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VISITATION NEEDS IN THE INTENSIVE CARE UNIT
AS PERCEIVED BY TRAUMA PATIENTS

A Thesis
Presented for the
Master of Science in Nursing
Degree
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Jackie M. Kirby

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ABSTRACT

The purpose of this study was to examine the perceived visitation needs of trauma patients in the intensive care unit. Eighteen male and two female subjects were interviewed within 48 hours of transfer from the intensive care unit to a general medical/surgical unit. Eight visitation needs were considered important or very important by at least 50 percent of the subjects. The fact that the needs were identified does not mean, however, that these needs had been met. Correlations between age and the perceived importance of four visitation needs were statistically significant ($p < .05$). The subjects' length of stay in the intensive care unit correlated with the perceived importance of one visitation need. The majority of subjects indicated that they were capable of making decisions regarding visitation. Also, the majority of subjects indicated that they perceived the need to see people outside their immediate family, primarily close friends. The findings from this study indicate that a uniform, strictly enforced visitation policy did not meet all of the trauma patients' needs to see their loved ones.

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CHAPTER I

INTRODUCTION

Nearly every hospital's intensive care unit (ICU) has some form of a visiting policy (Kirchhoff, 1982; Younger, Coulton, Welton, Juknialis, & Jackson, 1984). The major reason cited for visitor restriction has been to promote patient rest, however studies supporting or demonstrating that the restriction of visitors to critically ill patients promotes recovery could not be found by this investigator.

In a survey of 78 intensive care units, Younger et al. (1984) found that visitors were limited as to the amount of time that they could be with patients, the frequency with which they could visit, the number of visitors who could visit, and who could visit. Although most units altered the visitation policy when patients were critically ill (96%) and when patients had "emotional needs" (94%), the study did not identify whether the nurse or the patient determined if the patient met the requirements necessary for the rules to be modified. For example, could the patient say "I am lonely and scared and need to see my husband now" and be allowed to have visitors? Or did the nurse say "You look lonely and scared. I am going to ask your husband to visit."

There are indications that visitation schedules are being liberalized. Breu & Dracup (1978) described a policy in which

nurses were encouraged to "arrange flexible visiting hours that are agreeable to both the staff and spouse" (pp. 52) while patients in a coronary care unit (CCU) were critically ill. Dunkel and Eisendrath (1983) reported a new policy in effect in an ICU in which: (a) a maximum of two visitors at a time were permitted; (b) visitors could not detract (as determined by the bedside nurse) from good patient care; and (c) families could be asked to leave during a crisis in the unit, when medical or nursing procedures were being performed, and at the discretion of the ICU staff. Hoffman, Donckers, & Hauser (1978) reported that an "increased flexibility in visiting regulations" was instituted as a result of a study of perceived stressors of CCU patients. No studies were found, however, that examined the patients' perceptions of need for family visitation. Interestingly, 98% of the nurses surveyed by Younger et al. (1984) felt that their visiting policy met the patients' needs moderately or very well.

Purpose of the Study

The purpose of this study was to explore the following questions: (a) What are the visitation needs as perceived by the patient in the intensive care unit? and (b) Is there a relationship between the patient's age/length of stay in the ICU, and his or her perception of visitation needs?

Definition of Terms

Immediate family--parents, siblings, spouse, and children of the patient.

Intensive care unit (ICU)--a 10-bed unit which admits adult patients with a variety of medical and surgical problems that require cardiac monitoring, invasive and noninvasive monitoring, and specialized nursing care.

Interaction--verbal and nonverbal communication that occurs between individuals.

Length of stay--the number of days a patient is hospitalized in the intensive care unit or neuro-respiratory intensive care unit.

Lenient nurse--a registered nurse who permits modifications of the visiting policy including the frequency of visits, the timing of visits, and who is allowed to visit.

Medical/surgical unit--a 30-bed unit with private rooms which admits non-critically ill patients with medical or surgical problems.

Neuro-respiratory intensive care unit (NRU)--an eight-bed unit which admits adult patients with neurological and respiratory problems who require cardiac monitoring, invasive and non-invasive monitoring, and specialized nursing care.

Significant other--any person the patient perceives to be important, including adult family members, children, and individuals not related to the patient.

Staff nurse--a person who is a licensed registered nurse, and who provides direct care to patients in the ICU/NRU.

Trauma--accidental injury caused by an external force (Miller & Keane, 1972), such as a motor vehicle accident, gunshot wound, or fall.

Visitation need--any requirement the patient has to be with significant others, that, if supplied, relieves or diminishes his immediate distress or improves his immediate sense of adequacy or well-being (Orlando, 1961).

Scope of the Study

This study examined patients' perceptions of the following dimensions of their needs for interactions with significant others:

1. Length of the interactions: the amount of time the patients and significant others are together per visit.
2. Frequency of interactions: the number of visits the patients and significant others have per day.
3. Timing of interactions: the identification of situations which coincide with the patients' need to be with significant others.
4. Significant others involved in the interactions: any person the patients perceive a need to see while they are in the intensive care unit, including adult family members, children, and individuals not related to the patients.
5. Control of the interactions: the patients' desires to make decisions regarding the visits they have (or do not have) with significant others.

Assumptions

1. Within 48 hours of transfer to the floor, trauma patients are able to identify and communicate the visitation needs they perceived during the time they were hospitalized in ICU/NRU.
2. Family members have a significant influence on a patient's adaptation to the ICU/NRU.
3. Trauma patients are not able to anticipate their admissions to ICU/NRU, and therefore they will have different perceived visitation needs than patients who have scheduled their admissions to the ICU/NRU.

Research Design and Study Questions

No previous research could be found that focused on the perceived visitation needs of the trauma patient hospitalized in the ICU/NRU. The investigator determined that a descriptive, exploratory design would be used to answer the following questions:

1. How satisfied are trauma patients with the present visiting policy?
2. Is there a relationship between a trauma patient's age and his/her satisfaction with the present visiting policy?
3. Is there a relationship between a trauma patient's length of stay in the intensive care unit and his/her satisfaction with the present visiting policy?

4. What visitation needs are identified by trauma patients?
5. What is the importance of visitation needs to the trauma patient?
6. Are visitation needs being met?
7. Is there a relationship between a trauma patient's age and the importance of each visitation need?
8. Is there a relationship between a trauma patient's length of stay in ICU/NRU and the importance of each visitation need?
9. Do trauma patients perceive the ability to make decisions regarding visitation?
10. Why do trauma patients feel visitors are or are not important?
11. Who, in addition to the immediate family, does the trauma patient want to visit?
12. What visiting policy do trauma patients desire to meet their needs?

Conceptual Framework

The Roy Adaptation Model (Roy, 1976) was used as a conceptual framework for this study. The basic premise of this model is that an individual's changing environment (both internal and external) requires a "positive" response in order for successful adaptation to occur.

Roy (1976, p. 13) described three types of stimuli which determine the degree to which an individual must adapt:

1. Focal stimuli are those that immediately confront the individual. In this study the focal stimuli considered were the changes encountered by a patient upon his/her admission to an intensive care unit. Internal focal stimuli include sleep deprivation, pain, fear, and physiological changes that occur because of the disease state. External focal stimuli include sensory overload and deprivation, and restricted mobility.

2. Contextual stimuli are all other stimuli present that influence an individual's ability to adapt. The focus of this study was on the external contextual stimulus of the separation of the patient from significant others.

3. Residual stimuli are beliefs, attitudes, experience, or traits that affect behavior (Roy, 1976, p. 32). For the purpose of this study, three residual stimuli were considered. These included each patient's age, length of stay in the ICU/NRU, and the ages of his/her children.

Roy (1976, p. 14) identified four modes in which an individual adapts: physiological, self-concept, role function, and interdependence. In most cases, the admission of an individual to an intensive care unit is in response to an actual or perceived threat to his/her physical integrity. This threat is usually overwhelming and requires maximal adaptive effort by the individual. Of the four modes outlined by Roy, three (self-concept, role function and interdependence) are dependent on the relationship the individual has with significant others. Therefore, it seems logical to assume that significant

others have an important influence on patients' adaptation to the intensive care unit and to the disease process.

Roy (1976, p. 18) stated that the goal of nursing is to "promote man's adaptation in each of the adaptation modes . ." by manipulating the focal and contextual stimuli to which the individual is exposed. It is within the scope of nursing to "manipulate" the time the patient and his/her significant others have together (contextual stimuli). But how should this be done? Do patients in the intensive care unit perceive a need for more visitation than is customarily allowed, or less? Who does the patient think should make decisions related to visitation in the ICU/NRU? What residual stimuli influence patients' perceptions of visitation needs?

CHAPTER II

REVIEW OF THE LITERATURE

Internal Stressors Associated With Hospitalization

Reactions of patients to an intensive care unit have been described in the literature. Helplessness (Senescu, 1970; Schnaper & Cowley, 1976); alterations in body image (Schnaper & Cowley, 1976; Strain, 1978); and the "normal" reaction of depression, anxiety and denial (Tomlinson, 1974) have been cited. Regression to a more child-like state has been cited in several studies (Schnaper & Cowley, 1976; Strain, 1978; Tomlinson, 1974; Senescu, 1970). Several writers have suggested that such regression is a normal reaction to hospitalization in an intensive care unit (Strain, 1978; Tomlinson, 1974). Strain and Grossman (1975, p. 24) identified seven sources of psychological stress experienced by the "sick, hospitalized" patient:

1. Basic threat to narcissistic integrity;
2. Fear of strangers;
3. Separation anxiety;
4. Fear of the loss of love and approval;
5. Fear of the loss of control of developmentally achieved functions;
6. Fear of loss of injury to body parts; and
7. Reactivation of feelings of guilt and shame, and accompanying fears of retaliation for previous transgressions.

Roberts (1976) stated that many patients in the intensive care unit experience loneliness.

