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# A DESCRIPTION OF THE NEEDS OF FAMILY MEMBERS OF PATIENTS HOSPITALIZED IN A CORONARY CARE UNIT

A Thesis

Presented for the

Master of Science in Nursing

Degree

The University of Tennessee, Knoxville

Theresa L. Renfro

December 1991

## ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to Dr. Mary Lue Jolly, Dr. Mildred Fenske, and Dr. Inez Tuck, my committee members. Without Dr. Jolly's leadership skills and patience, Dr. Fenske's attention to details and supportive actions, and Dr. Tuck's motivating influence and expert qualitative assistance completion, of this research project would not have been possible.

I wish to thank Jim, the critical care nurses, and Bessie, at the institution serving as the site for this study, who provided me support and access to participants.

I would like to thank Dee, Cheryl, Beverly, and Lisa, my friends and colleagues, who listened to my thoughts and feelings and provided me with encouragement.

A special thanks, filled with love, is given to my husband, children, mother-in-law, mother, dad, brothers, sisters, and grandparents for their enduring love and support.

# ABSTRACT

The purpose of this descriptive, qualitative study was to identify the needs of family members of patients hospitalized in a coronary care unit for 24-48 hours. The participants were 8 spouses of patients hospitalized in a coronary care unit for less than 48 hours.

The instrument used was developed by the investigator and included four open-ended questions with probes. Eight qualitative content analyses at the latent level were performed on the data obtained from structured interviews. A five-step process adapted from Colazzi (1978) was used to organized the data inductively into categories.

The following nine categories of needs were identified: information, support, proximity, assurance, comfort, helpful, express feelings, express thoughts, and reflect. The findings indicated that all of the participants had all nine categories of needs. Implications for nursing practice and research were presented.

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# LIST OF ABBREVIATIONS

Critical Care Family Needs Inventory.....CCFNI

Coronary Care Unit..... CCU

Percutaneous Coronary Angioplasty..... PTCA

Basic life support..... BLS

Advanced cardiac life support..... ACLS

# CHAPTER I

## INTRODUCTION AND PURPOSE

### Introduction

Families structure the primary environment of patients before hospitalization and after hospitalization. Often patients confer with their families prior to hospitalization regarding the decision to enter the hospital (Friedman, 1986). The hospitalization of a family member affects the entire family system (Becar & Becar, 1982; Bozett, 1987; Friedman, 1986). Concern for family members "coparticipating" (Parse, 1981) in the experience of having a family member hospitalized in a coronary care unit with the potential for or with an actual life-threatening illness served as the driving force for this study.

The hospitalization of patients in critical care units has been described as a crisis situation for both patients and their families (Halm, 1990; Leske, 1986; Molter, 1979a). Several authors (Bedsworth & Molen, 1982; Caplin & Sexton, 1988) found that spouses of hospitalized critically ill patients feel threatened by the potential

loss of their mate, loss of a healthy mate, worsening of their mate's condition, financial concerns, changes in roles within the family system, and separation from their mate. Family members report feelings of anxiety, fear, anger, helplessness, and guilt associated with their attempts to cope with the hospitalization of another family member (Bedsworth & Molen, 1982).

The literature reports numerous nursing studies conducted to identify needs of family members of critically ill patients to increase the nurse's knowledge of nursing interventions to help family members confronted with a life-threatening illness of a family member. A review of nine of the studies identifying needs of family members of hospitalized critically ill patients revealed that eight of these nine studies (Daley, 1984; Dracup & Breu, 1978; Jacono, Hicks, Antonioni, O'Brien, & Rasi, 1990; Leske, 1986; Mathis, 1984; Molter, 1979a; Norheim, 1989; Norris & Grove, 1986; Spatt, 1986) used the questionnaire developed by Molter (1979b), or a modified version of it named the Critical Care Family Needs Inventory (CCFNI) developed by Molter and Leske (1983). Originally, Molter (1979b) developed her 45 need-statements questionnaire by identifying the needs of family members in the literature and from a survey of 23

nursing graduate students. Using it, family members identify their needs by ranking the importance of the need-statements from 1, not important, to 4, very important.

However, this investigator believed that critically ill patients' family member's recall was the best method to use to identify their needs. The needs identified by the family member's recall during one-to-one interviews may differ from the needs identified by a prompted list like the CCFNI (Molter & Leske, 1983); the needs revealed during a one-to-one interview would emerge from the valued images of the family members as described by Parse (1981). Parse (1981) explained that (a) individuals structure new meaning in daily living through verbal and nonverbal communication of their values and images (p. 42); (b) structuring meaning, valuing, and imaging constitute continuous processes (pp. 42-50); and (c) individuals structure new meaning with each new experience of daily living (Parse, 1987, pp. 164-168). The experience of having a family member with a life-threatening illness admitted to the hospital results in structuring new meanings by both the patient and family members. Although the meaning of an experience is unique to each individual family member, common themes may emerge.

Individuals communicate the meaning of an experience to others through a process called languaging. Languaging includes all forms of human verbal and nonverbal communication. The languaging of valued images of needs by the family members of critically ill patients during one-to-one interviews may differ from the common themes of needs identified by the use of the CCFNI (Molter & Leske, 1983).

## Statement of Purpose

The purpose of this study was to investigate the needs expressed during an open-ended interview by family members of patients hospitalized in a coronary care unit for 24-48 hours.

## Background and Significance

The published research related to needs of family members of critically ill patients has primarily investigated five domains of needs: support, comfort, information, proximity, and assurance by using a data collection instrument developed by Molter (1979b) or a modified version (Molter & Leske, 1983). A summary of the

top 10 needs identified by family members of critically ill patients presented in these studies supports the importance of assurance, proximity, and information. An investigation of the needs of family members of critically ill patients using an open-ended interview technique may not only reveal other needs but further support needs related to assurance, proximity, and information.

"The goal of man-living-health practice is the enhancement of the quality of life as viewed by the person and family" (Parse, 1989, p. 70). Nurses enhance the quality of life of family members first by providing opportunities for family members to express what the present situation means to them and then, by interacting harmoniously with their views and patterns of relating to others as their thoughts, feelings, and views solidify or change through the process of being in the present situation (Parse, 1989). According to Parse (1989), the nurse, in order to assist the family members to transcend their present situation, must focus on the meaning of the present situation and who and what provide comfort, from the viewpoint of the family members. An investigation of the needs of family members of critically ill patients using an open-ended interview technique would provide nurses with a strategy to acknowledge family members'

needs and simultaneously facilitate change and/or their transcendence.

## Conceptual Framework

The world view of Rosemarie Rizzo Parse (1981, 1987), man-living-health, serves as a framework to organize the phenomena of needs of family members. Parse's assumptions reflecting her world view evolved from Martha Roger's principles and concepts as well as from tenets and concepts from existential-phenomenological thought, primarily Heideggar, Sartre, and Merleau-Ponty (Parse, 1981, 1987). However, "she [Parse] created a new product, ... a totally different way of perceiving reality" (Phillips, 1987, p. 196). Parse's theory has been chosen as the foundation for this study because she recognized the coexistence of the patient and family, reality as the reality as perceived and cocreated by the patient and family, and "... the goal of man-living-health practice [as] the enhancement of the quality of life as viewed by the person and family" (Parse, 1989, p. 70).

Parse (1989) derived three dimensions of practice from her three principles:

| Dimensions | Principles |
| --- | --- |
| Illuminating meaning | Structuring meaning multidimensionally cocreates reality through the languaging of imaging and valuing |
| Synchronizing rhythms | Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting, while connecting-separating |
| Mobilizing transcendence | Cotranscending with the possibles is powering unique ways of originating in the process of transforming (p. 70) |

Since a nurse uses the dimension of illuminating meaning during one-to-one interview, this dimension and the principle from which it was derived will be discussed. Although the dimensions occur simultaneously (Parse, 1989, p. 71), illuminating meaning, being aware of and concentrating on the meaning as languaged by the patient and family, is explained as the first process to occur. Illuminating meaning involves having patients and/or families explain their perception of meaning or reality. In other words, illuminating meaning or structuring

meaning multidimensionally means the nurse perceives the values and images patients and/or families experience through the patient's and the family's verbal and nonverbal processes of communicating or languaging. Expression of this verbal and nonverbal communication structures meaning and cocreates reality of the patient and/or family during the continuous interchange between patient and/or family and their environment, which includes the nurse.

Parse (1981) relates three concepts, imaging, valuing, and languaging, to the principle of structuring meaning multidimensionally. A brief discussion of each concept in relation to the concept's definition and connection to structuring meaning or cocreating reality will be presented. An explanation of how the concepts and principles relate to this study follow the discussion.

Imaging--a multidimensional--both a thoughtful and implicit process, creates and "makes real" a mental picture or mental conception. Parse describes imaging as knowing, explicitly and tacitly. Imaging shapes an individual's knowledge or reality. During the experience of day-to-day living, knowledge evolves as a person thinks or engages in self-talk in the context of tacit

knowledge. This knowledge emerges from previous experiences, ideas, feelings, beliefs, values, and/or behavior. This explicit-tacit process enables the individual to assimilate new ideas and structure meaning, and forms a framework for knowing (Parse, 1981, pp. 42-44; Parse, 1987, pp. 163-164).

Valuing, the process of confirming cherished beliefs as individuals interact with the environment, begins as imaged options emerge from a framework composed of a matrix of principles and ideas, a value system. Individuals choose from these imaged options and acknowledge their choices as being true or valid to self and others by acting upon their choices. Individuals integrate choices into their value system that becomes the framework from which future imaged options will emerge (Parse, 1981, pp. 45-46). Parse defined the process of valuing based on the description of values by Raths, Harmin, and Simon (1978). They found that value results from the process of valuing that must meet seven criteria and includes three activities: (a) choosing, (b) prizing, and (c) acting (pp. 26-28). These authors further discussed that although beliefs, attitudes, and feelings do not meet the seven criteria of valuing, these value indicators

can develop into values. Both Parse (1981) and Raths et al. (1978) explain that when an individual (a) freely chooses, (b) thoughtfully considers, (c) prizes, (d) cherishes, (e) affirms publicly, and (f) acts upon attitudes, beliefs, or feelings; (g) repeatedly, these value indicators become values. Values create a sense of meaning for a person and reflect meanings of the person. For example, when a person freely chooses to stop smoking, prizes the choice of not smoking, and independently exercises the choice, the person has created a new meaning for self and now reflects a new meaning to others as a nonsmoker.

Expressions of languaging include talking, writing, smiling, moving, hesitating, and communicating verbally and nonverbally (Parse, 1981). "Languaging, the third concept of structuring meaning multidimensionally, is expressing valued images" (p. 46). The images a person cocreates, chooses, prizes, and acts upon as values give meaning to life's experiences and these are expressed through languaging. Languaging represents a person's cocreated reality and the process of structuring meaning (Parse, 1981, pp. 46-49).

The purpose of this study was to identify the structured meaning and cocreated realities of family

members of critically ill patients. Data were collected during one-to-one interviews consisting of responses to open-ended questions related to needs that reflected the languaging of values and images of needs. The data represented the meaning and reality related to needs from the family member's perspective (see Figure 1). To illuminate meaning, nurses must be aware of the languaging of family members.

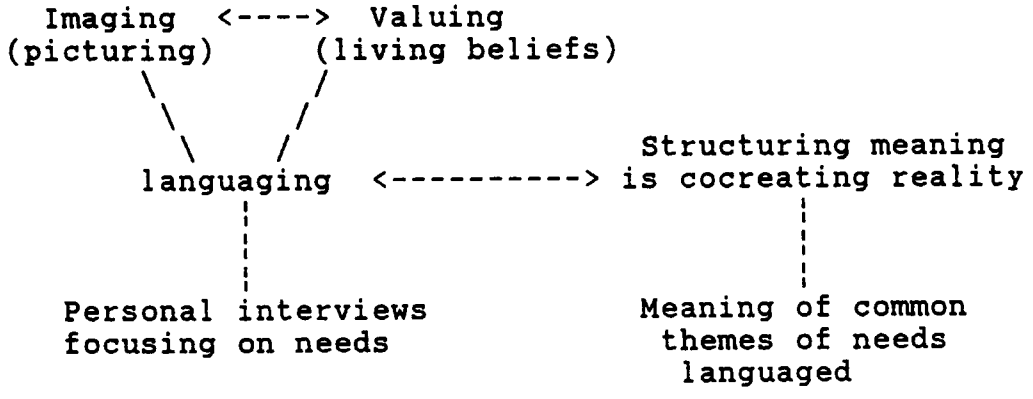


Figure 1. Languaging of valued images of needs.

