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EXPECTATIONS OF PURPOSES AND FUNCTIONS OF INTENSIVE CARE
UNITS AS EXPRESSED BY IMMEDIATE FAMILY
MEMBERS OF PATIENTS

by

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ABSTRACT

The purposes of this study were (1) to identify for the nursing staff of intensive care units the expectations of the purpose and function of intensive care units held by immediate family members of patients within these units; (2) to identify for the nursing staff of intensive care units the feelings about such care units as expressed by immediate family members of patients within the units; and (3) to provide a tool to be used by staff members of intensive care units to further identify individual expectations of the purpose and function of intensive care units when it seems apparent that individual expectations are not being met.

The investigator interviewed fourteen immediate family members of patients admitted to the intensive care unit of two hospitals in Montana. The patient had been in the intensive care unit no less than two hours nor more than eighteen hours when the family member was interviewed. An eighteen question interview guide, constructed by the investigator, was used as the data collection tool.

The results of this study are not conclusive because of the limited sample. Family members experienced both relief and anxiety when the patient was admitted to the intensive care unit. Deviances between family expectations and actuality in intensive care units identified in this study were (1) the training of the nursing staff; (2) staffing patterns; (3) the basic preparation and education of the nursing staff; and (4) the presence or availability of a physician.

The tool devised to assist staff nurses in identifying specific expectations needs further evaluation to determine its effectiveness.

CHAPTER 1

INTRODUCTION

One sign of successful nursing is the establishment of the mutual confidence and respect between the nurse and the patient, his family and his friends. The patient's peace of mind, and consequently his physical condition is effected by the feeling of confidence his family shows in his medical and nursing attendants.¹

The patient and his family are members of both the professional health team and the nursing team. The success of any team is dependent on the desire to work with others towards a common goal. The patient and his health are the point of departure and the focus of all activities of the nursing team. Among the members there must be recognition, acceptance and understanding of the goal, knowledge of the capabilities and responsibilities of each member, and coordinated planning and evaluation of activities.² To the investigator this implies a mutual understanding of the

¹Bertha Harmer and Virginia Henderson, Textbook of the Principles and Practice of Nursing (New York: Macmillan Co., 1955), p. 105.

²Ruth H. Matheny, et al, Fundamentals of Patient Centered Nursing (St. Louis: C. V. Mosby Co., 1964), p. 22.

expectations of the purpose and function of intensive care units if this is the patient environment.

STATEMENT OF THE PROBLEM

The problem of this study was to investigate families of patients in intensive care units to determine:

1. Their expectations of the purpose of intensive care units.
2. Their expectations of the function of intensive care units.
3. Their feelings about intensive care units.

PURPOSE OF THE STUDY

The purposes of this study were:

1. To identify for the nursing staff of intensive care units the expectations of the purpose and function of intensive care units held by immediate family members of patients within these units.
2. To identify for the nursing staff of intensive care units the feelings about such care units as expressed by immediate family members of patients within the units.
3. To provide a tool that could be used by staff members of intensive care units to further identify individual expectations of the purpose and function of intensive

care units when it seems apparent that individual expectations are not being met.

ASSUMPTIONS

The assumptions underlying this study were:

1. Immediate family members of patients in intensive care units will have expectations of the purpose and function of intensive care units and of the personnel in these units.
2. Immediate family members of patients in intensive care units will have feelings about intensive care units.
3. Immediate family members will be able to communicate these expectations and feelings during an interview.

LIMITATIONS

The scope of this study was influenced by the following limitations:

1. The study was limited to the intensive care units of two selected general hospitals in Montana.
2. The number of admissions to the intensive care units during the data collection period.
3. Only one immediate family member of each patient was interviewed.
4. Interpretation of the responses was subject to the biases

of the investigator, even though every effort was directed toward an objective analysis of the data.

METHODOLOGY

For this non-experimental descriptive study an eighteen question structured interview (Appendix) was utilized. The interview guide was devised by the researcher with an attempt to elicit information from immediate family members of patients in intensive care units. Specifically this information was their feelings about intensive care units and their expectations of the purpose and function of intensive care units.

Family members of any patient admitted to the intensive care unit of two selected general hospitals in Montana were included in the study. The patients considered were admitted to the intensive care unit for any reason other than recovery purposes after the post anesthesia room was closed. The interview was conducted no earlier than two hours after admission to the intensive care unit and no later than eighteen hours after admission.