Separateness from significant others and from one's own body are the two most significant components of psychological pain in existential loneliness. The individual is unable to derive security from his family, and he experiences a sense of unrelatedness with his own body. He entered the hospital with a feeling of relatedness to family and self, but when he became a critical care patient, he relinquished control over both. (p. 144)

Roberts also suggested that a critically ill patient is able to "derive strength from his family that sustains him through the biological crisis." (p. 352)

External Stressors Associated With ICU

In addition to these internal stressors, the environment in most acute care units is stressful. Excessive noise has been identified as a common problem (Woods & Falk, 1974; Woods, 1972; Helton, Gordon & Nunnery, 1980; Vanson, Katz, & Krekeler, 1980; DeMeyer, 1967). The noise combined with the need for frequent physical care leads to sleep deprivation (DeMeyer, 1967; Helton et al., 1980; Woods, 1972; Hoffman et al., 1972). Vanson, Katz and Krekeler (1980) and Sczekalla (1973) found that witnessing events that occur within the unit such as resuscitation procedures, insertion of Swan-Ganz catheters and temporary transvenous pacemakers, or cardioversions was stressful to patients.

Noble (1979), in a descriptive study of four ICUs, reported that the single most disturbing aspect of the critical care environment

was interstaff communication. In one ICU, 68% of all personal conversation took place at patients' bedsides or within hearing range of the patients, however only 14% of all observed communications were directed to patients, and of these 55% were considered to be "loud."

Effects of Family-Patient Interaction

Within this environment of overwhelming stress, why are patients and family members routinely separated? Younger et al. (1984) proposed four reasons that visitors have been restricted:

1. Visits are too upsetting for the visitors, especially children;
2. Visits may be physiologically disruptive and damaging to the patient;
3. Visitors or patients run the risk of infection;
4. Visiting disrupts the unit and depletes the staff's time and energy.

The idea that visitors might be stressful has been suggested by several authors. Kornfeld, Maxwell, and Momrow (1968) suggested that although visitors were a source of comfort to some patients, other patients were "made anxious by the obvious apprehension being experienced by the visitor." (p. 43) These authors advocated that the presence of visitors should be controlled by the nurse. Glasser and Strauss (1965, p. 156) noted that when visiting restrictions were relaxed due to a patient's worsening condition, some family members

"bothered" the patient. They also recommended that the nurse control visitation.

There is a paucity of studies demonstrating any adverse physiological effects of family visitation. Brown (1976) measured the pulse, blood pressure, and cardiac rhythms of 50 patients with known or suspected myocardial infarctions before, during, and after a 10-minute family visit. She found that patients' blood pressures increased significantly during visits and concluded that family visits were a source of stress. Theorell and Webster (1973) observed more severe and more frequent arrhythmias in patients who had visitors as compared with patients who did not have visitors.

These findings can be partially explained by research performed at the University of Maryland Hospital by Lynch, Thomas, Mills, Malinow, and Katcher (1974). These researchers examined the physiological effects of social and clinical interactions on patients in a CCU. They observed the patients' heart rates and rhythms during all interpersonal visits, and nursing interactions. The patients' heart rates varied as much as 45 beats/minute when the nurse measured their pulses and during family visits. In a single case report, Thomas, Lynch and Mills (1975) reported that twice as many ectopic heart beats occurred during clinical interactions than when the patient was alone. Interestingly, of the 18 separate interactions experienced by the patient during the observation, 17 involved nursing activity. Mills, Thomas, Lynch and Katcher (1976) studied the heart rhythm of 20 patients in a CCU while a nurse palpated their pulses. Again, the incidence of ectopic beats almost doubled.

Fuller and Foster (1982) measured patients' microtremor suppressions in the vocal muscles and concluded that family visits were no more stressful than staff-patient interactions. These studies seem to indicate that physiological changes are not limited to the family-patient interaction; any social or clinical interaction can cause physiological changes.

Zetterlund (1971) compared patients in units with strict 5-minute visiting times with patients in a unit that did not enforce a set visiting schedule. She found that patients in the more liberal unit experienced a 10% increase in their pulse rate initially, but the rates decreased to the pre-visit rate before the visitors left. Patients in the unit which enforced the visitation schedule experienced a 7% increase in heart rate and sustained the increased rate throughout the 5-minute visit. She concluded that it was the visiting schedule, not the visit, that caused the increased heart rate. It seems that from these few studies, there are no firm conclusions regarding the potentially harmful effects from family visitation. More research is needed in this area.

In 1978, Hoffman, Donkers, and Hauser studied the perceived stressors of 50 patients in a CCU. Of the 24 stressors identified in response to open-ended questions, visitor regulation ranked sixth after fear, relief of pain, presence of pain, staying in bed, and experiencing uncomfortable procedures. Riggio, Singer, Hartman, and Sneider (1982) surveyed 21 patients on ventilators and found that 41% of the sample indicated a preference for more visits from

close family members. These studies seem to indicate that the separation of patients from significant others imposes a stress on patients.

Effects of Increased Patient-Family Interaction

Schwartz and Brenner (1979) attempted to reduce the stress imposed on patients during the transfer from the CCU to the floor. They designed an intervention protocol in which the nurse advised the family of the stress involved and encouraged one or two key family members to be present during the transfer period, especially the first evening post-transfer. There was also an experimental group in which the nurse from the unit to which the patient would be transferred met with the patient while the patient was in the CCU. At that time, the nurse introduced herself/himself; explained the physical layout, nursing routines, and visiting hours of the receiving unit; and answered the patient's questions. The patients in both experimental groups scored lower than the control group on stress levels, noncompliance with medical orders, readmission to the coronary care unit, complications, and length of hospital stay. None of the patients in either experimental group (N=10 each) extended their infarctions or had a second infarction, whereas 40% of the patients in the control group (N=10) did. The results of this study suggest that family members who have information about patient needs are at least as effective as the nursing staff in reducing patient stress and complications.

Bruya (1981) studied the effect of planned rest periods on the intracranial pressure (ICP) of 20 patients with known or suspected increased ICP in an ICU. She serendipitously found that the ICP in "almost all" the patients studied decreased when family members approached the bed or touched the patients' arms. All but one of the patients were comatose or responded minimally. Bruya suggested that a treatment of choice might be to allow the family members to visit more often than routine visiting hours permit.

Needs of Family Members

Although there are relatively few studies on the perceived needs of patients regarding visitation, there are a number of studies concerning the perceived needs of family members. Hampe (1975) examined the needs of grieving spouses in the hospital setting, and others (Molter, 1979; Daley, 1984; Stillwell, 1984; Bouman, 1984; Prowse, 1984) have examined the needs of family members with loved ones in the intensive care unit. Three of these studies found that the need most often expressed by family members was the desire to be with their loved ones.

On the basis of these studies, some nurses have instituted more liberal visiting times, such as encouraging flexibility of visiting times and instituting policies with no predetermined visitation schedule (Breu & Dracup, 1978; Hoffman et al., 1978; Dunkel & Eisen-drath, 1973). The question that remains unanswered is whether increased family visiting meets patients' needs.

CHAPTER III

METHODOLOGY

Setting

The subjects for this study were patients who were admitted to the ICU or NRU at the University of Tennessee Memorial Hospital and Research Center with injuries resulting from trauma. The NRU is an eight-bed unit consisting of one private room and seven beds in an open area. In the open area, curtains can be pulled for privacy. Admission to the NRU is based on a patient's need for specialized nursing care and monitoring resulting from respiratory or neurological problems. In the event the ICU is full, this unit also admits critically ill patients with medical and surgical problems.

The ICU is a ten-bed unit consisting of one private room and nine beds in an open area. Like the NRU, in the open area, curtains can be pulled for privacy. This unit admits patients with a variety of medical and surgical problems that require cardiac monitoring, invasive and non-invasive monitoring, and specialized nursing care.

The vast majority of registered nurses in both units work 12-hour shifts for 7 days and are off for 7 days. An attempt is made to provide continuity of nursing care by assigning one nurse to care for each patient. Each nurse is responsible for the patient's total nursing care, with the exception of administering medications which is done by another registered nurse. The nurse to patient ratio

in each unit is ideally one nurse per two patients. Frequently, however, the ratio is one nurse per three patients.

The official visiting policies for the NRU and ICU are identical. Only two members of the patient's immediate family (parents, siblings, spouse, and children) are permitted to visit for 5 minutes at 10 a.m., 2 p.m., 4 p.m., 7 p.m., and 9 p.m. Visitors are not permitted to change during each visiting time. Children under the age of 14 years are not permitted to visit. The family members decide who will visit. Exceptions to the official visiting policy are made; the exceptions are determined by an individual nurse caring for a particular patient. Consequently, the exceptions vary considerably and are inconsistently made.

Subjects

A convenience sample of 20 patients was selected. All patients who met the following criteria were eligible to participate in the study. The patients were:

1. Initially admitted to NRU or ICU with injuries resulting from accidental trauma;
2. Interviewed within 48 hours of transfer to a post-intensive care unit;
3. At least 18 years old;
4. Free of documented head injury (e.g. subdural hematoma);
5. Hospitalized in ICU or NRU at least 24 hours;
6. Able to communicate either verbally or in writing;

7. Orientated to person, place, and time.

Interviews were conducted during the 6-month period between April 26, 1985 and September 10, 1985. While the investigator originally planned to interview all patients who met the criteria, constraints on the investigator's time made it impossible to conduct some of the interviews within the 48-hour time period.

Some eligible patients were omitted because they were not identified by the NRU and ICU staff. The investigator also decided to omit several patients who met the criteria. For example, one patient had severe facial fractures, lacerations, edema, a wired jaw, and a tracheostomy tube. She also had numerous fractures of her extremities. When the investigator met her, she decided that the patient appeared too sick and uncomfortable to be interviewed. In addition, one man began hyperventilating during the interview and the investigator immediately ended the interview. Further investigation revealed that he was taking major tranquilizers for a psychiatric problem. He had been a prisoner of war in Vietnam, and spoke at length of "flashbacks" which plagued him while he was restrained in ICU. Another subject responded with answers to the interview questions which seemed inappropriate and inconsistent. Further investigation revealed that he was in the beginning stages of alcohol withdrawal. Therefore, his interview was not included in this study.

The characteristics of the subjects are presented in Table 1. Table 2 presents a comparison of characteristics of the subjects with characteristics of the total available population of persons who met the study requirements.