Source:

Adapted from Parse, R. R. (1981). Man-living-health: A theory of nursing (p. 69). New York: Wiley.

## Statement of Problem

The question of interest was, "What needs do family members of patients hospitalized in a coronary care unit for 24-48 hours identify during an open-ended interview?"

## Definition of Terms

In this study the following conceptual definitions of concepts were used:

1. Need. "A requirement of an individual which, if supplied, relieves or diminishes his [her] immediate distress or improves his [her] immediate sense of adequacy or well-being" (Orlando, 1990, p. 6).
2. Family. A social system composed of a small group of closely interrelated and interdependent individuals who are organized into a single unit to attain specific purposes, namely, family functions or goals (Friedman, 1986, p. 83).

3. Critically ill patient. A person at high risk for developing life-threatening problems (Cardin & Ward, 1989, p. 4).

The following operational definitions of concepts were used:

1. Needs. The verbal expressions of family members recorded in response to open-ended questions.
2. Family members. Adults who are 18 years of age or older, who identify themselves as spouses or significant others, and who visit the patient at least once. Significant others who have had relationships with the patient for at least the immediate past year were included in the definition of family members.
3. Critically ill patients. Adults who are 18 years of age or older and who have been hospitalized in a coronary care unit (CCU) for less than 48 hours.
4. Coronary care unit. An eight bed CCU, which also served as an overflow medical intensive care unit, with special monitoring equipment and an average staffing ratio of 1 registered

nurse for every 2 patients. The CCU, medical intensive care unit, surgical intensive care unit, and coronary observation unit were located adjacent to each other and were collectively called the critical care units.

## Assumptions

Based on the literature, the following assumptions relevant to this study have been made:

1. Both family members and the patient hospitalized in CCU structured new meaning during the "hospitalization experience."
2. Family members revealed their needs through languaging responses to open-ended questions during a personal interview.
3. Coronary care nurses participated in illuminating meaning of family members.

# CHAPTER II

## LITERATURE REVIEW

Family members direct more energy toward supporting and helping patients and express more satisfaction when nurses identify and develop strategies to meet the expressed needs of family members (Bedsworth & Molen, 1982; Bozett, 1987; Daley, 1984; Gaglione, 1984; Gardner & Stewart, 1978; Hodovanic, Reardon, Reese, & Hedges, 1984; Jacono et al., 1990; Leske, 1986; Mathis, 1984; Molter, 1979a; Norheim, 1989; Spatt, 1986; Stillwell, 1984). Gardner and Stewart (1978) stated that "appropriate staff interventions with families may lead to decreased anxiety, increased reassurance, better cooperation, improved rapport, mutual understanding and empathy, and improved patient care" (p. 105). Likewise, research that identifies the needs of family members of critically ill patients may assist nurses in planning appropriate nursing interventions for family members.

## Effects of Hospitalization on Family Members

Several studies (Bedsworth & Molen, 1982; Caplin & Sexton, 1988) investigated the threats or stressors identified by spouses, family members, of patients with myocardial infarction. Bedsworth and Molen (1982) used a semi-structured interview with 20 spouses of patients with myocardial infarctions and reported the following incidence of eight stressors:

1. Fear of loss of mate (75%)
2. Fear of loss of healthy mate (50%)
3. Fear of recurrence of a myocardial infarction (30%)
4. Financial insecurity (20%)
5. New roles within the family unit (15%)
6. Changes in personal goals or motives (10%)
7. Separation from mate (10%)
8. Recurrence of personal illness (10%) (p. 452)

A later study by Caplin and Sexton (1988) ranked the following 11 stressors as the most highly stressful of 33 stressors by 14 spouses of patients with myocardial infarction:

1. Possible death of spouse
2. Seeing husband/wife sick
3. Dealing with husband's/wife's reaction to idea of having a heart attack
4. Trying not to upset or worry husband/wife
5. Thinking about difficulties when husband/wife gets home
6. Inability to sleep
7. Inconvenient and expensive parking
8. Difficulty concentrating
9. Not being informed about changes in husband's/wife's condition
10. Being lonely
11. Being asked to wait when calling on the intercom (p. 36)

They collected data from spouses of patients with myocardial infarction in two phases. During the first phase, 10 spouses identified 33 stressors during structured interviews. During the second phase, 14 spouses ranked the 33 previously identified stressors using a Q-sort technique.

These studies (Bedsworth & Molen, 1982; Caplin & Sexton, 1988) involving a total of 44 spouses found only the following three stressors present in all spouses:

1. Fear of potential death or loss of family member or loss of healthy family member
2. Concern about new roles, difficulties and goals
3. Loneliness

The differences in the stressors found in these two studies may be related to the different methods used to classify the data. Bedsworth and Molen (1982) classified the stressors expressed by spouses during semi-structured interviews into nine predetermined categories of stressors. In contrast, Caplin and Sexton (1988) listed all stressors identified by the subjects during the structured interviews.

In addition to identifying the stressors, Bedsworth and Molen (1982) reported the emotions experienced by family members and the coping strategies they used. The 20 spouses described 79 different emotions; each spouse reported two to nine of the emotions. Family members most frequently reported anxiety and fear, followed by anger, helplessness, and guilt. Bedsworth and Molen (1982) reported an association of anxiety with no action, anger with attack, and fear with avoidance. However, examples were not given to support these associations.

These research findings support the view that an individual's hospitalization affects the family members. To convey an initial understanding of the hospitalization's meaning, nurses should acknowledge the stressors and their associated emotions expressed by the family (Bedsworth & Molen, 1982; Caplin & Sexton, 1988). Parse (1989) explained that, during initial dialogue, a nurse and a family member focus on the meaning of the present event and its effects on the life of the family member; identify person(s) and action(s) who are important and/or which provide comfort to the family member; and discuss the major aspirations of the family member (p. 71). Clarification of who and what provide comfort and the person's needs, reveals to the nurse and to the family member the meaning of the situation and the person's languaged desired patterns of relating, which facilitates synchronization of rhythms between the nurse and family member. The family member's languaged desired patterns of relating reflect the meaning of the situation to the family member and cocreate new meaning of the situation and new patterns of relating by the family member (Parse, 1987, p. 170). To assist family members during the stressful and emotional time of

hospitalization of the patient, nurses must identify the needs perceived by family members.

## Needs of Family Members

Hampe (1973, 1975) used a semi-structured interview to identify the needs expressed and comfort measures used by grieving spouses of chronically ill patients. Dracup and Breu (1978) used the same instrument to identify the needs of spouses of acute, terminally ill patients in coronary care and found they expressed the same eight needs:

1. To be with the dying patient
2. To be helpful to the dying patient
3. To be assured the dying experienced comfort
4. To be informed of the patient's condition
5. To be informed of the impending death of the patient
6. To ventilate emotions
7. To experience comfort and support from other family members
8. To experience acceptance, support, and comfort from health professionals

Molter (1979a) described Hampe's study (1973, 1975) as the first study published describing "what relatives identify as personal needs during the crisis of a critical illness" (p. 332). She explained that the hospitalization of a patient can cause crisis in the family. The role of the nurse is to assist the family members to cope with the crisis of hospitalization of the patient by helping family members meet their own needs. Both Molter (1979a) and Hampe (1975) expressed the belief that nurses must efficiently use their time to assist family members to meet needs that are important to them. Their belief, the published literature, and the results of a survey of 23 graduate nursing students provided the basis for developing a 45 need-statements survey to identify the needs of family members of critically ill patients. Other investigators have used the instrument or a modified version of it. Molter and Leske (1983) randomly ordered the 45 need-statements, added an open-ended question to allow for additional needs not included in the 45 need-statements, and named the instrument the Critical Care Family Needs Inventory (CCFNI). Daley (1984) used a modified version of Molter's instrument and categorized 46 items according to six of the eight needs identified by Dracup

and Breu (1978). Leske (1986), Mathis (1984), Spatt (1986), and Norheim (1989) used the CCFNI for their studies. Norris and Grove (1986) and Jacono et al. (1990) had five intensive care nurses and five family members Q-sort the 45 need-statements and modified the original instrument to 30 need-statements. Reliability using a Cronbach alpha coefficient was reported in three of these studies as 0.98 (Leske, 1986), 0.85 (Norris & Grove, 1986) and 0.88 (Norheim, 1989).

An analysis of the top 10 need-statements ranked by various versions of Molter's (1979b) instrument revealed the following 10 needs range in frequency from 66% to 100%:

1. To have questions answered honestly (100%)
2. To be called at home about changes in patient's condition (94%)
3. To know specific facts about patient's progress or condition; to know what is wrong with the patient (88%)
4. To feel there is hope (88%)
5. To feel hospital personnel care about the patient (88%)
6. To know prognosis/outcome (83%)

7. To be assured the best possible care is being given to patient (77%)
8. To know exactly what/why things are being done for the patient (72%)
9. To have explanations given in terms that are understandable (66%)
10. To receive information about the patient once a day (66%)

In contrast to the previous study, Dracup and Breu (1978) found the following eight needs:

1. To be with the patient
2. To be helpful to the patient
3. To be assured the dying experienced comfort
4. To be informed of the patient's condition
5. To be informed of the impending death of the patient
6. To ventilate emotions
7. To experience comfort and support from other family members
8. To experience acceptance, support, and comfort from health professionals

Only 1 of these 8 needs, the need to be informed of the patient's condition, was identified in the top 10 needs of the eight previously cited studies.

Categories of needs

A factor analysis by Leske (1988) using 677 subjects demonstrated that the Molter and Leske (1983) instrument measures the following five categories of needs: support, comfort, information, proximity, and assurance. A review of the top 10 needs indicated 7 in the category of assurance (A), 2 in the category of proximity (P), and 1 in the category of information (I) (Leske, 1988) as follows:

1. To have questions answered honestly (A)
2. To be called at home about changes in patient's condition (P)
3. To know specific facts about patient's progress or condition; to know what is wrong with the patient (A)
4. To feel there is hope (A)
5. To feel hospital personnel care about the patient (A)
6. To know prognosis/outcome (A)
7. To be assured the best possible care is being given to patient (A)
8. To know exactly what/why things are being done for the patient (I)

9. To have explanations given in terms that are understandable (A)
10. To receive information about the patient (once a day) (P)

In contrast, after the eight needs identified by Dracup and Breu (1978) were labeled according to Leske's categories, a review indicated 1 in the category of assurance (A), 1 in the category of proximity (P), 2 in the category of information (I), 4 in the category of support, and 2 in the category of comfort (C) as follows:

1. To be with the patient (P)
2. To be helpful to the patient (I)
3. To be assured the dying experienced comfort (A)
4. To be informed of the patient's condition (I)
5. To be informed of the impending death of the patient (S)
6. To ventilate emotions (S)
7. To experience comfort and support from other family members (C) (S)
8. To experience acceptance, support, and comfort from health professionals (S) (C)

The differences between the needs in the studies may be related to the grave prognoses of the patients in the

study conducted by Dracup and Breu (1978). Daley (1984), however, indicated that two of the patients included in her study were gravely ill (one considered terminating life support and one experienced cardiac arrest). Another explanation for the differences between the needs identified in the studies may be related to differences in the data collection methods. The eight previously cited studies used Molter's instrument, a questionnaire compiled from the perceptions of 23 graduate students and review of the literature, while Dracup and Breu (1978) used semi-structured interviews. In the eight previously cited studies using a questionnaire technique, family members recalled if they experienced the particular need while languaging and structuring meaning in context of the questionnaire. In contrast, during the semi-structured interview technique family members expressed their needs within the context of their experience.

In summary, the findings published by Bedsworth and Molen (1982) and Caplin and Sexton (1988) support that the hospitalization of a patient in coronary care affects other family members. The family members of critically ill patients identify several stressors that contribute to the anxiety and fear perceived during this

experience. Parse (1989) explained that nurses need to be aware of the meaning of the present situation and who and what provides comfort to each family member. The current literature supported the importance and needs for assurance, proximity, and information to family members of critically ill patients, although some literature (Dracup & Breu, 1978) noted the importance of other needs. Additional study using different self-reported methods of data collection seemed warranted to further investigate if family members identify other needs.

