7	0	0	10
To be assured it is alright to leave the hospital for awhile.	0	20	0	10	43.3	0	0	26.7
To feel accepted by the hospital staff	0	0	0	0	56.7	10	0	30
To have directions as to what to do at the bedside.	0	0	0	6.7	83.3	0	0	10
To talk about feelings about what has happened.	3.3	40	6.7	6.7	0	3.3	13.3	26.7

Table 1 continued

Need Statement	Self	Family	Friend	Doctor	Nurse	SW/CM	RL	Other
To have a bathroom near the waiting room.	20	3.3	0	0	3.3	6.7	0	66.7
To have visiting hours start on time.	0	0	3.3	0	80	6.7	0	10
To have the waiting room near the patient.	0	0	3.3	0	10	13.3	0	73.3
To have a specific person to call at the hospital when unable to visit.	0	16.7	0	3.3	73.3	0	0	6.7
To have visiting hours changed for special conditions.	0	0	0	31	58.6	3.4	0	6.9
To be told about other people that could help with problems.	0	3.3	20	6.7	10	46.7	6.7	6.7
To know about the types of staff members taking care of the patient.	3.3	0	0	13.3	60	6.7	0	16.7
To have friends nearby for support.	6.7	16.7	60	0	3.3	0	6.7	6.7
To know which staff members could give what type of information.	0	0	0	16.7	50	6.7	0	26.7
To have good food available in the hospital.	0	0	3.3	0	3.3	3.3	0	90
To feel it is alright to cry.	50	13.3	6.7	3.3	6.7	0	6.7	13.3
To have someone to help with financial problems.	0	3.4	0	0	0	79.3	0	17.2
To help with the patient's physical care.	3.3	3.3	0	10	80	3.3	0	0

Table 1 continued

Need Statement	Self	Family	Friend	Doctor	Nurse	SW/CM	RL	Other
To have a religious leader / layperson visit.	10	3.3	6.7	0	0	0	76.7	3.3
To have comfortable furniture in the waiting room.	13.3	0	3.3	0	6.7	13.3	0	63.3
To have a place to be alone while in the hospital.	33.3	10	0	0	16.7	6.7	0	33.3
To get a break from my problems and responsibilities.	40	16.7	10	3.3	3.3	3.3	0	23.3
To have explanations of the environment before going into the critical care unit for the first time.	0	0	0	33.3	56.7	3.3	0	6.7
To talk to the same nurse every day.	0	0	0	0	100	0	0	0
To have someone be concerned with your health.	10	40	6.7	3.3	6.7	0	0	33.3
To be told about someone to help with family problems.	3.4	10.3	17.2	3.4	0	31	13.8	20.7
To be told about chaplain services.	3.3	6.7	0	0	10	13.3	50	16.7
To be alone at any time.	73.3	10	0	0	10	0	3.3	3.3
To have another person with you when visiting the critical care unit.	17.2	37.9	3.4	0	3.4	0	0	37.9

SW/CM = social worker/case manager, RL = religious leader or layperson

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion of Findings and Conclusions

This study looked at the importance and fulfillment of family needs in the ICU using the Neuman systems model (Neuman, 1995) as its conceptual framework. The model is concerned with the impact of stressors on the client system. For this study the major stressor affecting all of the subjects interviewed was assumed to be the admission of a family member to the intensive care unit. It was further assumed that meeting the priority needs of family members will enable the family to more effectively support the patient through the illness. This study had similar findings to previous studies in the area of family needs in the ICU.

Leske (1991c) in her empirical analysis of the results of 27 studies examining family needs identified 15 primary needs. This study found 14 of Leske's 15 primary needs to be among the most important needs, however, their order of importance was different. This study found the need to have help preparing for the worst, which was not among Leske's primary needs, to be one of the 15 most important needs. This may be related to the fact that this need was modified from the original need, to talk about the possibility of the patient's death. The need to talk to the doctor every day, one of Leske's primary needs, was ranked 19th in importance in the current study. Table 2 lists the rank order of the 15 most important needs for the current study and Leske's empirical analysis. The similarities in the primary needs point to the continuing importance of

these needs and means that nurses should focus interventions in these areas. One of the needs which was added to the modified CCFNI, to have help getting over my doubts and fears about the future, was ranked 17th in order of mean importance in the current study with a mean score of 3.77±.43. The other need added to the modified CCFNI, to get a break from my problems and responsibilities, was ranked 40th with a mean score of 3.10±.99.

Like the studies which preceded it, subjects in this study found it difficult to select who they perceived as the best person(s) to meet specific needs. For 21 of the needs, the subject could not choose only one best person(s) to meet the identified needs. For these needs, the subjects chose a combination of two or more persons whom they felt were able to meet the need. This demonstrates that a team or multi disciplinary approach may be the most effective way to meet family needs. Since nurses were perceived most often (18 times) as being the best person(s) to meet needs, and since nurses have traditionally coordinated the services of other members of the health care team, they are the natural choice to lead a team or multi disciplinary effort to meet family needs. The role of case manager, which is being held by nurses in many institutions, is an attempt to combine the caring and coordinating roles of the nurse. The fact that the social worker / case manager was not perceived as the best person(s) to meet needs may have been due to the fact that the case management concept is relatively new to the hospital where the research was done and may, therefore, not have been well understood by all subjects.