Table 1. Characteristics of Subjects

Subject	Age	Sex	Event Causing Trauma	Injuries	Length of Stay in the ICU/NRU
1	20	F	Motor vehicle Accident	Multiple facial lacerations; Fractured patella and medial femoral condyle; Fractured metacarpal	2 days
2	21	M	Motor vehicle Accident	Fractured pelvis; Fractured ribs 3-9 with bilateral pneumothorax	4 days
3	25	M	House Fire	1st-2nd-3rd degree burns over 45% of his body	7 days
4	25	M	Motor vehicle Accident	Ruptured spleen; Ruptured kidney; Lacerated forehead	2 days
5	26	M	Diving Accident	Fractured C ₄₋₅ with complete paralysis ^a	8 days
6	27	M	Motor vehicle Accident	Fractured C ₅₋₆ without paralysis ^a	4 days
7	29	M	Hit by a car	Fractured humerus; Bilateral open fractures of tibia and fibula; Shoulder dislocation; Severe lacerations	1 day
8	32	M	Motor vehicle Accident	Ruptured spleen	1 day
9	34	M	Electrical Explosion	Arc-flash 2nd and 3rd degree burns over 25% of his body	3 days
10	36	M	Threw Gas on Brush Fire	Second degree burns over 37% of his body	1 day
11	36	M	Motor vehicle Accident	Ruptured spleen; Lacerations	1 day
12	37	F	Motor vehicle Accident	Fractured femur; Fractured ribs 1-2; Hip dislocation; Brachial plexia injury; Chest wall contusion	1 day

Table 1. (Continued)

Subject	Age	Sex	Event Causing Trauma	Injuries	Length of Stay in the ICU/NRG
13	42	M	Motor vehicle Accident	Patellar tendon avulsion fracture; Hemarthrosis of ankle; Demerol addict	3 days
14	42	M	Motor vehicle Accident	Fractured mandible; Fractured patella	2 days
15	42	M	Fell out of a barn	Fractured skull; Ear laceration; Pelvic contusion	2 days
16	52	F	Motor vehicle Accident	Fractured C ₆ without paralysis; ^a Cardiac contusion	3 days
17	57	F	Motor vehicle Accident	Amputation of arm; Fractured femur; Fractured ribs 5-9 with pneumothorax	12 days
18	66	M	Motor vehicle Accident	Fractured ribs 3-6 with pneumothorax; Fractured clavical; Facial lacerations	2 days
19	71	M	Run over by tractor	Fractured pelvis; Fractured acetabulum; Pulmonary contusion	4 days
20	76	M	Fell off ladder	Fractured T ₇ without paralysis; ^b Open dislocation of thumb	8 days

a - cervical vertebrae

b - thoracic vertebrae

Table 2. Comparison of Available Population and Sample

	Available Population	Sample
NUMBER	47	20
AGE		
18-25 years	16 (34%)	4 (20%)
26-40 years	18 (38%)	8 (40%)
41-60 years	8 (17%)	5 (25%)
60+ years	5 (11%)	3 (15%)
range	18-76 years	20-76 years
average	37 years	39 years
SEX		
male	36 (77%)	16 (80%)
female	11 (23%)	4 (20%)
EVENTS SURROUNDING INJURY		
motor vehicle or motor- cycle accident	32 (68%)	12 (60%)
gunshot or stab wound	4 (9%)	0 (0%)
burn	5 (11%)	3 (15%)
hit by car	1 (2%)	1 (5%)
fall	2 (4%)	2 (10%)
run over by tractor	1 (2%)	1 (5%)
diving accident	2 (4%)	1 (5%)
LENGTH OF STAY ICU/NRU		
1-2 days	28 (68%)	10 (50%)
3-5 days	11 (23%)	6 (30%)
6-10 days	6 (12%)	3 (15%)
11-20 days	1 (2%)	1 (5%)
20+ days	1 (2%)	0 (0%)

Instrument

The questionnaire used in this study was developed by the investigator (see Appendix A). It was adapted in part from work by Molter (1979) and Daley (1984). The questionnaire consisted of 28 closed-ended questions and 9 open-ended questions.

The main consideration in developing the questionnaire was the physical condition of the subjects. It was expected that the subjects would be in pain, have restricted mobility due to tubes and injuries, and have respiratory problems. Therefore, the tool had to be brief, easily understood, and answerable with a minimal expenditure of energy. Since closed-ended questions tend to be more efficient (Polit & Hungler, 1983) the majority of questions were of this type. Closed-ended questions have the disadvantages of restricting the respondent to visitation needs identified in the questionnaire and being difficult to construct. Therefore, nine open-ended questions were included to allow patients to discuss visitation needs not identified in the questionnaire.

Validity

Three members of the investigator's academic committee were asked to examine the questionnaire for content validity. Each member was given a description of the five dimensions of patient-significant other interactions to be examined in the study:

1. Length of the interaction;

2. Frequency of the interaction;
3. Timing of the interaction;
4. Involvement of significant others in the interaction; and
5. Control of the interaction.

Each committee member was asked to rate each item on the questionnaire as to how well it measured each of the five dimensions, using the following scale:

-1 = the item definitely does not measure the dimension;

0 = the item may or may not measure the dimension;

+1 = the item definitely measures the dimension.

Average Congruency Percentage. To compute the average congruency percentage, the proportion of items rated congruent by each judge is calculated and converted to a percentage. Then the mean for all judges is calculated (Waltz, Strickland & Lenz, 1984). In this study, all items rated +1 in any of the five dimensions by committee members were considered congruent. Table 3 presents each committee member's rating.

TABLE 3. Committee Members' Ratings of Item Congruency

Committee Member	Percent Congruent
A	100%
B	97%
C	87%

The average congruency percentage was 94.6%. An average congruency percentage of 90% can be considered acceptable (Waltz, Strickland & Lenz, 1984).

Content Validity Index. The content validity index (CVI) is the proportion of items rated as relevant by two judges (Waltz, Strickland & Lenz, 1984). Again, items rated +1 in any of the five dimensions by the committee members were considered relevant. Committee members A and B agreed that 35 of 36 items were relevant, yielding a CVI of .96 ($35/36 = .96$). Committee members B and C agreed that 32 of 36 items were relevant; CVI = .88. Likewise, committee members A and C rated 32 of 36 items as relevant, yielding a CVI of .88.

It was also found that many items measured more than one dimension. The committee members agreed that 20 items were a definite measure of two dimensions and two items measured three dimensions.

It must be pointed out that the investigator initially believed that the present visiting policy was too strict and was not meeting the needs of patients or family members. For this reason, the clinical director of the acute care units who established the present visiting policy was asked to examine the questionnaire for subtle bias. The clinical director felt the questionnaire was free of bias.

Reliability

Crombach's alpha analysis was used to test the internal consistency of the twenty need items on the questionnaire (see

Appendix A). For most purposes, reliability coefficients above .70 are considered satisfactory (Polit & Hungler, 1983). For the need items, the Crombach's alpha was .84.

Data Collection Procedure

Prior to initiation of the study, the study was approved by the University of Tennessee's Committee on Research Participation (Appendix B) and the University of Tennessee Memorial Research Center and Hospital Clinical Research Committee (Appendix C).

To protect the patients' anonymity, a staff nurse in the ICU/NRU identified patients who met the study criteria. After the physicians wrote an order to transfer the patient to a medical/surgical unit, staff nurses caring for the patients asked the patients for permission to give their name to the investigator. The staff nurse said:

There is a nurse in the process of doing a study. Her goal is to find out how you feel about visitors. Would it be all right with you if the nurse explained the study to you after you are in your room? . . . You can be thinking about it and decide when she visits you if you want to participate.

All patients who were invited to participate in the study consented to participate.

The investigator visited the patient in his/her room within 48 hours of transfer from the ICU/NRU. The investigator decided that by waiting longer than 48 hours the patients might "forget" the visitation needs they had during their hospitalization in the

ICU/NRU. The investigator introduced herself and explained that the purpose of the study was to learn about the visitation needs of patients who were in the intensive care units. Interview procedures were discussed with the patients, including an explanation that the only additional risk to which the patients would be exposed was the possibility that they could become tired during the interview. It was emphasized that participation in the study was entirely voluntary and would not influence their care. The patients signed an informed consent form and were given a copy of the form to keep (Appendix D). The patients were advised that they could withdraw from the study at any time.

For the interviews, the investigator wore a white uniform, a name pin identifying her as a registered nurse and a graduate student, and no cap. Family members were asked to leave the patients' rooms during the interview. The investigator said, "I will be with (name of patient) for the next 20 or 30 minutes. Why don't you use this time to eat breakfast? I will get you if you are needed." Most family members seemed grateful for the opportunity to leave.

Originally, the investigator planned to give the questionnaires to the patients to complete. However, some patients had casts or immobilizers on their arms, three patients had severe burns, one patient had to remain flat due to spinal fractures and one patient could not read the questionnaire without his glasses which had been broken in the accident. Therefore, if the patient could not complete the questionnaire without assistance, the investigator read the

questions and possible responses to the patients, and the patients selected the appropriate responses. The investigator recorded the responses on the questionnaire. Two subjects completed the questionnaire without assistance from the investigator and 18 subjects required assistance. Assistance provided by the investigator did not appear to influence the subjects' responses.

Despite their weak physical conditions, many patients seemed eager to talk. Frequently the patients began discussing their concerns. The investigator listened to the concerns, but she guided the discussion back to the original question. Most interviews lasted 30 minutes. After the interview, the investigator reviewed the patients' charts for their ages, extent of their injuries, and the events preceding their hospitalization.

Finding an appropriate time to conduct the interviews was difficult. The investigator quickly learned to delay the interview until several hours after patients had been transferred. Immediately after being transferred, most patients were in pain, concerned about their physical needs, and did not want their families to leave their rooms. Inevitably, the patient asked the investigator to return at a later time. In the afternoons, the patients were frequently tired and sleeping. The investigator found that the best time for the interview was the day after the patient had been transferred, around 9 a.m.

CHAPTER IV

DATA ANALYSIS

Data were analyzed using the SAS program on the University of Tennessee's computing system. Because of the small sample size (N=20) and the nature of the data, descriptive and nonparametric procedures were used. The data which were used to answer each of the twelve study questions are presented below. Comments made by the subjects are included.