DEFINITION OF TERMS

The following terms were defined for the purpose of this study:

Intensive care unit (s)--a highly controlled environment especially designed to provide life saving and life sustaining supplies, equipment, and personnel resources³

Expectation--that which is looked or hoped for as likely to happen

Purpose--a result aimed towards by the intensive care unit; the reason for which an intensive care unit exists

Function--the activity of an intensive care unit that makes it unique from other care units

Feelings--a distinctive emotional tone such as fear, anger, hate, love

Immediate family member--spouse, parent, or child

JUSTIFICATION OF THE STUDY

When the feelings about intensive care units and family expectations of the purpose and function of intensive care units are not clearly understood, difficulty in communication between the family and the nursing staff can develop.

Gustav Ichheiser in Appearances and Realities states:

The way we feel about some things . . . influences not only our motives, ideas, and actions, but our

³Eleanor C. Lambertson, "The Nature and Objectives of Intensive Care Nursing," ed. Hattie Mildred McIntyre, The Nursing Clinics of North America, III, No.1 (Philadelphia: W. B. Saunders Co., 1968), p. 3.

perceptions as well. This means that the way we perceive the world . . . are the expressions, projections, manifestations of our emotions. The scientific realization that our emotions significantly determine and thus distort our perceptions seems to be comparatively new Not only do our emotions influence our perceptions but, in turn our perceptions evoke our emotions.⁴

Ichheiser continues by saying that of particular importance in this context is the fact that the law of the emotional conditioning of our perceptions applies also to our perceptions about other people and about ourselves. We believe that we simply see things "as they really are."

If members of two groups meet, both take it for granted that they themselves see the things, including themselves and each other, "as they really are." When they find that others see things differently, both reach the conclusion that it is the other fellow who is unable to see things "as they really are" and who has distorted conceptions about himself as well as about others. The final step which closes the cycle of the interpersonal misunderstanding consists in developing various defense mechanisms which serve the purpose of maintaining the belief in the validity of our own perception of reality by insisting that something is wrong with the others.⁵

⁴Gustav Ichheiser, Appearances and Realities (San Francisco: Jossey-Bass Inc., 1970). p. 124.

⁵Ibid., p. 125.

According to Arthur Comb's view, the behavior of a person is the direct result of his field of perception at the moment of his behaving. The three basic principles of this concept are: (1) how the individual sees himself; (2) how he sees the situation in which he is involved; (3) and the inter-relations of these two. In order for a nurse to communicate effectively with a patient or his family, it is necessary for her to understand the meaning derived from the first two principles and discover the relations between them. That is, the nurse needs to acquire an understanding of the other person's perceptual field before she can communicate effectively with him.⁶ Without this information about the family's perceptions and consequently the family's expectations, the nurse will be working blindly.

Kay Corman Kintzel in Advanced Concepts in Clinical Nursing states that a logical nursing objective would be the establishment and maintenance of meaningful communication with the patient and his family, reflecting an attitude of respect for the person and his emotional reactions and concerns.⁷

⁶Garland K. Lewis, Nurse-Patient Communication (Dubuque: Wm. C. Brown Co., 1969), p. 51.

⁷Kay Corman Kintzel, ed., Advanced Concepts in Clinical Nursing, (Philadelphia: J. B. Lippincott, Co., 1971), p. 69.

The intensive care unit nurse must remember that although only short periods of time may be available for quiet communication, the nurse-patient family relationship can be a strong one. Persons under considerable stress, both patients and their families, are seeking support in reducing emotional pressure.⁸

Because of a personal experience with a family whose expectations of the intensive care unit were probably not being met, and because of the apparent lack of published information concerning immediate family members and intensive care units, the investigator felt a need to explore family feelings and expectations of intensive care units.

⁸Ibid., p. 73.

CHAPTER 2

REVIEW OF LITERATURE

Patients have families: hospitals have patients: Therefore the hospital has something to do with the family.¹

Since World War II, medical educators and practitioners have become increasingly concerned over the relationship between family and medicine.² The need to consider home and family relationships in the promotion of health and in the etiology, treatment, and prevention of disease has been recognized by members of the medical, nursing and social welfare professions.³

Family life has been characterized as an arena of interacting personalities by John H. Mabrey in Families in Crisis. The family is the most intensive emotional unit of society. Each family has high and low emotional points which

¹Henry B. Richardson, "A Family as Seen in the Hospital," ed. Paul H. Glasser and Lois N. Glasser, Families in Crisis, (New York: Harper and Row, 1970), p. 222.

²John H. Mabrey, "Medicine and the Family," ed. Paul H. Glasser and Lois N. Glasser, Families in Crisis, (New York: Harper and Row, 1970), p. 241.