# CHAPTER III

# METHODOLOGY

## Design of Study

A descriptive, qualitative research design was used for this study conducted at a 525 licensed bed Regional Medical Center in a southeastern state. A convenience sample of the family members meeting the criteria for inclusion was selected.

## Instrumentation

The investigator-developed instrument was used to identify the needs of the family members (see Appendix B). Open-ended questions guided the structured interview. Members of a qualitative research support group and the thesis committee for this study reviewed the instrument to establish face validity and its adequacy to address potential needs of the proposed participants. Several revisions were made by the investigator prior to data collection.

Demographic information related to the patient and the participant was collected at the end of each interview. The data were used to describe the sample (see Appendix A). The demographic variables reported as possibly influencing the needs of family members of critically ill patients include: (a) age and socioeconomic status, (b) gender, and (c) relationship.

Participants were classified in socioeconomic groups according to the four-factor index of social position described by Hollingshead (1976). The four factors used to develop and calculate the index of social status: marital status, occupation, education, and gender were used to calculate a score to determine which of the five social classes best represented the family member's social status.

## Participants

A convenience sample procedure was used to select eight participants. Participants excluded from the study included those: (a) classified as "no information" patients, (b) not interested in participating, (c) not available within the 48 hours after admission of the patient, and (d) who did not visit the patient. Two

potential participants were excluded from the study. One potential participant was "upset" and not interested in participating. The other potential participant was not available within the 48 hours after the admission of the patient. As reported in a previous study (Leske, 1986), the investigator experienced no difficulty establishing rapport with the participants.

## Procedure

The committee on Research Participation, which is the institutional Review Board for the University of Tennessee, approved this study under Form B (research for expedited review).

The purpose and need for the study was described to the Senior Vice President of the hospital that served as the site for this study; After permission to collect data was obtained, a similar discussion was held with the Critical Care Clinical Nurse Coordinator and a letter explaining the purpose and procedure of the study was sent to the CCU staff.

A pilot study of the first 2 of 10 participants was conducted to evaluate the need to modify the procedure, consent form, demographic sheet, and/or instrument. The

participants participating in the pilot study did not offer any suggestions in response to the investigator's request for suggestions. However, after the pilot study, the interview was modified to begin the interview with a broader first question. The data collected during the interviews with the first two participants, the pilot study, were not included in the final analysis. The dates to conduct the pilot study and to begin the study were mutually established between the investigator and the hospital.

Each day of the study, the investigator reviewed the log book and identified all patients who had been admitted to the CCU during the past 24 hours and who had a living spouse. The investigator then asked the registered nurses working in the unit which of the patients admitted during the past 24 hours had living spouses or significant others who had visited the patients and if they were aware of any reason the investigator should not approach specific spouses or significant others about participating in the study. One patient was a "no information" patient and was excluded. The investigator introduced herself to the potential participants recommended by the registered nurses, provided an explanation of the study, and asked

if they would like to participate in the study. Each potential participant received a consent form (see Appendix C) explaining that their choice to participate in this study was strictly voluntary and that the treatment they and their spouse or significant other received would not be affected by their choice. If the potential participant consented to participate in the study, the investigator and participant arranged a time for the interview to occur within the 48 hours from admission of the patient to CCU. As mentioned previously, one of the potential participants did not wish to participate. The investigator acknowledged the desire not to participate and thanked the potential participant for allowing the investigator to approach him.

The investigator conducted seven of the interviews in the critical care family room, a room separated from the waiting room, and one interview in a classroom near the CCU. The investigator arranged and pretested the tape recorders, placed a demographic data sheet and blank lined sheets on a clip board near the tape recorders, placed an "in use" sign on the door of the interview room, and escorted the participants to the room. She then gave the participants a consent form and

asked the participants to read it. The participants were asked if they had any questions. All questions were answered before the participants signed the form. The investigator gave a carbon copy of the informed consent form to the participants and retained the original. The investigator read the purpose of the interview and explained the interview process (see Appendix B). Demographic information to describe the participants and patients was collected at the end of the interview.

## Data Analysis

The interviews were conducted over a period of 31 days. The investigator transcribed the audio tapes of the interviews using head phones and typed the content using a computerized word processing program, Word Perfect. Transcription of the tape recorded responses required a mean transcription time of 3 hours and 36 minutes per interview ranging from 2 hours and 5 minutes to 8 hours and 50 minutes per interview and resulted in 159 double-spaced pages of data. The average number of transcribed pages per interview was 19.88 with a range from 12 pages to 38 pages. The quotations presented in

this study were in vernacular and quoted verbatim from the transcribed interviews.

Eight qualitative content analyses at the latent level were completed (Berelson, 1971, pp. 114-134). Berelson (1971) explained that qualitative content analysis is more than just the inclusion of quotations and/or the use of an inductive process to discover or formulate categories. He described the following seven characteristics of a qualitative content analysis: (a) contains some quantitative statements, (b) is based on the presence or absence of content rather than frequency, (c) has a small sample size, (d) has a higher ratio of non-content to content statements since interpretations are part of the analytical process, (e) is less concerned with content than the meaning of content (more latent than manifest), (f) has less formalized categories, and (g) has a more complex content unit of analysis reflecting the context (pp. 114-134). During the process of conducting the comparative analysis, each participant's individual life experiences and way of being were acknowledged, explained, and collapsed into a category. While considering these seven characteristics of a qualitative content analysis, a systematic five-step process adapted

from Colaizzi (1978) was used to organize the data inductively into categories.

In the first step, the investigator listened to, transcribed, and read the tape recorded interviews to gain an understanding of the meanings the participants were languaging during the interviews. Colaizzi (1978) called the participant's description "protocols" and explained that an investigator should first read the protocols "... in order to acquire a feeling for them" (p. 59).

In the second step, each protocol (transcribed interview) was reread and themes (the recording unit) languaged by the participant related to needs were identified by brackets and extracted from the protocols. Colaizzi called this second step "extracting significant statements" that pertain to the phenomenon under study. As the extracted statements were taken directly from the protocols, they were labeled with the participant's code number and the protocol's line number (p. 59). Colaizzi explained that the extracted statements can be transposed to more general restatements and repetitions can be eliminated. A decision was made to include all extracted statements.

In the third step, the investigator reformulated the extracted statement into more general need-statements. The sentence containing the theme and the preceding and following sentences were used as the context unit to guide the investigator in restating the extracted statements. Colaizzi (1978) explained "formulating meanings" is an insightful process of restating what the participant says to what the participant means (p. 59). The following are examples of extracted statements (EX) and formulations (FM) from participants (03-10):

(EX) *I need to be doing something cause I guess because of my nervous system (03)*

(FM) to do something

(EX) *You're glad you can visit her (03)*

(FM) to express feelings about visiting

(FM) to visit patient

(EX) *At least let the wife or husband be in and uh, as long as you don't upset the patient, I think (07)*

(FM) to visit patient

(FM) to not upset patient

(EX) *It's helpful to have somebody that's with you (10)*

(FM) to have someone with you

(EX) *But uh, they (nurse) come in, they introduce themselves, and they've been real nice to me (07)*

(FM) to be treated well by staff

To ensure the formulations were connected to the extracted statements and protocols, the trustworthiness of the formulations was validated by one of the doctorally prepared thesis committee members experienced in qualitative research. A Master's prepared nurse with experience in critical care nursing administration was also given a copy of two randomly selected protocols and asked to identify and reformulate themes related to the needs languaged by the participants. The percentage of agreement was calculated by dividing the number of agreements by the number of agreements plus the number of disagreements (Polit & Hungler, 1987). The percentage of agreement was 92.5% (272 of 294). Ninety percent agreement of the coded responses was considered acceptable (Thomas, 1986).

In the fourth step, the process described above was repeated for each protocol, then repetitive formulations and extracted statements from all eight of the protocols

were combined, and finally, aggregate formulations were organized into theme clusters. General need-statements reflecting the meaning of the formulations within the theme clusters were used to label the theme clusters. In order to validate the connections between the theme clusters and protocols, the theme clusters were referred to the protocols by the investigator. The same committee member was asked to decide if other theme clusters were present in the protocols but not in the theme clusters identified by the investigator and/or if theme clusters identified by the investigator were not represented in the protocol. The trustworthiness of all the theme clusters was evaluated as Colaizzi (1978) recommended.

In the fifth step, aggregate theme clusters were organized into categories. An exhaustive description of the fundamental need languaged in the aggregate theme clusters was derived and used to label the category. This exhaustive description of the need languaged was developed to gain insight into the needs identified by family members of patients admitted to the coronary care unit. Initially, a total of 11 categories emerged from the aggregate theme clusters. After reviewing the 11 categories, 2 of the categories, care of dependent and

acceptance, where found to be a part of the remaining 9 categories. The theme clusters within these 2 categories were moved to the categories containing related aggregate theme clusters.

Summary of data analysis

The systematic, inductive process described above was used by the investigator to promote the emergence of the needs of family members from the original descriptions (transcribed interviews) given by the family members. An example of step 2 through step 5 is shown on Table 1.

Table 1 Steps 2 through 5 of inductive process

| Extracted Statements | Formulations | Theme clusters | Category |
|---|---|---|---|
| You're glad you can visit her.[03, 38-39] | to visit patient | to be with patient at bedside | proximity |
| we got to go in see him at 12, I mean 5 after 12.[04, 13-14] | | | |
| So I was going to go in,[04, 54] | | | |
| when I went in to visit him and everything else, just, you know if I needed to ask a question,[04, 62-64] | | | |
| (what's helpful) And when we first saw him from surgery.[04, 115] | | | |
| I visit her every one of them I could get into [05, 13-14] | | | |
| some of them they told me I'd have to come back later [05, 16-17] | | | |
| wouldn't get to see her [05, 17] | | | |
| when I didn't get in I stay as long as I could, they had to run me out. (laughs). [05, 18-19] | | | |
| Just being with her's what's made me feel better, I mean, that's the only thing, I guess.[05, 129-131] | | | |

# CHAPTER IV

# RESULTS

## Descriptive Statistics for Total Sample

### Interviews

The mean length of time from admission of the patient to CCU and interview with the participants was 24.62 hours with a range from 11 hours to 43 hours and a median of 24.25 hours. The interviews ranged in length from 18 minutes to 63 minutes with a mean time of 31 minutes and a median time of 27 minutes per interview.

### Participants and patients

The typical participant was female, married for 33 years, 60 years of age, a high school graduate, employed, and in socioeconomic class III (Hollingshead, 1976) (see Table 2). All of the participants and patients were caucasian. The patients' ages were similar to the participants' ages. Education for 87.5% (7) of the participants in contrast to 50% (4) of the patients was at or above the high school graduate level. The diagnoses of the patients, according to the

Table 2 Descriptive data of participants and patients

| Variables | Participant | Patient |
|---|---|---|
| **Gender** | | |
| Female | 5 (62.5%) | 3 (37.5%) |
| Male | 3 (37.5%) | 5 (62.5%) |
| **Age** | | |
| Range | 47-72 years | 45-72 years |
| Mean | 60.5 years | 60.9 years |
| Median | 62.5 years | 63 years |
| **Educational level** | | |
| Eighth grade | 1 (12.5%) | 3 (37.5%) |
| Ninth grade | 0 | 1 (12.5%) |
| High school graduate | 6 (75%) | 1 (12.5%) |
| Special training beyond high school | 0 | 2 (25%) |
| Partial college | 1 (12.5%) | 1 (12.5%) |
| **Employment status** | | |
| Employed | 4 (50%) | 3 (37.5%) |
| Retired | 2 (25%) | 3 (37.5%) |
| Housewife | 2 (25%) | 2 (25%) |
| **Hollingshead socioeconomic class** | | |
| Class I, major business owners and professionals | 1 (12.5%) | |
| Class III, skilled craftsman, clerical, and sales-workers | 4 (50%) | |
| Class IV, machine operators and semiskilled workers | 3 (37.5%) | |
| **Married (years)** | | |
| Range | 7-54 years | |
| Mean | 33.8 years | |
| Median | 32.5 years | |
| **Condition of patient (at time of interview)** | | |
| Fair | | 1 (12.5%) |
| Stable | | 6 (75%) |
| Critical | | 1 (12.5%) |

participants, included chest pain 37.5% (3), irregular heart rate 25% (2), ventricular tachycardia 12.5% (1), tumor in lung 12.5% (1), and complete laryngectomy 12.5% (1) (see Table 3). Nurses confirmed both the diagnoses and conditions of the patients as described by the participants. One patient, in critical condition, had a diagnosis of irregular heart rate (torsade de pointes), had experienced a cardiac arrest 10 hours prior to the interview, and had recurrence of ventricular tachycardia 4 hours prior to the interview.