1. How Satisfied are Trauma Patients with the Present Visiting Policy?

Responses to items 2, 3, 4, and 5 on the questionnaire schedule were used to answer the first study question (see Appendix A). In response to question 2, nine (45%) subjects indicated that the present visiting policy met their needs very well, and six (30%) subjects stated that the policy met their needs moderately well. Three (15%) subjects indicated that the policy met their needs poorly, and two (10%), very poorly. Two subjects commented on this question:

The nurses acted like my friends. If they didn't I would have wanted my family more.

The way I was feeling I couldn't enjoy visitors anyway. I was hurting.

In response to question 3, nine (45%) of the subjects indicated that the length of each visiting time was too short, and nine (45%) indicated that the length was just right. Two (10%) did not know. Comments included:

I felt the length was just right. One time the nurse let my wife stay one hour. She said I needed the company. I really appreciated that.

Length shouldn't make any difference. If a person has a good relationship with his family, he can say, "Hey, guys, I'm hurting. Go away right now. I love you."

In response to question 4, nine (45%) subjects indicated that the number of visitors was sufficient, nine (45%) subjects said they wanted to see more people per visit, one (5%) subject said he wanted to see fewer people, and one (5%) subject did not know. Comments included:

There are 6 kids in my family. Between my parents, grandparents, brothers and sisters I didn't get a chance to see them all. I think I should have seen as many as came to see me--especially if they are commuting.

I didn't want to see no one. It hurt me worse.

This place needs to let you switch out visitors like [another hospital].

You're not supposed to switch out visitors, but my nurses let my family do it. It was great.

In response to question 5, twelve (60%) subjects indicated that the frequency of visiting times was just right and six (30%) indicated that the frequency was not often enough. Two (10%) subjects did not know. Comments included:

Not often enough! My brother is a trucker. He was out West when he heard about my accident. He turned his rig around and drove day and night to come here. When he arrived, it was after the last visiting time. The receptionist called into ICU and the nurse said I was asleep and he couldn't see me. Early the next morning he called the trucking company to tell them where he was. They told him to get back immediately or he was fired. So he asked to come to see me before he left. The nurse said, 'No, he's resting.' So he left without seeing me. That upset me more than anyone will ever know.

It's ridiculous that someone drives 100 miles to see you and then has to wait 3 or 4 hours to see you.

We live 2 hours away. My wife can't drive. My family would get together and bring her everyday. Except I couldn't see but her and one other person at a time. It's awful to make them wait.

It was just right. I needed to rest between visitors.

Just right. I didn't want many visitors.

2. Is There a Relationship Between the Trauma Patient's Age and His/Her Satisfaction with the Present Visiting Policy?

Analysis of data using chi square would not have been valid, since over 20% of the cells had expected counts less than five. However, five of the six subjects who were 28 years old or younger indicated that visiting times were too short compared to none of the six subjects who were between the ages of 29 and 40 (Table 4).

Table 4. Relationship Between Age and Satisfaction with Length of Visiting Times (As Indicated In Response to Item 2)

Age	Ranking of Satisfaction with Length of Visiting Times		
	Just right	Too short	Don't know
20 - 28 years	1	5	0
29 - 40 years	5	0	1
41 + years	3	4	1

3. Is There a Relationship Between the Trauma Patients'
Length of Stay in the Intensive Care Unit and
His/Her Satisfaction with the Present
Visiting Policy?

Again, analysis of data using chi square would not have been valid, since over 20% of the cells had expected counts of less than five. However, there appeared to be a relationship between the subjects' length of stay and their satisfaction with the length of each visiting time. As can be seen from Table 5, 100% (7) of the subjects who spent more than 3 days in the ICU/NRU indicated that the visiting times were too short. Conversely, 77% (10) of the subjects who spent less than 3 days in the ICU/NRU indicated that the length was just right.

Table 5. Relationship Between Length of Stay (LOS) and Satisfaction with Length of Visiting Times (In Response to Item 3)

LOS	Ranking of Satisfaction with Length of Visiting Times		
	Too short	Just right	Don't know
1 - 3 days	2	10	1
4 + days	7	0	0

Ninety-two percent (12) of the subjects who were in the ICU/NRU less than 4 days indicated that the present policy met their needs moderately or very well (Table 6). However, only 42% (3) of the subjects who were in the ICU/NRU longer than 3 days indicated that the policy met their needs moderately or very well.

Table 6. Relationship Between Length of Stay and Satisfaction with the Visiting Policy (As Indicated by Response to Item 2)

Length of stay	Ranking of Satisfaction with the Visiting Policy			
	Very well	Mod well	Poorly	Very poorly
1 - 3 days	8	4	0	1
4 + days	1	2	3	1

Length of stay did not seem to be related to a subject's satisfaction with the frequency of visiting times (Table 7) or the number of visitors a subject wanted to see per visit (Table 8).

Table 7. Relationship Between Length of Stay (LOS) and Satisfaction With The Frequency Of Visiting Times (As Indicated by Response to Item 5)

LOS	Ranking of satisfaction with frequency of visiting times		
	Just right	Not often enough	Don't know
1-2 DAYS	5	3	2
3 + days	7	3	0

Table 8. Relationship Between Length of Stay (LOS) and Number of Visitors per Visit (as Indicated by Response to Item 4)

LOS	Number of Visitors Desired Per Visit			
	Fewer	More	Sufficient	Don't Know
1-2 days	1	5	3	1
3 + days	0	4	6	0

4. and 5. What Visitation Needs Are Identified by
Trauma Patients? What is the Importance
of These Needs?

The subjects' responses regarding the importance of each of the 18 needs are presented in Table 9. The needs are ranked in descending order of importance in this and all subsequent tables. The rankings of not important/slightly important and important/very important were collapsed for the purpose of data analysis. Eight needs were considered to be important or very important by 50% or more of the subjects. It should be noted that all needs were rated important or very important by three or more subjects. During the interviews, most subjects volunteered comments regarding their needs. All comments made by the subjects are included below.

1. The need to have an opportunity to have visitors with me when the doctor or nurse gave me good news.

Only one subject commented:

It's real important to share good news with others.

2. The need to have an opportunity to have visitors with me when the doctor or nurse gave me bad news.

Two subjects commented:

But, it just depends on who it is.

Table 9. Ranked Perceived Importance of Eighteen Visitation Needs

Need	Ranking of Needs			
	Not Important or Slightly Important		Important or Very Important	
	a	b	a	b
To have the opportunity to have a visitor with me when the doctor or nurse gave me "good news"	6	30%	14	70%
To have the opportunity to have a visitor with me when the doctor or nurse gave me "bad news"	8	40%	12	60%
To have the opportunity to have a visitor with me during transfer to the floor	8	40%	12	60%
To be able to decide who should visit	9	45%	11	55%
To be able to refuse to see visitors whenever I want	9	45%	11	55%
To have visiting hours start on time	9	45%	11	55%
To see my children (if under 14 years)*	5	46%	6	54%
To have a family member make decisions regarding visitation	10	50%	10	50%
To have the opportunity to have a visitor with me at night	11	55%	9	45%
To have an opportunity to have visitors with me when the doctor visits	11	55%	9	45%
To have my visitors help me with my physical care	12	60%	8	40%
To have my visitors leave me alone if I am asleep	12	60%	8	40%
To see people outside of my immediate family	12	60%	8	40%

Table 9. (Continued)

Need	Ranking of Needs			
	Not Important or Slightly Important		Important or Very Important	
	a	b	a	b
To have the opportunity to have a visitor with me when I was in pain	13	65%	7	35
To be able to decide the times of the visitors	13	65%	7	35
To be able to decide how many people should visit	13	65%	7	35
To have the opportunity to have a visitor with me when I was resting	14	70%	6	30
To have the opportunity to have a visitor with me during tests, procedures, and treatments	17	85%	3	15

a - Number of respondents ranking need in this category

b - Percentage of respondents ranking need in this category

* - 11 respondents had children under the age of 14 years

It's important because you can talk to a friend, not a professional.

3. The need to be able to decide who should visit.

Again, two subjects commented:

It's the family relationship that brings you through all this.

If I was more aware and wanted visitors and couldn't have them, I would have pitched a fit.

4. The need to have visiting hours start on time.

Comments included:

It's so important for the visits to begin promptly. You watch the clock and build up anticipation. If visitors are late you're disappointed. It is quite a let down.

I didn't think it was important. I didn't know when the times were anyway.

5. The need to see my children if under the age of 14.

This need received the most comments:

I really wanted to see my 7-year old daughter. She's very intelligent and I think she could handle it.

I wanted to see my 2-month old child, but I could see why I couldn't.

It was very important to me to see my 5-year old grandson, but I understand there was no way.

My 6-year old granddaughter snuck in. It pleased the fire out of me!

I felt so bad I just didn't care about seeing them.

I absolutely did not want my children to see me.

Because of my burns I did not want to see my kids. They could come in to see me now, but I won't let them.

I didn't want my 2-year old daughter to see me like this.

6. The need to have an opportunity to have visitors with me at night.

Six subjects commented:

There were times at night when I couldn't sleep and needed someone to sit and talk to. Someone to relax me.

Sometimes I'd wake up at night, be hurting and couldn't go back to sleep. Then it's very important.

I wanted my wife sometimes at night. Just to sit with me for 10 minutes or so. Would that hurt anything?

I didn't want any visitors at night. You should be asleep.

I definitely wouldn't want anyone at night all the time.

No one should visit after 10 p.m. It's so aggravating when the nurse wakes you up at 2 or 3 a.m.

7. The need to have the opportunity to have visitors when the doctor visits.

Four subjects commented:

The doctors use a lot of terms I don't have sense enough to understand and they don't tell me as much as they tell my wife.

It's important because I can't remember what the doctor says and my family can ask questions.

When you're in pain, you can't remember what the doctor says. Your family can remind you.

It would help me understand. The doctor said things I didn't know about. Then we could talk about it later.

8. The need to have my visitors help with my physical care.

Comments included:

That's not important. It's a staff function.

The nurses were really nice downstairs [in ICU], but I really wanted to go to the floor so my wife could help me more.

It was good to have my wife help me. I was used to her.

9. The need to have my visitors leave me alone if I am asleep.

Two subjects commented:

I didn't have a problem with the visitors leaving me alone if I was asleep--only the nurses. It just depends on who it is. If I liked them I would want to be awakened.

I only wanted to see people when I was awake.

10. The need to see people outside my immediate family.

Comments included:

When you're in here you're alienated from the whole world. You can do without your friends for a few days, but then WOW!. . . you really need them.