The nurse was perceived to be the best person to meet the need to talk to the same nurse every day 100% of the time. This is the only need where one person was

unanimously selected as the best person(s) to meet a need. Conversely, doctors were perceived as the best person to meet the need to talk to the doctor every day only 70% of the time. Subjects felt that they, themselves, were the best person to meet the need to talk to the doctor every day 10% of the time. Another 10% of the time the subjects felt that a combination of the doctor, nurse, and social worker / case manager were best able to meet the need. For many of the needs where the doctor was the perceived as the best person to meet a need, nurses or a combination of individuals were also chosen frequently as being the best person to meet a need. One subject would have preferred to get some of the needs met by the doctor but noted that since the nurse was the one consistently seen, the nurse was the one who usually met the need. This same subject commented that "I feel a sense of trust between the nurses and doctors which is very comforting. It's like there is a partnership in care, a we're all working together attitude."

The fact that none of the needs was perceived as being universally met demonstrates the need for formulation of additional interventions as well as improvement in existing interventions intended to meet family needs. The positive significant relationship between the need to have a telephone near the waiting room, to have help preparing for the worst, and to feel it is alright to cry, indicates that the more important these needs were, the more likely they were to be perceived as being met. This highlights the importance of meeting the primary needs of family members.

The only statistically significant difference among the various demographic data collected involved age. As already mentioned, an inverse relationship between age and overall need score was identified. This means that the younger the family member the

higher there overall need score was. The fact that the younger family members presumably have less knowledge and experience with critical care may be responsible for this finding.

Some of the ways that family members reported managing stress were identified as needs. Twenty percent of the family members reported that their spiritual beliefs helped them manage when they experience stress. The needs related to spiritual needs included the need to have a religious leader / layperson visit, the need to be told about chaplain services, the need to feel there is hope, to have a place to be alone while in the hospital, to be alone at any time, and to prepare for the worst. Another 20% of the family members reported that they used various forms of ventilation to manage stress. Two forms of ventilation, "to feel it is alright to cry" and "to talk about feelings about what has happened", were also identified as needs. For the family members who manage stress in one of these ways, the associated needs assume a greater importance.

Application to Practice

Hopefully, the information learned in this study will provide the underlying assessment data necessary to formulate multi disciplinary plans of care to meet family needs. Knowledge of the primary needs of family members can be supplemented by assessing the individual family members to identify concurrent stressors and coping mechanisms used by the individual. This knowledge and assessment data can guide the nurse in formulating interventions to meet the family's primary needs and strengthen the lines of resistance and defense by enhancing the family's existing coping mechanisms and guiding them in the development of new coping mechanisms.

A key point identified was that communication between the members of the health care team and the family was essential. Nurses, as the members of the health care team with 24-hour contact with the patient, play an integral role in that communication. They can also be instrumental in providing an area for communication to maintain patient confidentiality and facilitating the family's communication with other members of the health care team.

Limitations

This study was limited by the small sample size which makes it difficult to generalize its findings to the larger population. While the researcher attempted to identify some concurrent stressors that family members may have been experiencing, the small number of family members with each type of stressor did not allow identification of any relationship between concurrent stressors and family needs. It is assumed by the researcher that prior experience and concurrent stressors might have an impact on family needs. Some of the family members who declined to participate expressed that they were experiencing too much stress to be able to concentrate for the time period (45 minutes) required to complete the interviews. Their input may have affected the findings. The researcher, as a nurse working in the same hospital where the research was conducted may have contributed to the decision of some of the family members who declined to participate in the study. It may also have affected the responses given by some of the family members to certain questions.

Suggestions for Further Research

Further research on the needs of family members should incorporate the six

additional needs identified by the subjects in this study. The two needs from the FNQ that the researcher added to the modified version of the CCFNI also warrant further study. The need to maintain patient confidentiality when speaking with family members is one that should also be addressed. Further exploration of the effect family dynamics, prior experience and concurrent stressors have on family needs is also an area which could be studied in future research. Because the time required for the interviews was cited by some family members as discouraging participation, further research should look at ways to overcome this barrier to participation.

The next phase of research, as mentioned previously by Dracup (1993) is to look at how family needs are met. Using the priority needs identified in this and other studies, nurses need to formulate multidisciplinary interventions to improve the degree to which the priority needs are met. These interventions should then be evaluated for their effectiveness.

This researcher found the Neuman systems model (Neuman, 1995) a good framework for evaluating family needs. Its wholistic approach to the client in relation to the environment and focus on how various stressors affect the client fits well with the variables of interest in this study. Therefore, the researcher would recommend that further research on the needs of family members in the intensive care unit also evaluate the fit of the Neuman systems model.