Setting

The patients were hospitalized within an eight bed CCU which also receives overflow medical intensive care patients. Approximately 67% of the patients in the CCU during the time period of this study had medical diagnoses related to cardiac problems such as acute myocardial infarction, chest pain, congestive heart failure, cardiac arrest, atrial flutter, syncope, ventricular tachycardia, and arrhythmias. The other 33% had medical diagnoses such as drug overdose, appendectomy (at age 85 years), diabetic ketoacidosis, fractured ribs (automobile accident), carotid stenosis, end stage renal disease, stab wound, dehydration, and

Table 3 Brief history and medical diagnosis of patients of spouses participating in this study

| Code number | Description of history and medical diagnosis of patients |
|---|---|
| 03[b] | History arrhythmia, this admission recurrence of arrhythmia, unknown etiology, for heart catheterization |
| 04[d] | History back pain and numerous attempts to biopsy lung tumor using non-surgical approach, for biopsy lung tumor using surgical approach |
| 05[c] | History chest pain, ventricular tachycardia, cardiac arrest, hypoxemia, encephalopathy, and placement of internal defibrillator, this admission potassium imbalance, ventricular tachycardia |
| 06[a] | History of recent percutaneous coronary angioplasty (PTCA), this admission recurrence of chest pain for repeat PTCA |
| 07[a] | History of chest pain, myocardial infarction, quadruple coronary artery bypass graft, and hiatal hernia, this admission recurrence of chest pain |
| 08[b] | Recent history of stroke, this admission cardiac arrest, ventricular tachycardia (torsade de points) |
| 09[a] | History of mitral valve replacement, this admission chest pain, myocardial infarction, and for coronary artery bypass grafts |
| 10[e] | History cancer of larynx treated with radiation therapy, this admission complete laryngectomy |

Note. Description of medical diagnosis was obtained through conversation with spouses and nurses.

[a]Chest pain. [b]Irregular heart rate. [c]Ventricular tachycardia. [d]Tumor in lung. [e]Complete laryngectomy.

chronic obstructive pulmonary disease with pneumonia. The ages of these patients ranged from 22 to 85 years. Family members of patients hospitalized in the CCU shared the visitors' waiting room with family members of patients hospitalized in an adjacent eight bed surgical (open heart) intensive care unit and an eight bed medical intensive care unit. The visitors' waiting room was located near the double doors to all three of the critical care units. Family members could only see the patients for four 30-minute visits at specified times between 10:30 and 21:00 each day. Receptionists (one employee and several auxiliary members) staffed the visitors' waiting room between the hours of 7:00 and 23:00. The receptionists gave each family member a booklet containing information about the types of units within the critical care area and equipment; rules related to visiting, flowers, smoking, overnight lodging, nurse assignment, parking, eating facilities, and special services; and maps of the hospital's location, the main floor and the critical care area.

## Needs of Family Members

The purpose of this study was to identify the needs of family member of patients admitted to a coronary care unit within the first 24-48 hours. The results of the qualitative content analysis revealed that the participants had the following nine categories of needs: (a) information, (b) support, (c) proximity, (d) assurance, (e) comfort, (f) helpful, (g) express feelings, (h) express thoughts, and (i) reflect. A brief discussion of each category with examples from the protocols follows.

### Information

The category of information emerged from 220 extracted statements, 41 formulations, and 8 theme clusters as shown in Tables 4, 5, and 6. The definition of the category information emerged from the following theme clusters: (a) to receive information about condition or change in condition of patient, (b) to receive an update about changes in patient's status, specific diagnosis, test, operation, or treatment, (c) to have information provided through one-to-one contact, booklets, or films, (d) to have access to care givers

Table 4 Number of categories, theme clusters, formulations, and extracted statements

| Category | Theme clusters | Formulations | Extracted statements |
|---|---|---|---|
| Information | 8 | 41 | 220 |
| Support | 6 | 41 | 258 |
| Proximity | 4 | 12 | 109 |
| Assurance | 5 | 38 | 116 |
| Comfort | 5 | 31 | 86 |
| Helpful | 5 | 15 | 39 |
| Express feelings | 2 | 22 | 154 |
| Express thoughts | 8 | 27 | 146 |
| Reflect | 3 | 17 | 148 |

Table 5 Category, theme clusters, and formulations for information

| Category | Theme Clusters | Formulations |
|---|---|---|
| information | to receive information about condition or change in condition of patient | to know condition of patient |
| | | to know specific facts about patient's condition |
| | | to have specific facts about change in patient's condition |
| | | to know specific facts concerning patient's progress |
| | to receive an update about changes in patient's status, test, operation, or treatment | to know medical diagnosis |
| | | for information about diagnostic procedures and test |
| | | to know results of diagnostic test |
| | | to know about operation |
| | | to know about treatment |
| | to have information provided through one-to-one contact, booklets, or films | to have information |
| | | to have patient education nurse come see you |
| | to have access to care givers in order to obtain information | to have questions answered |
| | | to talk to doctor |
| | | to have doctor explain what's happening to patient |
| | | to have explanation from doctor about surgery |
| | | to know doctor |
| | | to talk to patient's therapist |
| | to receive information about what to expect | to know what to expect |
| | | to have explanation of what they're going to do |
| | | to explain everything step by step |
| | | to know priorities of medical plan of care |

Table 5 (continued)

| Category | Theme Clusters | Formulations |
|---|---|---|
| | | to know future medical plan |
| | | to know how long patient may be in hospital |
| | | to be prepared (by the nurse) or told what patient will look like |
| | | to know risk of test |
| | | to know when results of diagnostic test will be available |
| | to be able to understand information | to have explanation of what they're doing in understandable terms |
| | to receive information from patient | to know what concerns the patient |
| | | to know what husband thinks about care he is receiving |
| | | to know patient likes hospital |
| | | to receive information from patient |
| | to receive information related to orientation to environment | to know visiting rules |
| | | to have information about how to get somewhere |
| | | to know where conveniences are located |
| | | to be told why you can't be with patient |
| | | to know about why patient is no longer getting food that is ordered |
| | | to know about equipment in room |
| | | to be shown where patient will be after surgery |
| | | to know services that hospital offers |
| | | to know you can call and talk to doctor |
| | | to know when doctor visits patient |

Table 6 Percentage of participants languaging theme clusters

| Category and theme clusters | Participants included | Number participants | Percent of total |
|---|---|---|---|
| **information** | | | |
| to receive information about condition or change in condition of patient | 5, 6, 7, 8, 9, 10 | 6 | 75 |
| to receive an update about changes in patient's status, specific diagnosis, test, operation, or treatment | 3, 4, 7, 8, 9, 10 | 6 | 75 |
| to have information provided through one-to-one contact, booklets, or films | 6, 7, 9 | 3 | 37.5 |
| to have access to care givers in order to obtain information | 3, 4, 6, 7, 8, 9, 10 | 7 | 87.5 |
| to receive information about what to expect | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| to be able to understand information | 3, 8 | 2 | 25 |
| to receive information from patient | 5, 6, 7, 8, 9, 10 | 6 | 75 |
| to receive information related to orientation to environment | 4, 5, 6, 7, 8, 9, 10 | 7 | 87.5 |
| **support** | | | |
| to have family available and provide support | 3, 4, 5, 6, 7, 9, 10 | 7 | 87.5 |
| to have someone with you | 6, 7, 8, 10 | 4 | 50 |
| to have support from friends, neighbors, staff, visitors, and God | 3, 4, 5, 6, 7, 10 | 6 | 75 |
| for emotional supportive action from self, family, other visitors, neighbors, and staff | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| for physical supportive action from self, family, pastor, friends, and company | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| for spiritual supportive action from self, family, and friends | 4, 5, 6, 10 | 4 | 50 |

Table 6 (continued)

| Category and theme clusters | Participants included | Number Participants | Percent of total |
|---|---|---|---|
| **proximity** | | | |
| to be with patient at bedside | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| to share the experience with patient | 3, 5, 6, 7, 9 | 5 | 62.5 |
| to be in contact with patient | 3, 5, 6, 7, 8, 9 | 6 | 75 |
| to be with dependent | 6, 9 | 2 | 12.5 |
| **assurance** | | | |
| to have trust and confidence in care giver | 3, 4, 5, 6, 8, 10 | 6 | 75 |
| to feel care giver has technical competence | 3, 6, 7, 8, 10 | 5 | 62.5 |
| to feel care giver is responsive to patient | 3, 5, 6, 7, 10 | 5 | 62.5 |
| to feel good about the response of patient to others and environment | 3, 4, 5, 7, 9, 10 | 6 | 75 |
| to have confidence in dependent's care giver | 6, 9 | 2 | 12.5 |
| **comfort** | | | |
| to be physically active | 3, 5, 7, 8 | 4 | 50 |
| to have conveniences, accommodations, and comfortable environment | 4, 5, 8 | 3 | 37.5 |
| to have mental relief | 5, 7, 9, 10 | 4 | 50 |
| to have measures of relief | 5, 6, 7, 8, 9, 10 | 6 | 75 |
| to have relief from indebtedness | 3, 5, 8 | 3 | 37.5 |
| **helpful** | | | |
| to choose patterns of relating with patient which enable patient | 4, 5, 6, 7, 8, 9, 10 | 7 | 87.5 |
| to provide material items for patient | 8 | 1 | 12.5 |
| to interact with others on behalf of patient | 3, 8, 10 | 3 | 35 |
| to be helpful to staff | 6 | 1 | 12.5 |
| to be helpful to dependent | 5, 6, 9 | 3 | 35 |

Table 6 (continued)

| Category and theme clusters | Participants included | Number participants | Percent of total |
|---|---|---|---|
| **express feelings** | | | |
| to express negative feelings | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| to express positive feelings | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| **express thoughts** | | | |
| to express thoughts about feelings | 3, 5, 7, 8, 9, 10 | 6 | 75 |
| to express thoughts about staff | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| to express thoughts about nursing care and staffing | 7, 8, 9, 10 | 4 | 50 |
| to express thoughts about information | 4, 5, 6, 7, 8, 9, 10 | 7 | 87.5 |
| to express thoughts about visiting | 5, 10 | 2 | 12.5 |
| to express thoughts about patient | 5, 6, 8, 10 | 4 | 50 |
| to express thoughts about support | 5, 6, 7, 9, 10 | 5 | 62.5 |
| to express thoughts about indebtedness, relief measures, conveniences, and environment | 3, 6, 8, 10 | 4 | 50 |
| **reflect** | | | |
| reflecting on your own experiences | 5, 6, 8, 10 | 4 | 50 |
| reflecting on previous condition of patient | 3, 4, 5, 6, 7, 8, 9, 10 | 8 | 100 |
| reflecting on relationship with staff, family, and patient | 5, 6, 8, 9 | 4 | 50 |

in order to obtain information, (e) to receive information about what to expect, (f) to be able to understand information, (g) to receive information from patient, and (h) to receive information related to orientation to environment. Since the category of information contained several theme clusters, a decision was made to only show examples of the protocols from four of the theme clusters for which a total of 100% to 75% of the participants languaged the need.

All of the participants languaged the desire to receive or having had received information about what to expect. Two examples were as follows:

> *like the nurses telling us and preparing us what we would see. And when we first saw him from surgery. Uh, and uh, so they totally explained everything step by step, as what, they explain it before we got to that step (04)*

> *you can't make plans ahead of time for the next day because you don't know what you're going to be doing (07).*

Eighty-seven and one-half percent of the participants languaged their desire to have access to care givers as a means to obtain information. Two examples were as follows:

*I think they (doctor) should make a point to talk to the other family members, the one that is there. Not the patient. But most of them (doctors) will talk to the patient and that's where it stops at. I know it does in my case (08)*

*They are so sweet and answer any questions we have. That's real good, you don't feel like they are keeping things from you, you know (07).*

Eighty-seven and one-half percent of the participants also languaged that they received or desired to receive information related to orientation to environment. One example was as follows:

*I'll have to find out where it (the coffee) is. But I know it's (the coffee) there, back there somewhere. (04)*

Seventy-five percent of the participants languaged their knowledge of or desire to know the current condition or change in condition of the patient and to be updated about changes in the patient's status, test, or treatments. Two examples were as follows:

*cause if you setting there wondering, and don't hear, you don't know what's going on, do you (09)*

*He [doctor] has to cut it [medicine] out completely, but it takes another 48 hours to get it out of your system. Then they'd start and try to get something else that would work (08).*

Support

The category of support emerged from 258 extracted statements, 41 formulations, and 6 theme clusters as shown in Tables 4, 6, and 7. The definition of the category of support emerged from the following theme clusters: (a) to have family available and provide support, (b) to have someone with you, (c) to have support from friends, neighbors, staff, visitors, and God, (d) for emotional supportive action from self, family, other visitors, neighbors, and staff, (e) for physical supportive action from self, family, pastor, friends, and company, and (f) for spiritual supportive action from self, family, and friends. Several sources of support and supportive actions were identified and included those from family, friends, neighbors, staff, other visitors, and God. A decision was made to only show examples of the protocols from three of the theme clusters for which a total of 100% to 87.5% of the participants languaged the need.