I have a friend who works in this hospital. I really wanted to see him. He might have helped explain things to me.

11. The need to have the opportunity to have a visitor with me when

I was in pain.

Five subjects commented:

When I'm hurting I don't like to have visitors for a long time.

I didn't want to see anyone while I was in pain.

Sometimes my family put their hands on me and I felt better.

I wanted someone to hold on to. You just need someone when you hurt, you know!

I was in that little room. Because of my burns I couldn't use the call light. It was important to me to have someone there that could get the nurse when I was hurting.

12. The need to be able to decide the times of the visits.

Two subjects commented:

I wanted to see visitors all the time I was awake. It was very, very important. There's no T.V. or nothing.

Sometimes it was visiting time and I didn't feel good. I would have rathered they waited until later to see me.

13. The need to be able to decide how many people should visit.

Comments include:

They wouldn't let me decide the number of visitors, but I think two is about right.

No more than two should visit because it would disturb others.

14. The need to have an opportunity to have visitors with me during tests, procedures, and treatments.

Three subjects commented:

Tests are confidential. I didn't want my family if professionals were there.

My family wouldn't know what to do.

Sometimes the doctors and nurses did things that were embarrassing. I sure didn't want visitors then.

6. Are These Visitation Needs Being Met?

In Table 10, the number of subjects who ranked each need as important or very important is presented, as well as the number of subjects who felt that each need was not or occasionally met and frequently or always met. Only seven needs which were rated by the subjects as important or very important were perceived as being met more than 50% of the time. The seven needs which were met are: (a) "to have an opportunity to have a visitor with me during transfer to the floor," (b) "to be able to refuse to see visitors whenever I want," (c) to have visiting hours start on time," (d) "to have a family member make decisions regarding visitation," (e) "to have my visitors help with my physical care," (f) "to have my visitors leave me alone if I am asleep," and (g) "to be able to decide how many people should visit."

7. Is There a Relationship Between the Trauma Patients' Age and the Importance of Each Visitation Need?

To answer this question, data were analyzed using the Spearman's rho procedure. This nonparametric procedure is appropriate when data are inherently ordinal, such as rank ordering (Polit & Hungler, 1983). Responses to the questions about the 18 visitation needs were ranked as follows: not important = 1; slightly important = 2; important = 3; very important = 4. The subjects' ages were collapsed into the two categories, 20 - 35 years = 1; and 35 + years = 2.

Table 10. Responses of Subjects Who Rated Needs as Important/
Very Important to the Question: Was Need Met?

Number of Subjects Rating Need Important or Very Important	Need	Was Need Met?			
		Not Met or Occasionally Met		Always Met or Frequently Met	
		a	b	a	b
14	To have the opportunity to have a visitor with me when a doctor or nurse gave me "good news"	11	79%	3	21%
12	To have the opportunity to have a visitor with me when the doctor or nurse gave me "bad news"	9	75%	3	25%
12	To have the opportunity to have a visitor with me during transfer to the floor	3	25%	9	75%
11	To be able to decide who should visit	7	63%	4	37%
11	To be able to refuse to see visitors whenever I want	4	37%	7	63%
11	To have visiting hours start on time	5	45%	6	55%
6*	To see my children (if under 14 years)	5	83%	1	17%
10	To have a family member make decisions regarding visitation	4	40%	6	60%
9	To have the opportunity to have a visitor with me at night	7	78%	2	22%
9	To have the opportunity to have visitors with me when the doctor visits	7	78%	2	22%
8	To have my visitors help with my physical care	2	25%	6	75%
8	To have my visitors leave me alone if I am asleep	3	37%	5	63%
8	To see people outside my immediate family	6	75%	3	25%

Table 10. (Continued)

Number of Subjects Rating Need Important or Very Important	Need	Was Need Met?			
		Not Met or Occasionally Met		Always Met or Frequently Met	
		a	b	a	b
7	To have the opportunity to have a visitor with me when I was in pain	4	57%	3	43%
7	To be able to decide the times of the visits	6	86%	1	14%
7	To be able to decide how many people should visit	2	29%	5	71%
6	To have the opportunity to have a visitor with me when I was resting	4	67%	2	33%
3	To have the opportunity to have a visitor with me during tests, procedures, and treatments	3	100%	0	0

a - Number of subjects responding in this category

b - Percentage of subjects responding in this category

Table 11 presents the correlations between the subjects' ages and perceived importance of visitation needs. There was a negative correlation between age and nearly all of the visitation needs. Four of the correlations were statistically significant. Older subjects perceived the needs to be less important. The four items which were statistically significant in correlating with age are discussed below (items 8, 17, 19, 20).

Table 12 presents the subjects' answers to item 8, by age. The need "to be able to decide how many people should visit" was not considered to be important by 100% (9) of the subjects over 35 years of age. The need "to have the opportunity to have visitors during tests, procedures, and treatments" (item 17) was considered important by only three subjects. However, all three subjects were 25 years old or younger.

The need "to have the opportunity to have visitors while resting" was considered important or very important by 45% (5) of the subjects who were 35 years old or younger, whereas only 11% (1) of the subjects older than 35 considered it important or very important (Table 13).

Sixty-three percent (7) of the subjects 35 years of age or younger considered it important or very important to have the opportunity to have visitors while in pain (item 20). None of the subjects older than 35 considered it important or very important (Table 14).

Table 11. Correlation Between Age and Perceived Importance of Visitation Needs

Item #	Need	Spearman's rho p	
22	To have the opportunity to have a visitor with me when the doctor or nurse gave me "good news"	-.222	(.34)
21	To have the opportunity to have a visitor with me when the doctor or nurse gave me "bad news"	-.337	(.13)
23	To have the opportunity to have a visitor with me during transfer to the floor	.000	(1.0)
6	To be able to decide who should visit	-.170	(.47)
14	To be able to refuse to see visitors whenever I want	-.253	(.28)
15	To have visiting hours start on time	-.158	(.50)
9	To see my children (if under 14 years)	-.027	(.90)
11	To have my family make visitation decisions	-.190	(.42)
16	To have the opportunity to have a visitor with me at night	-.358	(.12)
18	To have the opportunity to have visitors with me when the doctor visits	-.319	(.17)
13	To have my visitors help with my physical care	-.077	(.74)
12	To have my visitors leave me alone if I am asleep	-.189	(.42)
10	To see people outside my immediate family	-.362	(.11)
20	To have the opportunity to have a visitor with me when I was in pain	-.584	(.006)*

Table 11 (Continued)

Item #	Need	Spearman's rho	p
7	To be able to decide the times of the visits	-.317	(.17)
8	To be able to decide how many people should visit	-.777	(.0001)*
19	To have the opportunity to have a visitor with me when resting	-.462	(.04)*
17	To have the opportunity to have a visitor with me during tests, procedures, and treatments	-.449	(.04)*

*p < .05

Table 12. Relationship Between Age and Perceived Importance of Deciding the Number of Visitors (in Response to Item 8)

Age	Ranking of Importance			
	Not important	Slightly important	Important	Very important
20-35 years	2	2	4	3
36 + years	9	0	0	0

Table 13. Relationship Between Age and Perceived Importance of Having a Visitor While Resting (in Response to Item 19)

Age	Ranking of Importance			
	Not important	Slightly important	Important	Very important
20-35 years	5	1	2	3
36 + years	8	1	0	0

Table 14. Relationship Between Age and Perceived Importance of Having Visitors when in Pain (in Response to Item 20)

Age	Ranking of Importance			
	Not important	Slightly important	Important	Very important
20-35 years	4	0	4	3
36 + years	8	1	0	0

8. Is There a Relationship Between the Trauma Patient's Length of Stay and the Importance of Each Visitation Need?

To answer this question, data were analyzed using the Spearman's rho procedure. Responses to the questions about the 18 needs were ranked as follows: not important = 1; slightly important = 2; important = 3; very important = 4. The subjects' lengths of stay in the ICU/NRU were collapsed into two categories: 1 to 2 days = 1; 3+ days = 2. Table 15 presents the correlations between the subjects' length of stay in the ICU/NRU and visitation needs.

Only one need, the need "to have a visitor during transfer to the floor" was significantly correlated with the subjects' length of stay in the ICU/NRU ($r = .447$, $p < .05$). Forty percent (4) of the subjects in the ICU/NRU for 1 or 2 days considered it important or very important, whereas 80% (8) of the subjects in ICU/NRU longer than 2 days considered it important or very important (Table 16).

Table 15. Correlation Between Length of Stay in ICU/NRU and the Perceived Importance of Visitation Needs

Item #	Need	Spearman's rho p	
22	To have the opportunity to have a visitor with me when the doctor or nurse gave me "good news"	.350	(.12)
21	To have the opportunity to have a visitor with me when the doctor or nurse gave me "bad news"	.223	(.34)
23	To have the opportunity to have a visitor with me during transfer to the floor	.447	(.04)*
6	To be able to decide who should visit	.264	(.26)
14	To be able to refuse to see visitors whenever I want	.317	(.17)
15	To have visiting hours start on time	.362	(.11)
9	To see my children (if under 14 years)	-.210	(.37)
11	To have my family make visitation decisions	.388	(.09)
16	To have the opportunity to have a visitor with me at night	.253	(.28)
18	To have an opportunity to have visitors with me when the doctor visits	-.163	(.49)
13	To have my visitors help with my physical care	.057	(.80)
12	To have my visitors leave me alone if I am asleep	.039	(.86)
10	To see people outside of my immediate family	.331	(.15)

Table 15. (Continued)

Item #	Need	Spearman's rho p	
20	To have the opportunity to have a visitor with me when I was in pain	.187	(.42)
7	To be able to decide the times of the visits	.239	(.30)
8	To be able to decide how many people should visit	.124	(.60)
19	To have the opportunity to have a visitor with me when I was resting	-.040	(.86)
17	To have the opportunity to have a visitor with me during tests, procedures, and treatments	-.012	(.95)

*p < .05

Table 16. Relationship Between Length of Stay (LOS) and Perceived Importance of Having a Visitor During Transfer to the Floor (in Response to Item 23)

LOS	Ranking of Importance			
	Not important	Slightly important	Important	Very important
1-2 days	5	0	2	3
3+ days	1	0	4	5

Although not statistically significant ($r = .350$, $p = .12$), the need "to have an opportunity to have visitors during good news" seemed to be related to length of stay. Ninety percent (9) of the subjects in ICU/NRU for 3 days or more considered this need to be important or very important. Fifty percent (5) of subjects in ICU/NRU for 1 or 2 days considered it important or very important (Table 17).