Table 2

Comparison of Priority Needs in Current Study vs Leske's (1991c)Empirical Analysis

Need Statement	Rank	
	Current Study	Leske's Analysis
To be assured that the best care possible is being given to the patient.	1	2
To be called at home about changes in the patient's condition.	2	6
To have questions answered honestly	3	1
To feel there is hope.	4	4
To see the patient frequently.	5	13
To know specific facts concerning the patient's progress.	6	5
To feel that the hospital personnel care about the patient.	7	8
To know how the patient is being treated medically.	8	7
To be told about transfer plans while they are being made.	9	15
To have explanations given that are understandable.	10	10
To receive information about the patient at least once a day.	11	9
To know exactly what is being done for the patient.	12	11
To have help preparing for the worst.	13	*

Table 2 continued

Need Statement	Rank	
	Current Study	Leske's Analysis
To know why things were done for the patient.	14	12
To know the expected outcome.	15	3
To talk to the doctor daily	19	14

Appendix A

Permission Letters

Date: Tuesday, January 28, 1997 **Time:** 6:06 PM

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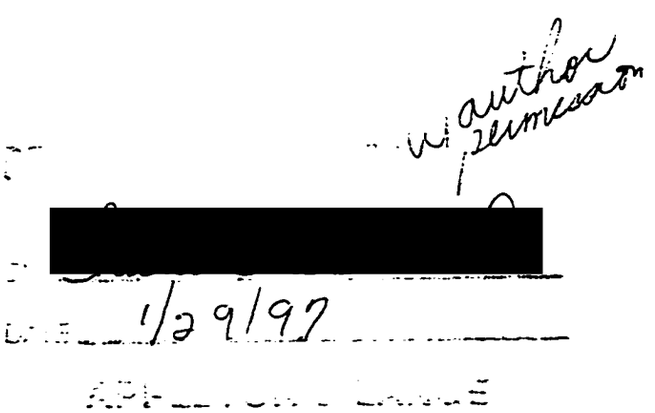

Memo:

Linda Baker
33178 CR 669
Lawton, MI 49065

Dear MS. Dempsey:

I am completing my Master of Science at Grand Valley State University. As a requirement for graduation, I am doing a thesis on the needs of family members of patients in the intensive care setting. I am using the Neuman Systems Model for the theoretical framework. I would like permission to reproduce a diagram of the model from the book: The Neuman Systems Model, third Edition, by Betty Neuman. The diagram in question is on page 17.

Thank you,

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Christine Dembski
Permissions Dept.

Encl.

Betty Neuman, RN
Box 488
Beverly, OH 45715

Betty Neuman
Box 488
Beverly, OH 45715

Dear Dr. Neuman,

I am a Master of Science in Nursing Student at Grand Valley State University. As a requirement for graduation, I am completing a thesis on the needs of family members of patients in the intensive care unit. I am using the Neuman Systems Model as my theoretical framework. I would like your permission to reproduce the diagram of your model (Figure 1-3, page 17) published in the third edition of your book. I have already received permission from Appleton & Lange pending your approval.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

[redacted]

Linda Baker

3/18/97 - Permission Granted.
Betty Neuman, RN, Ph.D. FAAN.

Appendix B

Neuman's Client Variables and Family Needs

Physiological Variable:

1. To have good food available in the hospital.
2. To have comfortable furniture in the waiting room.
3. To have a bathroom near the waiting room.

Psychological Variable:

1. To know the expected outcome.
2. To talk to the doctor every day.
3. To know how the patient is being treated medically.
4. To know why things were done for the patient.
5. To know exactly what is being done for the patient.
6. To be told about transfer plans while they are being made.
7. To know specific facts about the patient's progress.
8. To be called at home about changes in the patient's condition.
9. To receive information about the patient at least once a day.
10. To know which staff members could give what type of information.
11. To know about the types of staff members taking care of the patient.
12. To have questions answered honestly.
13. To be assured that the best care possible is being given to the patient.
14. To have the waiting room near the patient.
15. To have someone be concerned with your health.

16. To talk about feelings about what has happened.

17. To feel that personnel care about the patient.

18. To be assured it is alright to leave the hospital for awhile.

19. To have help getting over my doubts and fears about the future (added to original CCFNI by researcher).

20. To get a break from my problems and responsibilities (added to original CCFNI by researcher).

Sociocultural Variable:

1. To have a telephone near the waiting room.

2. To have someone to help with financial problems.

3. To have another person with you when visiting the intensive care unit.

4. To feel it is alright to cry.

5. To be told about other people that could help with problems.

6. To be told about someone to help with family problems.

7. To have friends nearby for support.

8. To have visiting hours start on time.

9. To help with the patient's physical care.

10. To have a specific person to call at the hospital when unable to visit.

11. To talk to the same nurse every day.

12. To see the patient frequently.

13. To have visiting hours changed for special conditions.

14. To visit at any time.

15. To feel accepted by the hospital staff.

Developmental Variable:

1. To have explanations of the environment before going into the intensive care unit for the first time.
2. To have directions as to what to do at the bedside.
3. To have explanations given that are understandable.

Spiritual Variable:

1. To feel there is hope.
2. To have a place to be alone while in the hospital.
3. To have a religious leader / layperson visit (modified from original CCFNI by researcher).
4. To be told about chaplain services.
5. To be alone at any time.
6. To have help preparing for the worst (modified from original CCFNI by researcher).