All of the participants languaged the desire to receive or having had received emotional supportive action from self, family, other visitors, neighbors, or staff. Two examples were as follows:

Table 7 Category, theme clusters, and formulations for support

| Category | Theme Clusters | Formulations |
|---|---|---|
| support | to have family available and provide support | to have children with you |
| | | to have family with you |
| | | to have support from family |
| | to have someone with you | to have someone with you |
| | to have support from friends, neighbors, staff, visitors, and God | to have support from friends and others |
| | | to have minister with you |
| | | to have others offer you support |
| | | to have support from other visitors |
| | | to have support from staff |
| | | to have faith in the Lord |
| | | to know "everybody doesn't get better" but to feel God is with you |
| | for emotional supportive action from self, family, other visitors, neighbors, and staff | to have a real positive attitude |
| | | to have responses from family member which you feel are supportive |
| | | to have other visitors ask about you and patient |
| | | to have neighbor ask about patient's condition |
| | | to have someone to talk to if I have a complaint |
| | | to be reassured it's alright to leave the hospital room |
| | | for staff to be understanding and considerate to you |
| | | to be treated well by staff |
| | | for staff to verbalize family's contribution of supporting patient |

Table 7 (continued)

| Category | Theme Clusters | Formulations |
|---|---|---|
| | | for staff to encourage you to touch patient |
| | | to be reassured by staff |
| | | to feel free or be encouraged to ask questions |
| | | to have staff joke with you |
| | for physical supportive action from self, family, pastor, friends, and company | to call family to be with you |
| | | to have family help you |
| | | to have financial help from family and pastor |
| | | to have friends or family help you keep dependent |
| | | to have brother with you when you visit patient |
| | | for family members to visit patient |
| | | to have other family members help with care of patient |
| | | to have others offer to help you |
| | | to have help from others when you go home |
| | | to have support from the company you work for |
| | | for staff to facilitate your being with patient |
| | | to be able to ask for something you need |
| | | to have staff try to contact family to be with you |
| | | to have help from the staff |
| | | to have nurses help you when you are visiting patient |
| | for spiritual supportive action from self, family, and friends | to pray |
| | | to have family and friends pray for you |

*I mean they [staff] were just excellent, I couldn't praise them enough, what they done for me. Help, and talk to me, support me, and they're all just wonderful. I mean if they treat everybody like they have me, uh, they have a lot going for them. (05)*

*I find that they're [staff] so considerate, they're understanding. Back there, knowing, I'm sure these girls know, a little of what you're goin, they've been taught, in school in the emotional side of this. And, uh, they joke, they make light of things, and tease with you. ...But as far as making you feel comfortable, trying to help you feel a little more at ease, they're great. They really are. (06)*

All of the participants also languaged the desire to receive or having had received physical supportive action from self, family, other visitors, neighbors, or staff. Two examples were as follows:

*I, one thing I have appreciated, when there's times that the nurses feel, you know, because he is not perhaps that critical as some. He's lying there worrying. Uh, feeling alone I'm sure, they'll come and get you. You know, 'come back spend a little time with your husband.' This is deeply appreciated, you know. This helps me and it helps him. And uh, this is one thing I've been very pleased with at this hospital. (06)*

*We even had a policeman friend coming by yesterday offering to mow the yard. [laughs] ...I told him, 'oh, my grandson mows the yard, he'll take care of that.' But I appreciate that. You just don't realize how many friends you have until you have something like this happen. And they just all come out of the woodwork, (10)*

The majority (85%) of the participants languaged the desire to have or as having their family available and providing support. One example was as follows:

> *And her family and my family have really been supportive. And if it hadn't been for all that [her and my supportive family] I don't know if I'd made it or not (05)*

The participants languaged that their family and the staff provided the majority of their support, 70% (180) of the 258 extracted statements. The source of support in 41% (106) of the 258 extracted statements was a family member and in 29% (74) was a staff member.

Proximity

The category of proximity emerged from 109 extracted statements, 12 formulations, and 4 theme clusters as shown in Tables 4, 6, and 8. The definition of the category of proximity emerged from the following theme clusters: (a) to be with the patient at the bedside, (b) to share in the experience with the patient, (c) to be in contact with the patient, and (d) to be with dependent. One example of each of these theme clusters was as follows:

Table 8 Category, theme clusters, and formulations for proximity

| Category | Theme Clusters | Formulations |
|---|---|---|
| proximity | to be with patient at bedside | to visit patient |
| | | to see patient before he goes to surgery |
| | | for special visiting times |
| | to share the experience with patient | to be able to touch patient |
| | | to talk to patient |
| | | to describe what being with the patient means to you |
| | to be in contact with patient | to have a family member at hospital |
| | | to be near patient |
| | | to be able to call hospital from home and talk to nurse |
| | | to stay at hospital at night |
| | | for staff to be able to find you if patient's condition changes |
| | to be with dependent | to be with dependent (children) |

*At least let the wife or husband be in and uh, as long as you don't upset the patient, I think. I think it hurts too much (07)*

*As long as you're there where you can touch her and she's smiling well you're happy (03)*

*your heart aches because you want to be home, but you can't stand to go that far, thinking something might happen any minute to them, and you're not here (06)*

*that's the reason I wasn't here. That's the reason I went home I had to see about [daughter]. I hate to leave her. (09)*

The participants languaged they had been or desired to be with the patient at the bedside and to be in contact with the patient in 77% (84) of the 109 extracted statements. Forty-three percent (47) of the 109 extracted statements were related to being with the patient at the bedside and 34% (37) to being in contact with the patient.

## Assurance

The category of assurance emerged from 116 extracted statements, 28 formulations, and 5 theme clusters as shown in Tables 4, 6, and 9. The definition of the category of assurance emerged from the following

Table 9 Category, theme clusters, and formulations for assurance

| Category | Theme Clusters | Formulations |
|---|---|---|
| assurance | to have trust and confidence in care giver | to have confidence in the doctor |
| | | to be happy with doctor |
| | | to trust the doctor |
| | | to not have bad experience |
| | | to trust and have confidence in staff |
| | | to never find a bad nurse |
| | | to be able to decide that a nurse will no longer care for patient |
| | | to feel good about the nursing care patient is receiving |
| | | to have best care possible |
| | | to feel the doctor will see you if something happens you think is important |
| | | to feel the doctor will see you if something happens he thinks is important |
| | to feel care giver has technical competence | to be reassured by others you know about the abilities of a doctor you don't know |
| | | to have nurses and doctors help patient |
| | | to feel staff know what their doing |
| | | to know staff responds alarms of machine going off in room |
| | | to know staff responds to changes in patient's condition |
| | | to have continuity of nursing care |
| | | to receive similar information from nurse and patient |

Table 9 (continued)

| Category | Theme Clusters | Formulations |
|---|---|---|
| | | to have doctor follow-up on patient's concerns |
| | | for staff to listen to patient and respect patient's knowledge |
| | | to have staff give information to patient |
| | | for staff to joke with patient |
| | | for nurses to be attentive to patient |
| | | for nurses to reassure patient |
| | | to feel the nurses love the patient |
| | | for the nurses to treat the patient like they've known her for years |
| | | to feel nurses care for patient like a member of their own family |
| | | to feel nurses treat patient like a member of their own family |
| | | for nurses to talk to patient and to treat patient with respect |
| | to feel good about the response of patient to others and environment | for the patient to feel the staff are nice |
| | | for patient to be happy or in good spirits |
| | | to know patient will call nurse if he needs something |
| | | for patient to be interested in outside events |
| | | for patient to recognize you |
| | | to be told by patient to go home |
| | to have confidence in dependent's care giver | to know dependent is receiving good care |

theme clusters: (a) to have trust and confidence in care giver, (b) to feel care giver has technical competence, (c) to feel care giver is responsive to patient, and (d) to feel good about the response of patient to others and environment. Seventy-five percent of the participants languaged their desire to have trust and confidence in the patient's care givers and to feel good about the response of the patient to others and the environment. One example of each of these theme clusters was as follows:

> *The best [care] that he can have, of course, which I feel he's getting. Uh, I don't have that much knowledge about what they're doing back there, even. Uh, I just feel like uh, you just have to put trust in them. You feel like if they're back there, they've surely got the knowledge they need to give that care or they wouldn't be back there, you. You just have to trust in them, you know" (06)*

> *Because knowing my husband he would not hesitate to call 'em if he needed something. And uh, as long as he's able to [do] that I know that if something's bothering him he'll let them know so they can take care of him. And uh, I know they're right there to do that. So, I've got all the confidence in the world in them. (10)*

The largest number of extracted statements in the category of assurance were found in the theme cluster to feel the care giver is responsive to the patient, 42%

(49) of the extracted statements. This theme cluster and the theme cluster to have trust and confidence in the care giver comprised of 74% (86) of the 116 theme clusters.

Comfort

The category of comfort emerged from 86 extracted statements, 31 formulations, and 5 theme clusters as shown in Tables 4, 6, and 10. The definition of the category of comfort emerged from the following theme clusters: (a) to be physically active, (b) to have conveniences, accommodations, and comfortable environment, (c) to have mental relief, (d) to have measures of relief, and (e) to have relief from indebtedness. A decision was made to only show the following examples of protocols from the theme clusters to have measures of relief, to be physically active, and to have mental relief, which had a total of 75% to 50% of the participants languaging the need:

> *I haven't been in bed, I don't think about 3 or 4 days. I just set in those chairs up there and doze off. And I'm getting too old to set around in chairs and sleeping (08)*

Table 10 Category, theme clusters, formulations for comfort

| Category | Theme Clusters | Formulations |
|---|---|---|
| comfort | to be physically active | to walk |
| | | to read |
| | | to do something |
| | | to smoke |
| | | to leave visitors' lounge |
| | to have conveniences, accommodations, and comfortable environment | to sit at hospital |
| | | to have place to park |
| | | to have low-cost parking |
| | | to have smoking area near patient |
| | | to have nice waiting rooms |
| | | to have a room to smoke in |
| | | to not have to sit in hot, cold, or sun |
| | | to go in a room and not smell smoke |
| | | to sit down and enjoy eating |
| | | to smoke cigarette after eating |
| | | to have conveniences |
| | | to have a place to sleep near hospital |
| | to have mental relief | to get mind off it |
| | to have measures of relief | to continue normal daily routine |
| | | to shave and change clothes |
| | | to sleep in bed |
| | | to take a bath |

Table 10 (continued)

| Category | Theme Clusters | Formulations |
|---|---|---|
| | | to leave the hospital |
| | | to sleep |
| | | to be alone |
| | to have relief from indebtedness | to return to work |
| | | to have adequate insurance |
| | | to understand how much of the cost is covered by insurance |
| | | to feel you can get by financially |
| | | to keep debts paid |
| | | to have money coming in |

*And reading a little bit, reading helps. And I, walking. Doing something, you, I need to do something, that's, I guess it's built-in personality or whatever you call it. I need to be doing something cause, I guess because of my nervous system. I need to move around (03)*

*And uh, all the things like that [lunch and walking with daughter-in-law], maybe get my mind off of him and on to other stuff. And uh, that really helps to get your mind off of it for a while (07)*

## Helpful

The category of helpful emerged from 39 extracted statements, 15 formulations, and 5 theme clusters as shown in Tables 4, 6, and 11. The definition of the

Table 11 Category, theme clusters, formulations for helpful

| Category | Theme Clusters | Formulations |
|---|---|---|
| helpful | to choose patterns of relating with the patient which enable the patient | to allow patient to rest |
| | | to be able to communicate with patient |
| | | to not upset patient |
| | | to reassure patient that other family members are being taken care of |
| | | to be with patient when patient is lonely or worrying |
| | | to understand patient's concerns |
| | | to do what patient wants you to do |
| | to provide material items for patient | to order food patient wants |
| | | to bring patient's personal items |
| | to interact with others on behalf of patient | to admit patient |
| | | to get out of staff's way (leave room) when patient's condition changes |
| | | to get staff to assist patient if patient needs something while you're at the bedside |
| | to be helpful to staff | to abide by visiting rules |
| | to be helpful to dependent | to provide physical care to dependent |
| | | to provide emotional care to dependent |
| | | to manage exchange of information about patient's condition to dependent |

category of comfort emerged from the following theme clusters: (a) to choose patterns of relating with the patient which enable the patient, (b) to provide material items to patient, (c) to interact with others on behalf of patient, (d) to be helpful to staff, and (e) to be helpful to dependent. The participants languaged the desire to be helpful to the patient, the staff, and their dependents. An example of each follows:

> *Cause I don't think there would be anything worse than for a patient to be lying there with all those tubes and a family member coming in and you see the shock on their face. And they think 'my goodness do I look that bad.' (10)*

> *And I abide by those (visiting) rules and go in when I'm suppose to. Leave when I'm suppose to, I try to do that (06)*

> *Well you see I got a daughter at, I have to keep all the time, you know, she's, I don't know what you'd call it, handicapped, and I have to tend to her. She's just like a baby, only she's 34 years old. And she, she can't do nothing, you know, she can't hear, and she can't holler for you or nothing that. So I have to, that keeps my mind on that, you know, a lot. For she has to be took care of, even, I don't care what happens. She can't do it herself. (09)*

Slightly over half (51%) or 20 of the 39 extracted statements reflected the need to choose patterns of relating with the patient which enable the patient.