Table 17. Relationship Between Length of Stay (LOS) and Perceived Importance of Having a Visitor During Good News (in Response to Item 22)

LOS	Ranking of Importance			
	Not important	Slightly important	Important	Very important
1-2 days	5	0	2	3
3 + days	1	0	4	5

There also seemed to be a correlation between the subjects' length of stay in the ICU/NRU and their need to see people outside of their immediate families, although this relationship was not statistically significant ($r = .331$, $p = .15$). Seventy percent (7) of the subjects in the ICU/NRU longer than 2 days considered this need to be important or very important, compared to 30% (3) of subjects in the ICU/NRU less than 3 days (Table 18).

Table 18. Relationship Between Length of Stay (LOS) and the Need to See People Outside Immediate Family (in Response to Item 10)

LOS	Ranking of Importance			
	Not important	Slightly important	Important	Very important
1-2 days	6	1	1	2
3 + days	2	2	5	2

10. Do Trauma Patients Perceive the Ability to Make Decisions Regarding Visitation?

In response to item 29, eleven (55%) subjects indicated that they were able to make decisions regarding visitation, eight (40%) subjects indicated they were not able to make decisions, and one (5%) subject did not know. Age and length of stay did not seem to affect the subjects' responses to this question.

11. Why Do Trauma Patients Indicate Visitors

Are or Are Not Important?

Many comments made by subjects, in response to item 30, suggested that visits by loved ones served as a source of energy--energy for healing, comfort, for decision making, for strength, and for recovery. Other subjects viewed visitation as a source of energy for the family to reassure them that their loved one was all right. Comments which suggested that visits were perceived as a source of energy for the patient included:

I believe there is a merging of personalities. It occurs on many levels, like friends, family, lovers. This merging can affect healing. I believe it. I can feel it like warmth from the sun coming through a window.

Visitors helped me in a lot of ways. I enjoyed talking with them. They pepped me up.

I'm a friendly person and visitors boosted me up.

Because of your surroundings, you need them to give you courage.

It's encouraging. Gives you a new boost on life to see people pulling for you. When you see them you can't help but want to get better.

It built up my morale.

I needed to know that someone was there to support me and that they weren't going to leave me alone with strangers.

You're in pain. You don't know what's going on. It's good to have someone there to care for you.

You feel reassured that they are behind you, that they are there if you need them.

Comments which suggested that visits were perceived as a source of energy for the family included:

Because I love them and want to see them to reassure them.

You have to take care of business and let your family know how you are.

I think visiting times were more for my family than me. They needed to know how I was.

12. Who, In Addition to the Immediate Family, Does
the Trauma Patient Want to Visit?

In response to item 28, eight (40%) subjects did not want to see anyone outside their immediate family and nine (45%) wanted to see close friends. One (5%) subject wanted to see a business associate, one (5%) subject wanted to see a minister, and one (5%) subject wanted to see his nephew.

13. What Visiting Policy Do Trauma Patients
Indicate Would Meet Their Needs?

In response to item 32, seven (35%) subjects indicated that they did not care or did not know what the ideal visiting policy should be. Three (15%) subjects indicated that the visiting policy should not be changed. Ten (50%) subjects responded that the policy should be changed. All responses indicated that a more liberal policy would be ideal. Four subjects indicated that the policy should be "open door."

Comments are included below:

Your wife should be able to visit any time you're in the hospital--unless you're in surgery. Even if you're in the emergency room or having tests. Parents should be able to visit if you are conscious.

There's a lot to be taken into consideration--how the patient is feeling, if they are hysterical, in pain or crazy. If the patient's mind is O.K., you should let anyone in they [the patient] want to have around.

I think it should be "open door." If a visitor is coherent, courteous and checks with the patient, they should be able to come in.

Immediate family should be able to stay indefinitely. However, there are some members of the family that irritate you. Make you tighten up. So, the patient should tell the nurse who he wants to see and for how long. The nurse can regulate this by telling everyone that visiting times are only 2 minutes. For friends, the patient should draw up a list of people he wants to see, and in what order. Friends should come in twice a day and not stay longer than 2 minutes.

The patient should decide who should visit. What difference would it make if a friend visits and not a family member? Visitors should be allowed in at unscheduled times. If your wife is there and she's not interfering, why the hell not? Why can't she stay for 20-30-40 minutes? I think it's more uncomfortable for the nurses than for the patients and family.

Visiting hours should be from 10 a.m. to 2 p.m. and from 6 p.m. to 10 p.m. The number should vary with how sick you are.

At 8 a.m., 1 p.m., and 5 p.m. visitors should come in for 1-1/2 hours. Then I could rest in between.

Four times a day for 30 minutes. Afternoons are better than mornings because the mornings are so busy. Visitors should be able to swap out as long as no more than 2 are in there at once.

Every two hours, for 10 minutes, two people.

Instead of letting all the patients have visitors at once, divide it up. Let patients 1 and 2 have visitors, then patients 3 and 4. As many visitors as the patient wants could come in for 20 minutes four times a day. That way you could see everyone.

CHAPTER V

DISCUSSION

Interpretation

This study examined the patients' perceptions of the need for interactions with significant-others, including: (a) length of the interactions, (b) frequency of the interactions, (c) timing of the interactions, (d) involvement of significant-others in the interactions, and (e) control of the interactions.

Length of the Interactions

Forty-five percent of the subjects indicated that the length of visiting times was "just right," 45% of the subjects indicated that the length was "too short," and 10% did not know. These findings are similar to results obtained by Zetterlund (1971), who found that 64% of 17 patients in a CCU indicated that 5-minute visits were "too brief." There is evidence that subjects in this study did not use 5-minute visits as their point of reference responding to this item. Forty-four percent of the subjects who stated that the length of visiting times was "too short" indicated that visiting times lasted 20-30 minutes, and one subject who stated that the length of visiting times was "just right" indicated that visiting times lasted 1 hour. When asked what length of visiting would most meet their visiting needs, the subjects' responses ranged from 5-minutes to an open visitation policy with no

prescribed time limit. Younger subjects (20-29 years) and older subjects (40+ years) tended to indicate that longer visits were needed, as did subjects who were hospitalized in the ICU/NRU for 3 days or more. These findings suggest that a strictly-enforced standardized visitation policy does not meet the visitation needs of all trauma patients.

Frequency of the Interaction

The majority (60%) of subjects indicated that the frequency of visiting times was "just right," and 30% of the subjects indicated that the frequency was "not often enough." There is data to indicate that some subjects would have preferred less frequent, but longer visits. One subject stated that he preferred less frequent visits so he could rest. However, 20% of the subjects indicated a desire for an "open door" policy with unlimited visitation. Again, this data indicates that a uniform visiting policy does not meet the perceived needs of all trauma patients.

Molter (1979), Daley (1984) and Stillwell (1984) studied the visitation needs of critically ill patients' family members. The most important need identified in all three studies was the need "to see my relative frequently." The need "to be able to visit whenever I want" ranked second in Molter's (1979) and Stillwell's (1984) studies, and third in Daley's (1984) study. It is very possible that the patients' and families' needs to be with each other may conflict, however further research on this topic is needed.

Timing of the Interaction

The most important needs identified by trauma patients were: (a) "to have an opportunity to have a visitor with me when the doctor or nurse gave me good news" and (b) "to have an opportunity to have a visitor when the doctor or nurse gave me bad news." This finding suggests that trauma patients consider it important to share both joys and disappointments with loved ones. These needs were considered not met or occasionally met 79% and 75% of the times, respectively. A possible explanation for these high percentages is that most "good news" and "bad news" is delivered by the physician (e.g. the absence of internal injuries, the need for additional surgery). As a general rule, physicians do not visit patients during scheduled visiting times, but wait until visiting times are over. After physicians visit the patients in the ICU/NRU, they visit the families in an adjacent lounge.

The need "to have the opportunity to have visitors during transfer to the floor" was the third most important need identified by the subjects. Sixty percent of the subjects indicated that this need was important or very important. Schwartz and Brenner (1982) suggested that the transfer time was a source of stress for the patient. These findings may indicate that the transfer time was, in fact, stressful and having visitors present was perceived as useful in reducing the stress. When asked to rate the importance of this need, one subject stated, "Oh, not important at all. But it was real important to have my family with me once I got to the floor." This subject interpreted the item to mean the period of time when his bed was moved

from the ICU to the medical/surgical unit. The investigator has no way of knowing how many of the other subjects interpreted this item similarly. This item was poorly stated, and should have been stated "to have the opportunity to have a visitor with me during the first 12 hours after transfer to the floor." Of the subjects who considered this need to be important or very important, 75% indicated that the need was frequently or always met. The patients' transfer to the medical/surgical unit is considered a rite of passage by many patients and family members for it provides closure of the critical phase of hospitalization. The transfer is anxiously anticipated by the family and arrangements are usually made for a family member to be present at this time.

The need "to have visiting hours start on time" was also considered important or very important by 55% of the subjects, and was considered frequently or always met by 55% of these subjects. Since the patients in the ICU/NRU are in one large room, there is a tendency for the nursing staff to delay the visiting time for all patients when emergency procedures or treatments are being performed for any patient. While this practice frequently delays visiting time, the delay is usually only 5-15 minutes.

Seven visitation needs related to timing of the interactions were considered to be important or very important by less than 50% of the subjects. These needs were: (a) "to have the opportunity to have a visitor with me at night," (b) "to have the opportunity to have a visitor with me when the doctor visits," (c) "to have my visitors help with my physical care," and (d) "to have my visitors leave me

alone if I am asleep," (e) "to have the opportunity to have a visitor when I was in pain," (f) "to have the opportunity to have a visitor when I was resting," and (g) "to have the opportunity to have a visitor during tests, procedures, and treatments." It must be noted, however, that all of these needs were considered to be important or very important by at least three (15%) of the subjects. Younger subjects (20-35 years) considered the needs to have a visitor "when in pain," "while resting," and "during tests, procedures, and treatments" to be more important than older subjects (36-76 years).