Appendix C

A Comparison of Neuman's Variables, CCFNI Categories, and Wilkinson's Categories

Related to the 45 Need Statements on the CCFNI

Need Statements	Neuman's Variables	CCFNI Categories	Wilkinson's Categories
To have questions answered honestly	Psychological	Assurance	Need for information
To be assured that the best care possible is being given to the patient	Psychological	Assurance	Need for a caring environment
To know the expected outcome	Psychological	Assurance	Need for information
To feel there is hope	Spiritual	Assurance	Need for hope
To know specific facts about the patient's progress	Psychological	Assurance	Need for information
To feel that personnel care about the patient	Psychological	Assurance	Need for a caring environment
To have explanations given that are understandable	Developmental	Assurance	Need for information
To be called at home about changes in the patient's condition	Psychological	Proximity	Need for information
To receive information about the patient at least once a day	Psychological	Proximity	Need for information

Need Statements	Neuman's Variables	CCFNI Categories	Wilkinson's Categories
To see the patient frequently	Sociocultural	Proximity	Need for access and close proximity
To be told about transfer plans while they are being made	Psychological	Proximity	Need for information
To have the waiting room near the patient	Psychological	Proximity	Need for access and close proximity
To have visiting hours changed for special conditions	Sociocultural	Proximity	Need for access and close proximity
To visit at any time	Sociocultural	Proximity	Need for access and close proximity
To have visiting hours start on time	Sociocultural	Proximity	Need for access and close proximity
To talk to the same nurse everyday	Sociocultural	Proximity	Need for social support
To know how the patient is being treated medically	Psychological	Information	Need for information
To know why things were done for the patient	Psychological	Information	Need for information
To talk to the doctor everyday	Psychological	Information	Need for information
To have a specific person to call at the hospital when unable to visit	Sociocultural	Information	Need for social support

Need Statements	Neuman's Variables	CCFNI Categories	Wilkinson's Categories
To know which staff members could give what type of information	Psychological	Information	Need for information
To know about the types of staff members taking care of the patient	Psychological	Information	Need for information
To help with the patient's physical care	Sociocultural	Information	Need for access and close proximity
To feel accepted by the hospital staff	Sociocultural	Comfort	Need for social support
To have a telephone near the waiting room	Sociocultural	Comfort	Need for access and close proximity
To be assured it is alright to leave the hospital for awhile	Psychological	Comfort	Need for social support
To have a bathroom near the waiting room	Physiological	Comfort	Need for access and close proximity
To have good food available in the hospital	Physiological	Comfort	Need for access and close proximity
To have comfortable furniture in the waiting room	Physiological	Comfort	Need for access and close proximity
To have explanations of the environment before going into ICU for the first time	Developmental	Support	Need for information

	Neuman's Variables	CCFNI Categories	Wilkinson's Categories
To have friends nearby for support	Sociocultural	Support	Need for social support
To have help preparing for the worst *	Spiritual	Support	Coming to terms with critical illness
To have someone be concerned with your health	Psychological	Support	Need for social support
To be told about someone to help with family problems	Sociocultural	Support	Need for social support
To have someone help with financial problems	Sociocultural	Support	Need for social support
To have a place to be alone while in the hospital	Spiritual	Support	Need for a caring environment
To be told about chaplain services	Spiritual	Support	Need for social support
To be told about other people that could help with problems	Sociocultural	Support	Need for social support
To talk about feelings	Psychological	Support	Need for social support
To have another person with you while visiting the ICU	Sociocultural	Support	Need for social support
To be alone at any time	Spiritual	Support	Need for a caring environment
To feel it is alright to cry	Sociocultural	Support	Need for social support

Need Statements	Neuman's Variables	CCFNI Categories	Wilkinson's Categories
To know exactly what is being done for the patient	Psychological	Information	Need for information
To have directions as to what to do at the bedside	Psychological	Information	Need for information
To get a break from my problems and responsibilities*	Psychological	Support	Need for social support
To have help getting over my doubts and fears about the future*	Psychological	Support	Need for social support
To have a religious leader / layperson visit*	Spiritual	Support	Need for social support

* Modified from the original CCFNI

Appendix D
Critical Care Family Needs Inventory

Please check ( ) how **IMPORTANT** each of the following needs is to you.		Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
1.	To know the expected outcome	_____	_____	_____	_____
2.	To have explanations of the environment before going into the critical care unit for the first time	_____	_____	_____	_____
3.	To talk to the doctor every day	_____	_____	_____	_____
4.	To have a specific person to call at the hospital when unable to visit	_____	_____	_____	_____
5.	To have questions answered honestly	_____	_____	_____	_____
6.	To have visiting hours changed for special conditions	_____	_____	_____	_____
7.	To talk about feelings about what has happened	_____	_____	_____	_____
8.	To have good food available in the hospital	_____	_____	_____	_____
9.	To have directions as to what to do at the bedside	_____	_____	_____	_____
10.	To visit at any time	_____	_____	_____	_____
11.	To know which staff members could give what type of information	_____	_____	_____	_____
12.	To have friends nearby for support	_____	_____	_____	_____
13.	To know why things were done for the patient	_____	_____	_____	_____
14.	To feel there is hope	_____	_____	_____	_____

		Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
15.	To know about the types of staff members taking care of the patient	_____	_____	_____	_____
16.	To know how the patient is being treated medically	_____	_____	_____	_____
17.	To be assured that the best care possible is being given to the patient	_____	_____	_____	_____
18.	To have a place to be alone while in the hospital	_____	_____	_____	_____
19.	To know exactly what is being done for the patient	_____	_____	_____	_____
20.	To have comfortable furniture in the waiting room	_____	_____	_____	_____
21.	To feel accepted by the hospital staff	_____	_____	_____	_____
22.	To have someone to help with financial problems	_____	_____	_____	_____
23.	To have a telephone near the waiting room	_____	_____	_____	_____
24.	To have a pastor visit	_____	_____	_____	_____
25.	To talk about the possibility of the patient's death	_____	_____	_____	_____
26.	To have another person with you when visiting the critical care unit	_____	_____	_____	_____
27.	To have someone be concerned with your health	_____	_____	_____	_____
28.	To be assured it is alright to leave the hospital for awhile	_____	_____	_____	_____
29.	To talk to the same nurse every day	_____	_____	_____	_____
30.	To feel it is alright to cry	_____	_____	_____	_____

		Not Important (1)	Slightly Important (2)	Important (3)	Very Important (4)
31.	To be told about other people that could help with problems	_____	_____	_____	_____
32.	To have a bathroom near the waiting room	_____	_____	_____	_____
33.	To be alone at any time	_____	_____	_____	_____
34.	To be told about someone to help with family problems	_____	_____	_____	_____
35.	To have explanations given that are understandable	_____	_____	_____	_____
36.	To have visiting hours start on time	_____	_____	_____	_____
37.	To be told about chaplain services	_____	_____	_____	_____
38.	To help with the patient's physical care	_____	_____	_____	_____
39.	To be told about transfer plans while they are being made	_____	_____	_____	_____
40.	To be called at home about changes in the patient's condition	_____	_____	_____	_____
41.	To receive information about the patient at least once a day	_____	_____	_____	_____
42.	To feel that the hospital personnel care about the patient	_____	_____	_____	_____
43.	To know specific facts concerning the patient's progress	_____	_____	_____	_____
44.	To see the patient frequently	_____	_____	_____	_____
45.	To have the waiting room near the patient	_____	_____	_____	_____
46.	Other:	_____	_____	_____	_____

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5333 W. River Trail
Mequon, WI 53092

Linda Baker
33178 CR669
Lawton, MI 49065

February 6, 1995

Dear Linda,

You have my permission to use or modify the copyrighted Critical Care Family Needs Inventory as long as credit is referenced in your work. The reliability and validity information is available in Leske, J.S. "Selected Psychometric Properties of the Critical Care Family Needs Inventory" unpublished doctoral dissertation, University of Wisconsin-Milwaukee, 1988 and Leske, J.S. (1991). Internal psychometric properties of the Critical Care Family Needs Inventory, Heart & Lung, 20, 236-244.

If I can be of any further help, please do not hesitate to write. Best wishes for a successful research endeavor.

Sincerely,

[redacted]

Jane S. Leske PhD, RN

Appendix E

Modified CCFNI / Data Collection Sheet

Need Statement	How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
1. To know the expected outcome.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
2. To have explanations of the environment before going into the critical care unit for the first time.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
3. To talk to the doctor every day.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
4. To have a specific person to call at the hospital when unable to visit.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
5. To have questions answered honestly.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
6. To have visiting hours changed for special conditions.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
7. To talk about feelings about what has happened.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement		How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
8.	To have good food available in the hospital.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
9.	To have directions as to what to do at the bedside.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
10.	To visit at any time.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
11.	To know which staff members could give what type of information.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
12.	To have friends nearby for support.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
13.	To know why things were done for the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
14.	To feel there is hope.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
15.	To know about the types of staff members taking care of the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement		How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
16.	To know how the patient is being treated medically.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
17.	To be assured that the best care possible is being given to the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
18.	To have a place to be alone while in the hospital.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
19.	To know exactly what is being done for the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
20.	To have comfortable furniture in the waiting room.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
21.	To feel accepted by the hospital staff.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
22.	To have someone to help with financial problems.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
23.	To have a telephone near the waiting room.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement		How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
24.	To have a religious leader / layperson visit.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
25.	To have help preparing for the worst.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
26.	To have another person with you when visiting the critical care unit.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
27.	To have someone be concerned with your health.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
28.	To be assured it is alright to leave the hospital for awhile.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
29.	To talk to the same nurse every day.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
30.	To feel it is alright to cry.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
31.	To be told about other people that could help with problems.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement		How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
32.	To have a bathroom near the waiting room.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
33.	To be alone at any time.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
34.	To be told about someone to help with family problems.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
35.	To have explanations given that are understandable.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
36.	To have visiting hours start on time.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
37.	To be told about chaplain services.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
38.	To help with the patient's physical care.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
39.	To be told about transfer plans while they are being made.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement		How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
40.	To be called at home about changes in the patient's condition.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
41.	To receive information about the patient at least once a day.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
42.	To feel that the hospital personnel care about the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
43.	To know specific facts concerning the patient's progress.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
44.	To see the patient frequently.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
45.	To have the waiting room near the patient.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
46.	To get a break from my problems and responsibilities.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4
47.	To have help getting over my doubts and fears about the future.	1 2 3 4	1 2 3 4 5 6 7 8 If 8, specify:	1 2 3 4

Need Statement	How important is this need to you?	Who do you think is the person best able to meet this need?	Has this need been met?
48. **Other, please specify:**	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4
	1 2 3 4	**1 2 3 4 5 6 7 8** **If 8, specify:**	1 2 3 4

What else would you like to share with me about getting your needs met?