Express feeling

The category of express feelings emerged from 154 extracted statements, 22 formulations, and 2 theme clusters as shown in Tables 4, 6, and 12. A wide variety of both positive and negative feelings, the theme clusters for this category, were languaged by all the participants. The following four examples demonstrate how the participants languaged both negative and positive feelings:

> *You worry about her and you worry about hospital payments. You worry about the cost. Just worry about the whole little bit. It's a continual worry and uh. You have uh, like myself I'll be very emotional and uh. That works on you. And the longer it last the waiting is uh, in my opinion one of the worse things about it. Waiting, waiting, waiting. And uh, the longer it last uh, the more it gets to you. You finally, get to a point where you, hard to keep from crying, or whatever you might do. (03)*

> *It [visiting you wife] makes you happy. You're glad you can visit her. (03)*

> *You always have that fear, that something can go wrong. (10)*

Table 12 Category, theme clusters, and formulations for express feelings

| Category | Theme Clusters | Formulations |
|---|---|---|
| express feelings | to express negative feelings | expressing feelings about patient |
| | | expressing feelings about finances |
| | | express feelings about situation |
| | | express feelings about expressing feelings |
| | | express feelings about waiting |
| | | express feelings about information |
| | | express feelings about care of patient |
| | | express feelings about conveniences |
| | | express feelings about relationship with staff |
| | | express feelings about dependent |
| | to express positive feelings | expressing feelings about patient |
| | | express feelings about finances |
| | | express feelings about situation |
| | | express feelings about expressing feelings |
| | | express feelings about waiting |
| | | express feelings about visiting |
| | | express feelings about staff coming to get you to visit |
| | | express feelings about information |
| | | express feelings about care of patient |
| | | express feelings about conveniences |
| | | express feelings about relationship with staff |
| | | express feelings about hospital |

*when we first went in I don't know the nurses name in there, but soon as I walked in she said, 'Oh, he's just doing great.' And boy, that just gave me a big lift. I hadn't even seen him. And she (the nurse) just couldn't say enough about how good he was doing. And that really made me feel good. (10)*

Express thoughts

The category express thoughts emerged from 146 extracted statements, 27 formulations, and 8 theme clusters as shown in Tables 4, 6, and 13. All of the participants languaged evaluative comments or opinions about their feelings, the staff, the nursing care, information, visiting, the patient, support, or indebtedness. Fifty eight (39.7%) of the 146 extracted statements emerged into one formulation, to talk about your positive perceptions of staff, which emerged into the theme cluster to express thoughts about the staff.

Reflect

The category to reflect emerged from 148 extracted statements, 17 formulations, and 3 theme clusters as shown in Tables 4, 6, and 14. All of the participants reflected on the previous condition of the patient. Due to length of the extracted statements in reflect, only one example follows:

Table 13 Category, theme clusters, and formulations for express thoughts

| Category | Theme Clusters | Formulations |
|---|---|---|
| express thoughts | to express thoughts about feelings | to talk about how people feel and lanuage feelings in the situation |
| | | to talk about how you feel about the situation |
| | | to talk about why you are worried or nervous |
| | to express thoughts about staff | to talk about your positive perceptions of staff |
| | | to talk about not seeing the doctor |
| | to express thoughts about nursing care and staffing | to talk about nursing care |
| | | to talk about having enough nurses |
| | to express thoughts about information | to talk about how staff has provided you with information |
| | | to talk about the information you have received |
| | to express thoughts about visiting | to talk about not being able to visit patient |
| | | to talk about visiting the patient |
| | to express thoughts about patient | to talk about patient's feelings and way of being |
| | | to talk about patient being admitted the same day as surgery |
| | | to talk about patient going home |
| | | to talk about who you think helped the patient |
| | | to talk about what's not helpful to patient |
| | | to talk about imaging the future related to patient |
| | to express thoughts about support | to talk about family and support from family |
| | | to talk about what kind of help others can give |
| | | to talk about what helps |

Table 13 (continued)

| Category | Theme Clusters | Formulations |
|---|---|---|
| | to express thoughts about indebtedness, relief measures, conveniences, and environment | to talk about indebtedness |
| | | to talk about relief measures |
| | | to talk about financial situation |
| | | to talk about smoking and having a room to smoke |
| | | to talk about food |
| | | to talk about visitor's lounge |
| | | to talk about hospital |

Table 14 Category, theme clusters, and formulations for reflect

| Category | Theme Clusters | Formulations |
|---|---|---|
| to reflect | reflecting on your own experiences | to talk about experience you had when visiting patient |
| | | to talk about coming home and staying home after you were notified that patient had had a heart attack |
| | | to talk about seeing a family that works at hospital prior to patient's admission to CCU |
| | | to talk about a complaint you had prior to patient being admitted to CCU |
| | | to talk about another time you were staying in the visitors' lounge |
| | reflecting on previous condition of patient | to talk about what the patient has been going through before admission to CCU |
| | | to talk about previous hospitalizations of the patient |
| | | to talk about the past when patient worked at hospital |
| | reflecting on previous situations | to talk about experiences related to transferring patient to another unit |
| | | to talk about being asked to stay in room with patient due to a shortage of nurses |
| | | to talk about how you and your sister have similar feeling about a situation |
| | | to talk about telling nurses to put posey on patient |
| | | to talk about getting through last hospitalization of patient and having to come back |
| | reflecting on relationship with staff, family, and patient | to talk about interactions with doctor prior to admission to CCU |
| | | to talk about relationship with wife |
| | | to talk about family members and their relationship with patient |
| | | to talk about dependent |

*he's been in and out, in and out. Since the thirteenth of June. He came in for a scan on his and they found a tumor on his lung. So they didn't do anything with his back, they're just taking care of the tumor that's in his lung. So they've tried to go every except for surgery to find out if it's malignant or not. So they couldn't get to it, it was in a rare place. So they had to do surgery and take out the whole thing at the top of his lung. He had a spot in his lung. So we'll know something Friday or Monday. (04)*

## Summary of findings

The results of this study indicate that the family members of patients admitted to a coronary care unit had needs for information, support, proximity, assurance, comfort, to be helpful, to express feelings, to express thoughts, and to reflect. These categories emerged from the protocols, to the extracted statements, to the formulations, to the theme clusters. A label for each category was chosen after careful analysis of the theme clusters and extracted statements. This investigator's attempt to demonstrate the diversity of responses influenced selection of the cited examples.

# CHAPTER V

# DISCUSSION

## Categories of Needs

The findings in this study supported the findings of previous studies and provided new information about the needs of family members of patients admitted to a coronary care unit. All five of the categories of needs measured by the CCFNI as identified by Leske (1988, 1991) were found to be present in this study. These five categories included: information, support, proximity, assurance, and comfort. Four new categories emerged from the data: helpful, express feelings, express thoughts, and reflect. A brief discussion of the findings related to the nine categories of needs follows.

### Category: Information

The first five theme clusters of the category of information (see Table 5) were similar to the definition found in the earlier studies (Leske, 1988, 1991). In addition, all of the previously cited studies also

identified that the need for information was important to family members (Daley, 1984; Jacono et al., 1990; Leske, 1986; Mathis, 1984; Molter, 1979a; Norheim, 1989; Norris & Grove, 1986; Spatt, 1986).

The need to be able to understand information (a theme cluster) was identified among the top 10 needs in the previously cited eight studies. Daley (1984) and Jacono et al. (1990) considered the need to have information explained in understandable terms as a part of information. On the other hand, Leske (1988, 1991) considered this theme cluster as a part of assurance. The context of this need, analyzed in this study, reflected the need to increase the participant's understanding or knowledge about what was happening to the patient rather than to increase their confidence or trust in the care the patient was receiving (assurance).

Another theme cluster, the need to receive information related to orientation to the environment, was found in this study and by Spatt (1986). Spatt found that the need to know about facilities where visitors can be alone, about sources of support available through various hospital services, about directions to and hours of opening for the cafeteria and coffee shop, and about the reasons why family members

must wait before seeing the patient were all important to participants in her study and were among the most frequently cited unmet needs or additional comments needing improvement. The need to receive information in this study also included the need to receive information related to orientation to the environment. After careful scrutiny of the data, this investigator believed this need emerged as a part of information and increased the participant's understanding or knowledge but did not directly provide aid, assistance, or understanding from others, as a support need would require as labeled by Leske (1988, 1991).

A new aspect of information absent in previous studies related to the need to receive information from the patient. Having knowledge of the patient's concerns, the patient's perceptions about the care being delivered, the patient's likes, and the patient's understanding of what's happening were languaged as important factors to the participants with regard to making decisions and guiding their actions and thoughts. One participant explained that most of the information she received was from the patient. The CCFNI did not measure this need. Molter (1979a) mentioned that subjects identified the patient as one of the "other"

sources of meeting family members' needs, however the specific needs of the family members that were met by the patient were not revealed.

Category: Support

The category of support had the highest number of extracted statements (see Table 4). All of the theme clusters (see Table 7) were similar to the definition of support in the literature (Leske, 1988, 1991). The pattern of relating to others by connecting with them was seen as enabling by all the participants. As previously stated in the results section, other family members were identified as being the primary source of support for family members, followed by the staff. This finding is supported by other studies (Daley, 1984; Dracup & Breu, 1978; Hampe, 1975; Jacono et al., 1990; Molter, 1979a; Norheim, 1989; & Spatt, 1986).

Hampe (1975) and Molter (1979a) stated that the participants in their studies did not expect the health care professionals to show concern for visitors but, expected them to be primarily concerned about the patient. They felt that professionals should be friendly and courteous toward them. Their data, however, supported an opposite view, 96% of the

participants in Hampe's (1975) study identified the need for support from the staff and 65% (26) of the participants in Molter's (1979a) ranked the need to have an explanation of the environment before visiting as important or very important. These contradictory findings were further confused by the fact that over 15% of the participants in Hampe's (1973, 1975) study and 50% in Molter's (1979a) study perceived this need as being met.

The participants in this study languaged the need to have support from the staff. Examples of the formulations were as follows: to have support from staff, to be treated well by the staff, for the staff to be understanding and considerate to them, to verbalize the family's contribution of supporting the patient, to encourage you to touch the patient, to be reassured by the staff, to feel free or be encouraged to ask questions, to facilitate your being with the patient, to be able to ask the staff for something you need, to have staff try to contact family to be with you, to have help from the staff, and to have nurses help you when you are visiting the patient.