From this data it appears that trauma patients perceive the need for visitors at different times. A visiting policy with a predetermined schedule cannot meet all trauma patients' perceived needs to be with their loved ones. The timing of visits must be individualized for each patient.

Significant-others Involved in the Interaction

The majority of subjects (60%) indicated a need to have visits from individuals outside of their immediate families. Forty-five percent of the subjects wanted to see close friends. Eleven subjects had children under the age of 14 years. Of these, 54% considered the need "to see my children" to be important or very important. Only one subject (9%) indicated that this need was frequently or always met. Three subjects absolutely did not want their children to see them while they were patients in the ICU/NRU. All three of these subjects had facial injuries (e.g. burns, lacerations, fractures). It is possible

that the types of injuries patients have influence their desires to see their children. For example, these same subjects who did not want to see their children may have indicated different needs if their injuries were not so obviously cosmetically disfiguring (e.g. ruptured spleen or liver).

Control of the Interaction

Fifty-five percent of the subjects indicated that the need "to be able to decide who should visit" was important or very important. Only 37% of these subjects considered this need to be frequently or always met. A possible explanation for this is that neither the staff nurse caring for the patient nor the lounge receptionist asks the patients in the ICU/NRU who they would like to have visit. It is the family members who determine who will visit. The patients must communicate their needs to their families, and the families must honor the patients' wishes.

Fifty-five percent of the subjects indicated that the need "to be able to refuse to see visitors whenever I want" was important or very important. These responses suggest that critically ill patients desire control over who visits. There does not seem to be a need for control per se, since the needs "to be able to decide the times of the visits" and "to be able to decide how many people should visit" were considered important or very important by only 35% of the subjects.

The need "to have a family member make decisions regarding visitation" was considered important or very important by 50% of the subjects.

It is conflicting that this need, and the need "to be able to decide who should visit" would both be considered so important by the subjects. In fact, of the 11 subjects who rated the need "to be able to decide who should visit" important or very important, five considered the need "to have family make decisions regarding visitation" to be important or very important! What were the subjects saying? Did they want to make the visitation decisions, or did they want their families to make these decisions?

Fifty-five percent of the subjects indicated that they were capable of making decisions regarding visitation. A few of the subjects who seemed very weak and apathetic during their interviews stated that they were capable of making visitation decisions. Conversely, a few subjects who seemed strong and very sure of their visitation needs indicated that they were not capable of making visitation decisions.

Limitations

The sample size was small and several variables that could be related to perceived visitation needs of trauma patients were not measured in this study. These variables included the patient's:

1. Marital status;
2. Socioeconomic status;
3. Relationships with family members;
4. Injuries and any residual disability;
5. Type of employment;
6. Injuries and their impact on the individual's employment status;

7. Prior methods of coping with stress;
8. Locus of control;
9. Personality type.

A major limitation was the inconsistent manner in which the visitation policy was implemented by the staff nurses. The data suggested that some nurses "broke the rules" and others did not. The investigator could not identify the subjects who had lenient nurses, or the effect of lenient nurses on the subjects' responses to the questionnaires. For example, one subject who was severely burned stated that the length and frequency of the visiting times were "just right," the present visiting policy met his needs "very well," and it was "not important" to have a visitor help with physical care. He later indicated that his wife was permitted to visit for approximately one hour at every meal time and to feed him. She also visited at the regular visiting times. Obviously, this subject was not saying that the present visiting policy of five visits per day for five minutes met his needs "very well," although it appeared that way in the data analysis.

Subjects might consider a need to be "not important" if the need was met. However, a need could have been met by the staff nurse when she allowed the visitation policy to be broken. If, on the other hand, the same need was not met by another nurse who cared for the subject and did not allow the policy to be broken, the subject might have considered the need to be "very important."

Subjects were unable to state whether a need which was "not important" was met. This caused considerable confusion and frustration during the interviews. Several different attempts at re-wording this question were unsuccessful. After the third subject was unable to answer this question, the investigator stopped asking if a need considered by the subjects to be "not important" was met. Subjects were only asked if "important" or "very important" needs were met. Subjects had no difficulty stating whether these needs were met.

To enhance patient recall, the decision was made to interview the patient within 48 hours of discharge from the ICU or NRU. It was assumed that the patient would be able to identify and communicate his or her visitation needs at that time. The patient could have been so stressed by the separation from significant-others that 48 hours was too early for the patient to be able to discuss it. Conversely, separation from family members could be such an insignificant problem that the patient "forget" it as soon as he/she left the ICU/NRU.

The intent of this study was to obtain information that could be generalized to all trauma patients in intensive care units. The majority of subjects, however, were from East Tennessee, Southern Kentucky, and Northern Georgia. It is possible that certain cultural characteristics influenced their visitation needs. No attempt was made to identify these characteristics and this limits the generalizability of these results to trauma patients in East Tennessee, Southern Kentucky, and Northern Georgia.

Implications For Practice

Roy (1976) stated that the goal of nursing is to manipulate focal and contextual stimuli to promote patients' adaptation. The focus of this study was on the external contextual stimuli of the separation of the patient from significant-others. The findings were so diverse that only one tentative conclusion can be made: a uniform, strictly enforced visitation policy cannot meet the needs of all trauma patients to see their loved ones. While one critically ill patient may perceive a need to make all the visitation decisions, another patient may not want to make such decisions. Some patients may desire long (or continuous) visits with significant-others, while others may desire shorter visits. Some patients may perceive a need to have visitors while they are in pain, while other patients may prefer to be alone if they are in pain.

Breu and Dracup (1978) instituted a visiting policy for critically ill patients in a CCU that instructed the nurse to "arrange flexible visiting hours that are agreeable to both the staff and spouse." In view of the findings from this study, this visiting policy might be changed for the trauma patient to state "arrange flexible visiting hours that are agreeable to both the staff and patient." The results of this study indicate that each trauma patient perceives different visitation needs. The nurse must involve trauma patients in visitation decision making if the patients' needs are to be met. If the trauma patient is able to communicate, the nurse could ask:

"Do you want to make decisions regarding visitation?" "Are you able to make these decisions?" "Are you able to tell your family members or loved ones to stop talking or leave the unit when you want to sleep or rest?" If the patient responds affirmatively to these questions, the nurse could ask the patient: "Who do you want to see?" "In what order?" "How long do you want to see them?" "When do you want to see them?" Once the nurse knows the answers to these questions, he/she is in a position to work "with" the patient, to make him/her a partner in his/her care. The relationship can then be based on respect and caring, rather than on a paternalistic attitude which suggests "I know what is best for you." This viewpoint is consistent with other nursing authors who have emphasized the importance of allowing patients in the intensive care setting to make decisions regarding visitation (Foster & Andreoli, 1970; Biddle, 1981; Breu, 1979; and Heater, 1985).

The nurse must make it clear, to both the patients and their families, that his/her primary concern is the patients' physical and psychological well-being (adaptation). If the patients become stressed or exhausted during visits, the nurse must intervene (manipulate the contextual stimuli). In the experience of Younger et al. (1984), family members follow recommendations to limit visitation, even when an "open" visitation policy is in effect.

When the nurse decides to limit visitation, he/she must be very sure that the problem he/she is trying to solve is related to visitation. The nurse's impressions should be validated by the patient

before decisions are made to extend or limit the visitation schedule. For example, a patient who is restrained because he/she is intubated may respond with restlessness and a tachycardia when his/her family members approach the bedside. The nurse could conclude that the stressor is the presence of the family members and decide to limit the length and frequency of visiting times. Upon closer investigation, however, the nurse could discover that the patient is frustrated because he/she cannot communicate with his/her loved ones. In this situation, the stressor is not the patient's family, but the patient's inability to communicate. Limiting the frequency or length of visiting times will not solve this problem, but providing pen and pencil may (personal conversation, Lynda Harrison, 1985).

Nurses should consider asking patients if they would like a family member to be present when updates about their physical condition are given. The nurse could invite a patient's family member into the ICU when the physician has finished examining the patient. The physician, family, patient, and nurse could then discuss the patient's prognosis and related matters of importance. The nurse could encourage the family member to remain with the patient after the physician leaves, thereby giving the patient an opportunity to clarify, validate, and integrate the information presented by the physician. Occasionally the nurse must deliver "good news" or "bad news" to the patient. He/she should remember that many patients perceive a need to share this information with a loved one and ask the patient if he/she would like a loved one to visit.

The residual stimuli examined in this study were the patient's age, length of stay in the ICU/NRU, and the ages of his/her children. Even though there was a significant correlation between these residual stimuli and certain visitation needs, the nurse must not make assumptions regarding these relationships in practice. The needs of each trauma patient are unique and require that the nurse include the patient in visitation decision making if the patient's needs are to be met.

Recommendations For Research

A number of recommendations for research concerning the trauma patient can be made based on this study. Most trauma patients should not be interviewed the day they are transferred from the ICU/NRU to a medical/surgical unit, especially if family members are asked to leave the room. The researcher should consider extending the time limitation on interviewing patients from 48 hours to 76 hours, or more. A few patients had difficulty organizing their thoughts, other patients seemed very weak, and most patients were unable to complete the questionnaire without assistance. This tended to be especially true for patients who were hospitalized longer than three days in the ICU/NRU. Interviews should not last longer than one hour. Some patients tired from the 20-40 minute interviews used in this study.

The following research questions were raised:

1. Do patients with different medical diagnoses have similar visitation needs?

2. Is there a relationship between certain patient characteristics (e.g. locus of control, personality type) and visitation needs?
3. Does an open visitation policy, with unlimited visitation, meet patients' visitation needs?
4. What criteria do nurses use to make decisions regarding extensions and limitations of visitation policies?
5. What effect does a visit to see a loved one in ICU have on young children?
6. Are critically ill patients able to make visitation decisions? Are their decisions valid?
7. What is the correlation between the perceived needs of patients and family members regarding visitation in the ICU?

Conclusions

The results of this study indicate that the perceived visitation needs vary greatly among trauma patients. It is clear that a strictly enforced uniform visitation policy does not meet all trauma patients' visitation needs.