Appendix F

Response Sheet

For each need statement you will be asked to respond to three questions. Please tell the interviewer the number of your response.

How important is this need to you?

1. not important 2. slightly important 3. important 4. very important

Who do you think is the person best able to meet this need?

1. self
2. other family member
3. friend
4. doctor
5. nurse
6. social worker / case manager
7. religious leader or layperson
8. other, please specify who

Has this need been met?

1. not met at all 2. slightly met 3. mostly met 4. totally met

Appendix G

Interview Script

Approaching family member in visitor's lounge or patient care areas:

Hello, my name is Linda Baker. I am conducting research on the needs of family members in the intensive care. I believe an illness affects both the patient and his or her family and that the family plays a vital role in the recovery of the patient. I also believe that the family has needs which must be met to allow them to provide optimal support to the patient. I hope that through my research it will be possible to improve care to both the patient and the family.

I am asking for family members to allow me to interview them privately and confidentially. Could I get you to go to a more private room to discuss participating in this study and what it would entail. Coming with me now in no way obligates you to participate.

In private setting:

As I mentioned earlier, I would like to invite you to participate in my research on the needs of family members. If you agree to participate, any and all answers you give to questions will be kept private and confidential. Neither you nor the patient will be identified by name or in such a way that you could be recognized. I will ask a series of demographic questions. Things like your age, race, education, and previous experiences with hospitals and intensive care. Those responses will be used to statistically describe the family members who participate in my study so that I don't have to identify you individually.

The actual interview consists of a series of 47 needs statements identified by previous researchers. I will give you a sheet with possible responses. For each need statement, using the possible responses, I will ask you to tell me how important the need is to you, who you feel is the person or persons best able to help you meet that need, and how well that need has been met. I will give you an opportunity to identify any additional information you think might be helpful about meeting your needs as a family member.

Your responses to all questions will be recorded on a form identifying you only by a number. I will not record your name at any time during the data collection process. I will ask the name of your family member in the intensive or coronary care unit only to make sure I do not speak to more than three members from each family. You may withdraw from the study at any time. If at a later date you decide you do not wish to participate, I will give you a postcard to return to me stating that fact. I will also give you my phone number so that you may contact me if you have questions. I will provide

you with a summary of the results upon your request. Would you be willing to participate in this study?

If response is yes:

I have a couple of questions to confirm that you are eligible to participate.

1. Has the patient been in intensive or coronary care for at least 24 hours?
2. Are you at least 18 years old?
3. Who is the patient?

If the response to questions 1 and 2 are both yes and there are not already three participants from the patients family:

I have a consent for participation that I need you to read and sign acknowledging that you are agreeing to participate in this study. Here is a phone number where you can contact me with questions that might arise and your identification number. I would also like to give you this postcard. If at any time you decide that you would like to withdraw from this study, just drop this postcard in the mail. If you would like to receive a summary of the study results, please print your name and address on these address labels which I will use to mail results to you.

After consent obtained Go to demographic data.

After demographic data collected give participant response sheet:

This sheet lists the responses for each of the next series of questions. I will read a need statement and ask you to answer three questions: (a) how important is this need to you? (b) who do you think is the person best able to meet this need? and (c) has this need been met? Please tell me the number that correlates with your response. So, if the first need statement I read to you is only slightly important to you, you would respond "2."

Go to data collection questionnaire.

Appendix H
Consent for Participation

I understand that this is a study to identify the needs of family members of patients in an intensive care setting. An illness affects both the patient and his or her family. Because the family is a source of support for the patient and plays a role in the patient's recovery, it is important for the staff to know what the needs of the family are. The information gathered in the study will be used to help the staff be more responsive to the needs of family members.

I also understand that:

1. participation in this study will involve one 45 minute interview regarding my needs as a family members of a patient in the intensive or coronary care unit.
2. that I have been selected for participation because I have a family member as a patient in the intensive or coronary care unit.
3. it is not anticipated that this study will lead to physical or emotional risk to myself or my family member in the intensive or coronary care unit and it may be helpful to have someone to talk to about my needs while my family member is a patient in the intensive or coronary care unit.
4. the information I provide will be kept strictly confidential and the information will be coded so that identification of individual participants or their family member will not be possible.
5. a summary of the results will be made available to me upon my request.

I acknowledge that:

1. "I have been given an opportunity to ask questions regarding this research study, and that these questions have been answered to my satisfaction."
2. "In giving consent, I understand that my participation in this study is voluntary and that I may withdraw at any time using the postcard provided by Linda Baker, without affecting the care my family member or I receive from the staff at Elkhart General Hospital."
3. "I hereby authorize the investigator to release information obtained in this study to scientific literature. I understand that neither my family nor I will be identified by name."
4. "I have been given Linda Baker's phone number so that I may contact her if I have questions."
5. "I may address additional questions to Paul Huizenga, Chair, Human Research Review Committee at (616)895-2472.