This study also found that the need for spiritual support was languaged by 62% of the participants. The

formulations were as follows: to have minister with you, to have faith in the Lord, to know "everybody doesn't get better" but to feel God is with you, to pray, and to have family and friends pray for you. Hampe (1973) identified that 78% of the participants in her study expressed the need for religious support. Molter (1979a) found that God was identified as a source in meeting the spiritual needs of the family members in her study. This study supported the need for spiritual support.

Category: Proximity

The parameters of proximity, demonstrated by the theme clusters (see Table 8), were similar to the aspects of proximity presented in the previous literature (Leske, 1988, 1991). The need to be with the patient at the bedside was languaged by all the participants in this study and was thought to be similar to the need to frequently see the patient identified in the previously cited studies (Daley, 1984; Jacono et al., 1990; Leske, 1986; Mathis, 1984; Molter, 1979a; Norheim, 1989; Norris & Grove, 1986; Spatt, 1986).

A new aspect of proximity, to share the experience with the patient, was found in this study. A review of

the CCFNI questionnaire revealed that this aspect of proximity is not evaluated by the instrument. Parse (1987) described the need for the nurse-patient relationship to be a "subject-to-subject interrelationship", which is a loving relationship between two individuals who are "truly" present with each other (p. 169). Paterson (1971) also described this quality of being with others that reflects the need languaged by the family members in this study in relation to sharing the experiences with their family members.

Another aspect of proximity found in this study but not measured by the CCFNI was related to being with dependent(s). The participants explained that their need to be near the patient conflicted with their need to be near their dependents. Similar findings were found by Titler, Cohen, and Craft (1991). In this study participants felt they had to make difficult choices, which were limiting no matter what their choice was. One participant who decided to stay near the patient explained she worried, was frightened, especially at night, was upset, and had an awful uneasiness while being away from her dependent. The other participant who decided to be with her dependent explained that she

had to wait for transportation to the hospital; for someone to come to care for her dependent; did not get to see the doctor before her husband went to surgery; was worried that she would not get to see her husband before he went to surgery; and was scared her husband might have a stroke during surgery but hoped he would not.

Category: Assurance

Two of the theme clusters included in the parameters of assurance for this study (see Table 9) contained formulations that were similar to two of the assurance needs in the Leske (1988, 1991) studies. Daley (1984), Jacono et al. (1990), Mathis (1984), Molter (1979a), Norheim (1989), Norris and Grove (1986), and Spatt (1986) identified that these two needs, assurance that the patient was receiving the best care possible and that hospital personnel cared about the patient, were important to the participants in their studies.

The need to feel good about the response of the patient to others and environment (a theme cluster) was not addressed in the CCFNI. Hampe (1975) and Dracup and Breu (1978) discussed the need for assurance of the

comfort of the dying patient. This seemed to correlate with the previously stated theme cluster.

A new theme cluster, to have confidence in dependent's care giver, also emerged as part of the definition of assurance. Two of the three participants with dependents in this study languaged this need. These participants explained that they were not only concerned about the quality of care their spouse was receiving but they were also concerned about the quality of care their dependents were receiving. The third participant stated that his child (16 years old) stayed "glued" to him most of the time, an indication that he was the care giver of his dependent. Even though Titler et al. (1991) reported that children were taken care of by others, the parent's need to have confidence in the dependent's care giver was not discussed as a finding.

Category: Comfort

The first four theme clusters included in the category of comfort in this study (see Table 10) support the findings in the literature (Leske, 1988, 1991). Molter (1979a) and Daley (1984) explained that the need for personal comfort was the least important to the family members in their study, although 80% (32) of the

40 participants in Molter's study ranked the need to have comfortable furniture, 67.5% (27) ranked the need to have a telephone in the waiting room, and 70% (28) ranked the need to have good food as important or very important. The need to have a telephone and a place to rest was also found to be important by Daley (1984). The comfort needs above were not found to be important in the study conducted by Leske (1986). Norheim (1989) found that the need to have a bathroom near waiting room and to have good food available was significantly ($p<.001$ & $p<.001$) more important to spouses than to other relatives. The difference in the importance of the need for comfort in Leske's (1986) study and this study may be related to the difference in the relationships of family members, only 12.7% of the family members in Leske's study were spouses compared to 100% of the participants in this study.

The fifth theme cluster, the need to have relief from indebtedness, was related to one of the support needs in the CCFNI (Leske 1988, 1991), the need to have someone help with financial problems, and in this study, the need to have financial help from their family and pastor. The need to have relief from indebtedness was different from these support needs in that relief was

languaged as being enabled through interaction with conveniences, accommodations, and environment by the following: to return to work (for money), to have adequate insurance coverage, to feel you can "get by" financially, to keep debts paid, and to have money coming in. The need for relief from indebtedness was languaged by all of the male participants and none of the female participants.

Only 8 (25%) of the 31 formulations concerning indebtedness emerging from the extracted statements were languaged by women. However, one of the female participants in the pilot study languaged the need to have relief from indebtedness. For this reason the assumption that only the men had this need can not be made. It is further noted that three of the four participants languaging this need managed the family's finances. The fourth participant explained that he handled his own finances. There is no evidence of similarity in demographic data or other characteristics among these four participants. Thus insufficient information exists to make broad generalizations about the participants. The remaining participants did not language their role in managing the family finances.

Category: Helpful

The category of helpful was not identified as a separate category in the CCFNI (Leske, 1988, 1991), but was identified by Hampe (1973, 1975) and Dracup and Breu (1978). The extracted statements and formulations evidenced in this study the need to be helpful was related to providing the patient with emotional support, bringing the patient material items, or interacting with the patient in a manner that enabled the patient's recovery (see Table 11).

The results of studies by Daley (1984), Jacono et al. (1990), and Norris and Grove (1986) found that the need to provide physical care was important to the participants. Norheim (1989) found that the need to help with the physical care of the patient was more important to spouses than to other relatives. Molter (1979a) indicated a difference in the need to provide physical care in family members of patients in socioeconomic class III & IV, with less of a need found in class V and even less in class I & II. Since all the participants in this study were spouses and the majority were in socioeconomic class III & IV, the absence of languaging the need to provide physical care to the patient may be related to the participants being

intimidated by the equipment and fear of hurting the patient as explained by Hampe (1973, 1975) and Dracup and Breu (1978). Although the need to provide physical care was not languaged during the interview, the investigator did observe one male participant feeding his wife, which was considered a helpful behavior.

Two additional theme clusters of helpful were found to be present in this study but not in the literature: (a) to be helpful to the staff by abiding by visiting rules and (b) to be helpful to dependents by providing them with physical and emotional care, and managing the exchange of information to them about the patient's condition. The need for the family member to be helpful to the patient, to the nurses, and to dependents was another area that resulted in the family members making difficult choices. For example, one participant explained she wanted to be helpful to the patient by being at the bedside as often as she could and especially when the patient was feeling lonely or worrying. At the same time, this participant wanted to be helpful to the nursing staff and comply with the visiting rules. Another participant with dependents explained that she had tried to help her daughter by keeping information from her daughter about the

impending hospital admission. The participant explained that her daughter sensed something was wrong and began crying. The participant said, "You know, you go through all that. All that is a part of this. That you have to deal with." Titler et al. (1991) also found that parents attempted to help their children by shielding them from certain information and experiences that the parent felt the child could not comprehend and by not allowing the children to visit the hospitalized parent. Titler et al. (1991) explained that the parents expressed they were unsure about how to talk to their children. However, interviews with the children revealed that they did understand what was happening to the hospitalized parent.

Category: Express feelings

The category to express feelings included the expression of a variety of both positive and negative feelings by all participants (see Table 12). Others (Dracup & Breu, 1978; Hampe, 1975; Jacono et al., 1990; Spatt, 1986) have also found that family members need to express their feelings. The CCFNI measures the expression of feelings but categorizes these expressions under support as to talk about negative feelings such as

guilt and anger and to be encouraged to cry. The need to express feelings was not ranked as important by the family members in other studies (Daley, 1984; Leske, 1986; Norris & Grove, 1986). These contradictory findings may be related to small sample size. Another reason for these differences was the variety of feelings that were found to be experienced and languaged by the family members in this study that are not reflected on the CCFNI.

Category: Express thoughts

As mentioned in the results section, the category to express thoughts included evaluative comments or opinions verbalized by the participants. The theme clusters that emerged from the analysis of the evaluative comments in the extracted statements were related to the seven categories of needs previously presented (see Table 13). Hampe's (1975) and Dracup and Breu's (1978) studies were based on the participant's evaluative comments about whether or not their needs were met. Molter (1979a) also asked the participants for an evaluative response in relation to who met their needs. In contrast, the evaluative comments in this

study emerged as a part of the description of participant's experience.

Parse (1989) stated that when a nurse engages in dialogue with a family member with the goal to understand the family member's meaning, the family member's meaning is revealed as thoughts and feelings are shared by the family member through languaging and illuminating meaning. Two examples of responses to the first interview question, "tell me what it's been like for you since your husband/wife was admitted to CCU," demonstrate the expression of the participants' thoughts and feelings as follows:

> *Well uh, I don't have any complaints, at all because they have been so nice to let us go back there. And since he was doing so well since the very start. I think they were pretty lenient with us. Course I don't know they may do with everybody. I don't know. [laughs] And if he had been worse off, I'm sure they would have stuck more to it, you know. (10)*

> *[Pause] Not really know how to express it, uh. You worry about her and you worry about hospital payments. You worry about the cost. Just worry about the whole little bit. It's a continual worry and uh. You have uh, like myself I'll be very emotional and uh. That works on you. And the longer it last the waiting is uh, in my opinion one of the worse things about it. Waiting, waiting, waiting. And uh, the longer it last uh, the more it gets to you. You finally, get to a point where you, hard to keep from crying, or whatever you might do. When you get in a situation like that. I don't know.*

*Some people it effect different, but these are the people [with] different personalities. Where I might set down and bawl, somebody else might get mad and put their fist through the wall. (03)*

A review of these two different types of responses revealed that the experience of having a family member in a CCU is languaged differently for each of the participants. The meaning of the experience for each participant begins to unfold as the participants shares their thoughts and feelings.

Category: Reflect

The participants languaged the need to reflect on their own experiences, previous condition of the patient, previous situations, and their relationship with staff, family, and patient (see Table 14). This finding was not reported in any of the literature reviewed, which may be related to the different conceptual frameworks used in the other studies. The extracted statements in the category to reflect were thought to be the revealing of the past meaning that was emerging and was part of the process of languaging valued images and structuring new meaning. Parse (1981) explained that meaning emerges from an individual's past history and intentions. As meaning emerges, new meaning

is structured that creates the situation and the context of the situation. The category to reflect emerged from 148 extracted statements, 17 formulations, and 3 theme clusters (see Table 4).

## Limitations

Parse (1981) clearly stated that languaging is more than verbal or written expression. Languaging includes patterns of relating, gestures, intonation, and silence; all that is revealed and concealed between two or more people (p. 47). Valuing, imaging, cocreating of reality, and structuring of meaning continuously change. For this reason, she strongly recommended the use of a qualitative methodology to investigate lived experiences when using the man-living-health theoretical framework (Parse, 1987) to study the nature or structure of common lived experiences, such as hope, courage, or caring. This study was designed to reveal the reality of family members in a limited setting.

Limitations include potential interviewer and response biases due to the possible influences of the investigator using an investigator-developed instrument, personally conducting the interviews, recording the

responses to the interview questions, and analyzing the data. Attempts were made to correct for these, as previously discussed.

## Implications for Practice

The findings from this study indicate that it is crucial for nurses to talk to, listen to, and to practice being "truly" present with family members. Nurses must understand the meaning of the situation to the individual family members and synchronize rhythms with the family members before they can facilitate the movement of family members toward their goals. This process occurs through one-to-one interaction between the nurse and the family member. As nurses actively listen in an open, non-judgmental manner, they attempt to understand what the family member is experiencing and what the family member desires to achieve. The nurse's responses vary from explaining rules and the reasons limiting certain activities to facilitating the desires of the family member.

Further, the findings in this study indicated that a nurse needs to provide family members with information about the patient's condition; about changes in the

patient's condition; about tests, procedures, and/or treatments; about what to expect; and about the environment. One method of providing this information was viewed by the participants as most helpful. This method was the one-to-one contact with the patient education nurse who answered questions and through the use of booklets, models, and a video, explained what was happening and what was anticipated to happen to the patient. Expansion of the use of this method for the exchange of information beyond family members of patients going for a heart catheterization and open heart surgery needs to be considered.