The subjects indicated that the most important needs were "to have an opportunity to have a visitor with me when the doctor or nurse gave me bad news," "to have the opportunity to have a visitor with me when the doctor or nurse gave me good news," and "to have an opportunity to have a visitor with me during transfer to the floor." All eighteen visitation needs were considered important or very important by at least three subjects.

Only seven visitation needs which were rated by the subjects as important or very important were perceived as being met at least 50% or more of the time. These needs were: (a) "to have the opportunity to have a visitor with me during transfer to the floor," (b) "to be able to refuse to see visitors whenever I want," (c) "to have visiting hours start on time," (d) "to have a family member make decisions regarding visitation," (e) "to have my visitors help with my physical care," (f) "to have my visitors leave me alone if I am asleep," and (g) "to be able to decide how many people should visit."

Younger subjects perceived the following visitation needs as more important than did older subjects: (a) "to be able to decide how many people should visit," (b) "to have an opportunity to have a visitor with me during tests, procedures, and treatments," (c) "to have an opportunity to have a visitor with me when I was resting," and (d) "to have an opportunity to have a visitor with me when I was in pain." The patients' satisfaction with the present visiting policy in general and the length of each visiting time in particular tended to decrease as the patients' length of stay in the ICU/NRU increased.

The majority of subjects indicated that they perceived a need to see people outside their immediate family, primarily close friends. Also, the majority of subjects indicated that they were capable of making decisions regarding visitation.

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APPENDIXES

APPENDIX A

DATA COLLECTION TOOL

Data Collection Tool

Hosp # _____ Date _____ Age _____ Sex _____

Length of stay in ICU/NRU _____

Events surrounding incident _____

Diagnosis (blunt/penetrating) _____

Complications _____

Absence of head injury? _____

Hours since discharged from ICU _____

Ability to communicate verbally or in writing? _____

Oriented to person, place and time? _____

INTERVIEW:

Verbal/written (circle one)

Length of interview _____

Below is a list of visiting needs that you might have had while in the intensive care unit. Please rank how important each need was to you. Circle a "1" if the need was not important, a "2" if the need was slightly important, and so forth. Then for each need statement indicate whether or not the need was met by circling a "1" for not met, a "2" for occasionally met, and so forth. If you have any questions please ask.

Need	RANKING OF NEED				WAS NEED MET?			
	Not imp	Sli imp	Imp	Very imp	Not met	Occ met	Freq met	Alw met
6. To be able to decide who should visit	1	2	3	4	1	2	3	4
7. To be able to decide the times of the visits	1	2	3	4	1	2	3	4
8. To be able to decide how many people should visit	1	2	3	4	1	2	3	4
9. To see my children that are under the age of 14 (leave blank if you do not have children under 14)	1	2	3	4	1	2	3	4
10. To see people outside my immediate family	1	2	3	4	1	2	3	4
11. To have a family member make decisions regarding visitation	1	2	3	4	1	2	3	4
12. To have my visitors leave me alone if I am asleep	1	2	3	4	1	2	3	4
13. To have my visitor help with my physical care	1	2	3	4	1	2	3	4
14. To be able to refuse to see visitors whenever I want	1	2	3	4	1	2	3	4
15. To have visiting times start on time	1	2	3	4	1	2	3	4

Need	RANKING OF NEED				WAS NEED MET?			
	Not imp	Sli imp	Imp	Very imp	Not met	Occ met	Freq met	Alw met
To have the opportunity to have a visitor with me:								
16. at night	1	2	3	4	1	2	3	4
17. during tests, procedures, and treatments	1	2	3	4	1	2	3	4
18. when the doctor visits	1	2	3	4	1	2	3	4
19. when I was resting	1	2	3	4	1	2	3	4
20. when I was in pain	1	2	3	4	1	2	3	4
21. when the doctor or nurse gave me "bad news"	1	2	3	4	1	2	3	4
22. when the doctor or nurse gave me "good news"	1	2	3	4	1	2	3	4
23. during transfer to the floor	1	2	3	4	1	2	3	4
*24. the first few days in the unit	1	2	3	4	1	2	3	4
*25. the last few days in the unit	1	2	3	4	1	2	3	4

26. Can you think of any other time(s) that you wanted to see visitors?
If so, how important was it? Was your need met?
27. Can you think of any time(s) that you did not want to see visitors?
If so, how important was it? Was your need met?
28. Did you want to see anyone who is not a member of your immediate family? If so, who?
29. Do you think you were able to make decisions regarding visitation?
30. Tell me why it was or was not important for you to have visitors?
31. IF YOU WANTED TO SEE CHILDREN UNDER 14:
 - A. What are the ages of your children?
 - B. Do you feel your children would have been able to "handle" seeing you in the intensive care unit?
32. Describe what you would consider to be the ideal visiting policy.

- *33. Certain things happen to us in our lives that influence how much time we want to spend with our family and loved ones. I would like you to indicate if any of these things are happening to you or have happened to you in the last few months. Again, anything you say is confidential.
- a. _____ illness of a loved one
 - b. _____ death of a loved one
 - c. _____ marital difficulties
 - d. _____ girlfriend or boyfriend problems
 - e. _____ divorce (or divorce of your parents)
 - f. _____ problems getting along with your parents
 - g. _____ any other problems or situations you can think of that would influence how you feel about seeing visitors? If so, what?

Thank you very much for participating in this study.

*Although this information was collected, it was not analyzed for this study.

APPENDIX B

APPROVAL LETTER FROM THE UNIVERSITY
OF TENNESSEE

THE UNIVERSITY OF TENNESSEE, KNOXVILLE
KNOXVILLE 37996-0140

OFFICE OF THE VICE PROVOST
FOR RESEARCH

Research Compliance Coordination
974-7697

404 ANDY HOLT TOWER

AREA 815
TELEPHONE 974-3466

April 11, 1985

Jackie Kirby
9819 George Williams Road
Knoxville, TN 37922

Dear Ms. Kirby:

As Chairperson of the Committee on Research Participation I have reviewed your project, "Visitation Needs in the Intensive Care Unit as Perceived by the Trauma Patient," CRP #1623. The project qualified for expedited review and is approved. However, I would like to make the following suggestion to change the third paragraph of the informed consent form to make the wording clearer and nonthreatening/nonconfusing. When you have made this change or one similar please send a copy of the revised informed consent form to be placed in the CRP file.

"Information bearing your identity will be shared only with the research team of faculty members in the UTK College of Nursing. Your name will not be recorded on the data collection sheet and a coding system will hold your personal identity confidential. Future publications and reports will not identify individual respondents. All materials bearing your identity will be destroyed following analysis of the data."

Responsibilities of the investigator during the conduct of this project include the following:

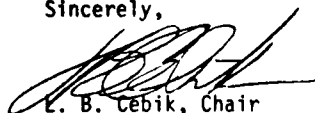
1. Obtain prior approval from the Committee before instituting any changes in the project.
2. Retain signed consent forms from subjects for at least three years following completion of the project.

Jackie Kirby
CRP#1623
April 11, 1985
Page 2

3. Submit a Form D to report termination, to renew approval, or to report changes in the project at 12-month or less intervals.

The Committee wishes you every success in your research endeavor.

Sincerely,



E. B. Cebik, Chair
Committee on Research Participation

cc: Dr. Thomas C. Collins, Vice Provost for Research
Dr. Sylvia E. Hart
Dr. Barbara M. Reid
Dr. Mildred Fenske

APPENDIX C

APPROVAL LETTER FROM THE UNIVERSITY OF TENNESSEE
MEMORIAL HOSPITAL AND RESEARCH CENTER



1924 Alcoa Highway • Knoxville, Tennessee 37920

M E M O R A N D U M

TO: Jackie M. Kirby, R.N.
UTK College of Nursing

FROM: Joseph E. Fuhr, Ph.D.
Chairman, Clinical Research Committee

DATE: April 16, 1985

RE: Research Project

Your submitted application entitled "Visitation Needs in the Intensive Care Unit as Perceived by the Trauma Patient" has been expeditiously reviewed and has received the chair approval. We remind you of the responsibility of reporting any untoward events in the project and seeking annual approval.

Best wishes for a successful project.

JEF:jlc

APPENDIX D

INFORMED CONSENT FORM

INFORMED CONSENT FORM

You are invited to participate in a study of individuals who have recently been patients in the intensive care unit. I hope to learn what the patient in the intensive care unit feels his or her visiting needs are. This study is being done by the investigator to partially fulfill requirements for a Master's degree at The University of Tennessee, Knoxville, College of Nursing.

If you decide to participate, the investigator will conduct a one time interview in your hospital room. This interview consists of approximately 30 questions and will take approximately 30 minutes. Your hospital chart will also be reviewed by the investigator for information such as age and diagnosis. Knowledge gained from this study will help nurses understand the needs of patients in the intensive care unit.

Information bearing your identity will be shared only with the research team of faculty members in the UTK College of Nursing. Your name will not be recorded on the data collection sheet and a coding system will hold your personal identity confidential. Future publications and reports will not identify individual respondents. All materials bearing your identity will be destroyed following analysis of the data.

Your decision about whether or not to participate in this study is entirely voluntary and will not affect the care you receive in the hospital. The only risk to you is the chance that you might become tired during the interview. You are free to stop the interview at any time.

If you have any questions about the study feel free to ask or call: Jackie Kirby 693-6759.

You may have a copy of this form to keep.

Your signature below indicates that you have decided to participate in a study on the visiting needs of the patient in the intensive care unit and have read the information provided above.

Signature of Patient

Date _____

Signature of Investigator

Date _____

- () Check here if you would like a summary of the results after the study is completed.

VITA

Jacqueline Mudge Kirby was born in Rockland, Maine on August 9, 1952. She graduated from Farragut High School in Knoxville, Tennessee in 1970. The following September she entered The University of Tennessee in Knoxville and was awarded a Bachelor of Science degree in Nursing in June, 1974.

Following graduation she was employed by The University of Tennessee Hospital and Research Center. From 1974 to 1976 she served as a staff nurse on a general medical unit. She then transferred to the intensive care unit, where she worked until she entered The Graduate School of The University of Tennessee, Knoxville, in June, 1984. She received the Master of Science Nursing degree in December, 1985.

The author is certified as a CCRN by the American Association of Critical Care Nurses. She is married to Rick L. Kirby and has one son.