"I acknowledge that I have read and understand the above information, and that I agree to participate in this study."

_____ witness / date

_____ participant signature / date

record number _____

Appendix I

Demographic Data

The following information will help us to understand your background and how it might relate to the current situation as well as statistically describe the participants in the study. As with all the information gathered for this study, the data you provide will be treated confidentially.

1. When was the patient admitted (date and time)? _____

2. Date and time of interview _____

3. Time since admission _____

4. What is your relationship to the patient?
   1. Spouse
   2. Child
   3. Parent
   4. Grandparent
   5. Sibling
   6. Other relative, please specify _____
   7. Friend
5. What is your age? _____
6. What is your sex?
   1. Male
   2. Female
7. What is your ethnic background?
   1. White
   2. Black
   3. Hispanic
   4. Asian American
   5. Native American
   6. Other, please specify _____
8. What is your religious affiliation?
   1. Anabaptist
   2. Catholic
   3. Jewish
   4. Protestant
   5. None
   6. Other, please specify _____

9. What is your highest level of education?
   1. Less than grade 12
   2. Graduated high school
   3. Completed vocational / trade school
   4. Some college
   5. Graduated college
   6. Some graduate school
   7. Completed graduate school
10. What is your occupation

Do you have any previous experience with intensive care:

11. As a patient?
    1. no
    2. yes
12. As a family member?
    1. no
    2. yes
13. As a visitor?
    1. no
    2. yes
14. As an employee?
    1. no
    2. yes
15. If yes, specify _____

If questions 11 - 14 are no skip to question 17

16. On a scale of 0 - 10, with 0 being low and 10 being high, how would you rate your satisfaction with the quality of care during your previous intensive care experience (if more than one experience with critical care, use your last experience)?

    0 1 2 3 4 5 6 7 8 9 10

17. Was this hospitalization
    1. planned
    2. unplanned
18. What is the patient's age? _____
19. What is the patient's diagnosis (family perception of diagnosis)? _____

20. On a scale of 0 - 10, with 0 being not serious and 10 being very serious (or critical), how would you rate the seriousness of the patient's condition?

0 1 2 3 4 5 6 7 8 9 10

21. Have you experienced any recent stressful events in your life, other than this hospitalization?
    1. no
    2. yes
22. If yes, please specify _____

23. What helps you to manage when you feel stressed?

24. On a scale of 0 - 10, with 0 being low and 10 being high, how would you rate your current level of stress?

0 1 2 3 4 5 6 7 8 9 10

Appendix J

Mean Importance and Mean Fulfillment of Identified Needs

		Mean Importance			Mean Fulfillment		
Rank	Need Statement	M	SD	N	M	SD	N
1.	To be assured that the best care possible is being given to the patient.	4.00	.00	30	3.67	.55	30
2.	To be called at home about changes in the patient's condition.	3.97	.18	30	3.29	.98	28
3.	To have questions answered honestly.	3.93	.37	30	3.57	.73	30
4.	To feel there is hope.	3.90	.31	30	3.13	1.01	30
5.	To see the patient frequently.	3.90	.31	30	3.83	.38	30
6.	To know specific facts concerning the patient's progress.	3.90	.31	30	3.60	.67	30
7.	To feel that the hospital personnel care about the patient.	3.90	.31	30	3.77	.50	30
8.	To know how the patient is being treated medically.	3.87	.35	30	3.70	.53	30
9.	To be told about transfer plans while they are being made.	3.87	.35	30	3.55	.83	29
10.	To have explanations given that are understandable.	3.87	.35	30	3.60	.50	30

Rank	Need Statement	Mean Importance M	SD	N	Mean Fulfillment M	SD	N
11.	To receive information about the patient at least once a day.	3.83	.38	30	3.57	.68	30
12.	To know exactly what is being done for the patient.	3.83	.46	30	3.63	.56	30
13.	To have help preparing for the worst.	3.83	.38	29	3.40	.81	30
14.	To know why things were done for the patient.	3.80	.48	30	3.53	.63	30
15.	To know the expected outcome.	3.80	.41	30	2.97	.89	30
16.	To have a telephone near the waiting room.	3.77	.43	30	3.80	.48	30
17.	To have help getting over my doubts and fears about the future.	3.77	.43	30	3.00	.98	30
18.	To visit at any time	3.73	.64	30	3.52	.63	29
19.	To talk to the doctor every day	3.70	.53	30	3.3.	.84	30
20.	To be assured it is alright to leave the hospital for awhile.	3.63	.56	30	3.73	.52	30
21.	To feel accepted by the hospital staff	3.63	.67	30	3.43	.63	30
22.	To have directions as to what to do at the bedside.	3.63	.56	30	3.50	.86	30
23.	To talk about feelings about what has happened.	3.60	.62	30	3.55	.83	29