Another important finding related to information that has implications for practice is the accessibility of staff to family members. The findings indicated that the staff, both nurses and especially physicians, need to create opportunities to talk to family members each day, even if they have no new information to give to the family members. One suggestion is that the nurses remind the physicians that the family members are in the lounge and have requested to see them. Another suggestion is to allow the family members to stay at the bedside with the patient during times when the physician may visit. Finally, nurses could write the names,

specialties, and phone numbers of all physicians caring for the patient on a card and encourage the family members to call the physicians if they have questions.

A new finding in this study indicates that the patient as well as the nurse and physician are sources of information to the family members. To promote the exchange of information between the patient and family members, a nurse should allow the family members to spend time with the patient.

Nurses need to tell family members why they cannot visit or have to wait before being allowed to visit. When family members are at the bedside, they need to be familiarized with the equipment in the patient's room. They need to be reassured about the amount of interaction they and the patient can safely have.

In addition to information, the family members in this study languaged very clearly that they need support from their self, family, the staff, and God. The implications for practice include: encouraging family members to use positive self-talk and imaging, structuring of the visitors' lounge to accommodate other family members, providing an area that will accommodate children, and encouraging family members to activate their family support system by calling others who are

supportive to them. Some of the emotional and physical supportive actions of staff identified by the participants as helpful include: to have someone available who can listen to complaints; to verbalize the families contribution of supporting the patient; to treat family members well by being understanding, considerate, reassuring, and responsive to them; to encourage questions; to provide information about support services available within the hospital, including the chapel and pastoral services; to help family members with patient care when they are at the bedside; and to facilitate the family member being at the bedside.

Proximity also has implications for practice in that nurses need to facilitate family members being with the patient. This study found that being with the patient is more than a physical presence, it also allows the family member to share the experience with the patient. Being with the patient is a part of information, assurance, and helpful as well as proximity and has fourfold implications.

In addition to facilitating the family members to be at the bedside with the patient, designing a system of communication that promotes contact between the

family members, the patient's nurse and the patient is needed. Encouraging family members to leave the hospital is a part of comfort, and offering encouragement for the family members to call the nurse, while they are away, to check on the patient promotes proximity as well. Some hospitals issue beepers to family members in order to maintain the desired contact with the patient while promoting comfort for the family member and allowing the family member to be near family, friends, and dependents. The need to promote proximity becomes a complex and challenging issue for regional referral health care institutions and requires creative and innovative ideas from the staff and family members. The use of focus groups that include family members could promote comfort and expression of feelings and thoughts for the family members as well as provide the institution with valuable ideas from their customers, the family members.

The implications for practice identified in this study to promote assurance are as follows: develop a trusting relationship with family members, share positive comments about other health care providers, be attentive, responsive, and reassuring toward the patient, give the patient information, follow up on the

patient's concerns, and treat the patient with respect. As one participant said, "treat the patient like a member of your own family."

The implications for practice related to comfort in the institution serving as the site for this study include providing a system that allows the family members to walk, to eat, and to sleep at home in their bed while maintaining contact with the staff and patient. In addition to this implication, the family members expressed the desire to do something to "get their mind off of it." Nurse managers need to plan and implement activities for family members to participate in, if they desire, while they are waiting in the lounge. In addition to offering educational opportunities, such as relaxation techniques or current issues in insurance coverage, other activities may also be beneficial; for example, those provided by the auxiliary department within the hospital. A nurse manager's level of responsibility is necessary in order to solicit cooperation and resources from other departments, to budget and schedule staff nurse participation, and to coordinate all activities. Whatever activities are planned, a system must be in place so that the family can be contacted.

The need to be helpful has challenging implications for nursing practice. Nurses need to involve the family members in the care of the patient while maintaining safety and rest for the patient. Dracup and Breu (1978) explained that when they began to involve the family members in the care of the patient, it was a challenging and time consuming goal for the nursing staff. The need to have a nursing staff committed to the goal seems to be paramount in order to successfully achieve the goal. The findings indicate that family members desire to help the patient in ways other than providing physical care, such as being able to communicate with the patient, allowing the patient to rest, reassuring the patient, doing what the patient wants, and not upsetting the patient. Nurses can offer support to the family members as they learn to communicate with the patient, rearrange visiting hours if the patient is resting, call for the family when the patient wants to see them, and reassure family members that their interactions with the patient are beneficial.

Another finding related to helpful is the care of dependents. Nurses need to be prepared to guide family members with dependents as they share the experience of having another family member hospitalized. Nurses can

first ask if family members have dependents and then ask them to please tell what it has been like for the dependents since the hospitalization of the patient. Nurses can also help family members who desire to stay at home with their dependents by arranging special visiting times or by providing different opportunities for these family members to be in contact with the patient.

In addition to the above implications, the findings from this study indicate that nurses need to create the opportunity for family members to express their feelings, their thoughts, and to reflect. This means that nurses need to spend time with family members. During the process of the family member sharing feelings, thoughts, and reflecting, the nurse needs to listen and encourage expression. The family members' languaging of their feelings, thoughts, and reflections in itself cocreates reality for the family members and structures new meaning, without advice from the nurse. Although it is very beneficial to others, being present with others is a difficult skill to achieve and requires practice.

In summary, even though nine recurring patterns of needs were identified in this study, each individual

family member had his or her own set of desires that facilitated movements toward satisfaction of needs. The implications for practice presented above were derived from the patterns of needs languaged by the participants. In the daily practice of nursing, nurses must listen to the desires of individual family members and then interact in harmony with their desires.

## Implications for Research

The study explored the needs of family members of patients hospitalized in a CCU and has limited scope. It is recommended that the study be replicated at a different site and/or with a different population.

Additional research also needs to be conducted to evaluate the effectiveness of nursing interventions implemented to facilitate the family members' perception of satisfaction that their needs have been met.

In addition to the evaluative research study described above, other implications for qualitative research include examining specific interventions such as conveying information in understandable terms, relating to family members in manner that is supportive, promoting proximity and assurance, providing a

comfortable environment for family members, and facilitating the family member's involvement in the care of the patient and dependent.

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# APPENDIXES

# Appendix A

## Demographic data

Directions: Ask spouse for the following information.
Code number: _____
Date and time of interview: _____

Sex of participant: Male Female
Age of participant in years: _____
Age of spouse in years: _____

Marital status: (Married and living with spouse)
How long married or living with spouse _____

Educational level: (check one for self and spouse)

| | Self | Spouse |
|---|---|---|
| Less than 7th grade | ____ | ____ |
| Junior high school (9th grade) | ____ | ____ |
| Partial high school (10th or 11th grade) | ____ | ____ |
| High school graduate | ____ | ____ |
| Specialized training | ____ | ____ |
| Partial college (at least one year | ____ | ____ |
| Community college graduation | ____ | ____ |
| College or university graduation | ____ | ____ |
| Graduate professional training (graduate degree) | ____ | ____ |

Occupation:
Self _____
Spouse _____

Employment status:
Self: employed unemployed retired
Spouse: employed unemployed retired

Diagnosis or explanation of why spouse admitted to critical care:

_____
_____

Date and time of admission of spouse to critical care:

_____

Condition of patient: (May be described during interview)
What is the current condition of your husband/wife?

_____
indicated on condition sheet:
Good Fair Serious Critical

# Appendix B

## Instrument

Open-ended interview developed by investigator

Explanation of purpose of interview:

Through this interview I hope to find out the types of needs you've had during the past 24 hours, since your spouse was admitted to CCU.

Explanation of the interview process:

The investigator told the family member,

"I'm going to turn the tape recorders on now. Your code number is (state the code number)."

The investigator turned on the tape recorders and stated the code number.

The investigator then asked the family member the following questions, listened to the response of the family member and used probes, when needed, to encourage a response from the family member.

She then said,

"Are you ready to start?"

"In order to the make the questions shorter, I will first explain that the questions I ask are about the time, from when your husband/wife was admitted to CCU until now?"

**1. Tell me what it's been like for <u>you</u> since your husband/wife was admitted to CCU.**

Probes: Describe what it felt like.

Tell me about visiting your husband/wife.

Tell me about the information you've received about the condition of your husband/wife.

Tell me about your experiences with the nursing staff.

Tell me about your experiences with the doctor.

Tell me about your experiences with other staff.

Who or what has been helpful?

Tell me about other staff who have been helpful.

What have you done to help yourself feel better?

**2. Tell me about the nursing care your spouse has been getting during his/her stay in CCU.**

Probes: Tell me more.

Tell me about the kind of care you want your husband/wife to receive.

Tell me about what has been helpful to you or your husband/wife.

**3. Tell me about who has been with you during this time.**

Probes: Are there others who have been here?

Have they been helpful?

How have they been helpful?

Talk about the help or support you have received from family members.

**4. (If a participant's response to the questions above indicate the participant was upset, anxious, scared, or nervous). During this time, what would have helped to make you feel better?**

Probes: What advice do you have for the nursing staff that would help other husbands/wives feel better during this time?

What advice do you have for the doctors?

What advice do you have for other hospital personnel?

The investigator explained the following:

To help me describe the age, sex, education, and occupation of the family members that participated in this study please answer the following questions. (Ask information from demographic data sheet.)

The investigator then explained that this concluded the interview process and thanked the participants for their participation. She then placed the audio tape, consent form, and demographic sheet into the locked box.

# Appendix C

## Informed Consent

Code number _____

You are invited to be in a research study. This research is being undertaken to find out what needs the family members of critically ill patients say they have. You will be asked some questions about the needs you feel you have. You will also be asked to give some information about yourself and your family member to complete demographic information. You will be asked to give the diagnosis of your family member or to explain why your family member is in critical care. The interview will take about one hour and will be audio tape recorded.

The interview needs to be taped to make sure the investigator understands your exact response to the interview questions. The investigator and Lisa Long will listen to your tape and type your response into a computer. Then the investigator will read and study the typed copy of your interview. The investigator will identify and make a list of your needs from the typed copy of your interview.

The information you give is confidential. Your name will only be on this informed consent form. This informed consent form, the two audio tapes, computer diskettes, and the typed copy of your interview will be kept by the investigator in a locked box. Only the investigator will have access to the locked box. Only the investigator will see this informed consent form. The audio tapes will only be listened to by the investigator and Lisa Long with the use of head phones in a private room. The information on the typed interview will only be shared with Dee Sanders, members of the research committee, and individuals designated by the investigator to assist with data analysis. All of the information will be kept in a locked box at the investigator's home. The investigator will destroy the written information and erase the tapes and diskettes after three years or longer as deemed appropriate by the investigator. The results of this research study will be published and shared with the hospital.

Your decision to participate in this research study is voluntary and will not change the care you or your family member are receiving. The only risk to you is that you may become tired or feel uncomfortable when answering the questions or responding to the statements

about your family member during the interview. You are free to stop the interview at any time. The only direct benefit to you is the chance for you to share your thoughts about your needs with the researcher. If you would like to take part in this study please sign below. If at any time you change your mind, you can stop or withdraw from this research study.

If you have any questions about this study feel free to call: Theresa L. Renfro, Rt. 3 Box 38DD, Maynardville, TN, 615-992-8438.

This is your copy to keep.

| | |
|---|---|
| Signature of spouse | Date |
| Signature of investigator | Date |

# VITA

Theresa Louise Renfro, daughter of Herbert Carson and Mildred Louise Branum, was born in Knoxville, Tennessee, on January 22, 1954. She attended public schools in Knoxville, Tennessee, and graduated from South High School in 1972. In 1976, she earned a Bachelor of Science Degree in Nursing from the University of Tennessee, Knoxville.

As a registered nurse, she practiced as a critical care nurse employed by the University of Tennessee Hospital from 1976 to 1978. In 1978, she changed her employment to Fort Sanders Regional Medical Center where she became the clinical nursing coordinator responsible for a 32 bed critical care department in 1979. In 1989, she transferred to an "occasional primary nurse position" and applied for admission to the Master's nursing program at the University of Tennessee, where she continues as a student.

She is a member of the American Nurses Association and American Association of Critical Care Nurses. She has obtained certification through the American Heart Association in instructor basic life support (BLS) and advanced cardiac life support (ACLS), and through the

American Association of Critical Care Nurses in critical care nursing.

She is married to David Eugene Renfro. They have two children, Erin Louise, age 10, and Austin Lee, age 4. She is a member of Miller's Chapel Methodist Church and serves as Sunday school teacher for children ages 2 through 6. She is a volunteer in the library at the public school attended by her daughter.