Rank	Need Statement	Mean Importance			Mean Fulfillment		
		M	SD	N	M	SD	N
24.	To have a bathroom near the waiting room.	3.60	.56	30	3.83	.46	30
25.	To have visiting hours start on time.	3.57	.63	30	3.73	.58	30
26.	To have the waiting room near the patient.	3.57	.63	30	3.83	.38	30
27.	To have a specific person to call at the hospital when unable to visit.	3.57	.63	30	3.43	.73	30
28.	To have visiting hours changed for special conditions.	3.53	.86	30	3.24	.91	29
29.	To be told about other people that could help with problems.	3.47	.51	30	3.18	.82	28
30.	To know about the types of staff members taking care of the patient.	3.47	.68	30	3.47	.57	30
31.	To have friends nearby for support.	3.47	.68	30	3.63	.49	30
32.	To know which staff members could give what type of information.	3.47	.63	30	3.53	.57	30
33.	To have good food available in the hospital.	3.43	.63	30	3.10	.88	30
34.	To feel it is alright to cry.	3.40	.77	30	3.27	.94	30
35.	To have someone to help with financial problems.	3.37	.72	30	2.78	1.15	27
36.	To help with the patient's physical care.	3.37	.67	30	3.62	.62	29

Need Statement		Mean Importance			Mean Fulfillment		
		M	SD	N	M	SD	N
37.	To have a religious leader / layperson visit.	3.37	.67	30	3.67	.66	30
38.	To have comfortable furniture in the waiting room.	3.33	.92	30	3.20	.76	30
39.	To have a place to be alone while in the hospital.	3.27	.83	30	3.17	1.02	30
40.	To get a break from my problems and responsibilities.	3.10	.99	30	3.17	1.12	30
41.	To have explanations of the environment before going into the critical care unit for the first time.	3.10	.92	30	3.50	.57	30
42.	To talk to the same nurse every day.	3.07	.94	30	3.31	.71	29
43.	To have someone be concerned with your health.	3.03	.85	30	3.57	.63	30
44.	To be told about someone to help with family problems.	3.00	.79	30	2.90	1.05	29
45.	To be told about chaplain services.	2.97	.89	30	2.87	1.20	30
46.	To be alone at any time.	2.87	1.04	30	3.47	.73	30
47.	To have another person with you when visiting the critical care unit.	2.47	1.17	30	3.79	.49	29

M = mean, SD = standard deviation, N = number of subjects

Appendix K

Rank Order of the Importance of Needs within each of Neuman's Variables.

Psychological Variable

Need Statement	Mean	Standard Deviation
To be assured that the best care possible is being given to the patient.	4.00	.00
To be called at home about changes in the patient's condition.	3.97	.18
To have questions answered honestly.	3.93	.37
To feel that the hospital personnel care about the patient.	3.90	.31
To know specific facts concerning the patient's progress.	3.90	.31
To know how the patient is being treated medically.	3.87	.35
To be told about transfer plans while they are being made.	3.87	.35
To receive information about the patient at least once a day.	3.83	.38
To know exactly what is being done for the patient.	3.83	.46
To know why things were done for the patient.	3.80	.48
To know the expected outcome.	3.80	.41
To have help getting over my doubts and fears about the future.	3.77	.43
To talk to the doctor every day.	3.70	.53
To be assured it is alright to leave the hospital for awhile.	3.63	.56
To talk about feelings about what has happened.	3.60	.62

To have the waiting room near the patient.	3.57	.63
To know about the types of staff members taking care of the patient.	3.47	.68
To know which staff members could give what type of information.	3.47	.63
To get a break from my problems and responsibilities.	3.10	.99
To have someone be concerned with your health.	3.03	.85

Sociocultural Variable

Need Statement	Mean	Standard Deviation
To see the patient frequently.	3.90	.31
To have a telephone near the waiting room.	3.77	.43
To visit at any time.	3.73	.64
To feel accepted by the hospital staff.	3.63	.67
To have visiting hours start on time.	3.57	.63
To have a specific person to call at the hospital when unable to visit.	3.57	.63
To have visiting hours changed for special conditions.	3.53	.86
To be told about other people that could help with problems.	3.47	.51
To have friends nearby for support.	3.47	.68
To feel it is alright to cry	3.40	.77
To have someone to help with financial problems	3.37	.72
To help with the patient's physical care.	3.37	.67
To talk to the same nurse every day.	3.07	.94

To be told about someone to help with family problems.	3.00	.79
To have another person with you when visiting the critical care unit.	2.47	1.17

Spiritual Variable

Need Statement	Mean	Standard Deviation
To feel there is hope.	3.90	.31
To have help preparing for the worst.	3.83	.38
To have a religious leader / layperson visit.	3.37	.67
To have a place to be alone while in the hospital.	3.27	.83
To be told about chaplain services.	2.97	.89
To be alone at any time.	2.87	1.04

Developmental Variable

Need Statement	Mean	Standard Deviation
To have explanations given that are understandable.	3.87	.35
To have directions as to what to do at the bedside.	3.63	.56
To have explanations of the environment before going into the critical care unit for the first time.	3.10	.92

Physiological Variable

Need Statement	Mean	Standard Deviation
To have a bathroom near the waiting room.	3.60	.56
To have good food available in the hospital.	3.43	.63
To have comfortable furniture in the waiting room.	3.33	.92

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