³Ibid., p. 242.

result from the pleasure and vicissitudes of living together. Thus the emotional atmosphere of the home reflects how well each person is able to do his part in helping the family function as a unit.⁴

Behavior patterns and attitudes in the home often interfere with efforts to treat illness or to promote good health. Not infrequently, there are difficulties in coordinating the goals of medicine with those of the family. Family patterns may not function effectively with treatment regimens, giving rise to the paradox that treatment is often thwarted by those for whom it is intended.⁵

The commonly held perception of the family is that of a sheltering, nurturing, and emotionally satisfying unit.⁶ Esther Lucille Brown in Newer Dimensions of Patient Care states that immediate members of the family often need attention and help almost as much as do many patients during the period of hospitalization or crisis.⁷

⁴Ibid., p. 242.

⁵Ibid., p. 243.

⁶Esther Lucille Brown, Newer Dimensions of Patient Care, Part I: The Use of the General Hospital for Therapeutic Purposes (New York: Russel Sage Foundation, 1961), p. 27.

⁷Ibid., p. 78.

When a person goes to a hospital, his admission has many meanings for him and his family, as discussed by Barbara Blackwood Kozier and Beverly Witter DuBos in Fundamentals of Patient Care. If he was ill at home his care and responsibility for it probably fell to his family. After he enters a hospital, the responsibility for his care is transferred to hospital personnel. This transfer of responsibility often produces emotions of relief and guilt on the part of the family. Relief because trained people will now provide professional care, and perhaps guilt because members of the family feel that the patient would be happier at home or that they have passed on responsibilities that they should be accepting as a family. These feelings are sometimes expressed in activities such as bringing food to the patient or by extreme criticism of personnel and the institution. If the needs of the family are recognized, the family will feel more comfortable in their new roles and be better able to meet their responsibilities.⁸

It therefore becomes the therapeutic task of the persons caring for patients to attempt to discover what his

⁸Barbara Blackwood Kozier and Beverly Witter DuBos, Fundamentals of Patient Care, (Philadelphia: W. B. Saunders Co., 1968), p. 29.

and his family's needs and expectations are and how they can be handled constructively.⁹

Most families realize that there can be no immediate solution to some of their problems, but there are forms of help they both desire and believe capable of achieving. Esther Lucille Brown includes the following nursing interventions: (1) recognition of the family as individual persons by the staff; (2) interest in and sympathetic understanding of their difficulties; and (3) assistance in making the hospitalization of the patient as non-frustrating as possible.¹⁰ The family wants a physical and social setting that reproduces some of the symbols of the things and associations that have long given them support and comfort.¹¹ They want particularly to be able to obtain information and counsel both about the patient's present condition and the extent to which he will recover or be handicapped in the future.¹²

A feature of the intensive care unit is its relative inaccessibility by the immediate family of the patient. The intensive care unit staff is removed from family contact

¹⁰Ibid., p. 18.

¹¹Ibid., p. 26.

¹²Ibid., p. 80.

because of the physical separation from the remainder of the hospital. Typically the family is allowed to visit only a few minutes at a time and at stated intervals. Typically the family is very concerned about the critically ill relative and alarmed at the sight of him. Only on successive visits, if the patient seems to be improving, are they more relaxed when in the intensive care unit.¹³

In the intensive care unit, the function of the nurse is chiefly to reassure (e.g. the machinery is for the patient's good; he is getting better) in the opinion of Anslem Strauss in "The Intensive Care Unit: Its Characteristics and Social Problems." Nurses coach the family members in proper ways to behave in such restricted environments and in the presence of very ill patients. Nurses act as time keepers, announcing the end of a visiting period. Nurses learn or devise various tactics for handling these events to minimize inconvenience to themselves and interference with their work.¹⁴ If family management and attempting to meet

¹³Anslem Strauss, "The Intensive Care Unit: Its Characteristics and Social Problems," ed. Hattie Mildred McIntyre, The Nursing Clinics of North America, III, No. 1, (Philadelphia: W. B. Saunders Co., 1968), p. 12.

¹⁴Ibid., p. 12.

family needs is regarded as "nursing care", families of patients in intensive care units generally do not get much good nursing care.¹⁵

The primary purpose of an intensive care unit is to provide high level nursing care for patients who require continuous, comprehensive observation and detailed intensive care in an atmosphere of compassion and understanding.¹⁶ The nursing team in the intensive care unit is gradually becoming aware of the emotional impact on the patient who is critically ill. However, because intensive care units are a relatively new specialty area, current literature still focuses upon its technical dimensions, such as the design of the unit, who should staff it, ways of monitoring patients, and the use of equipment. Relatively little is being written about the patient and his needs.¹⁷ Literature about the family and its role, needs and expectations is even less available.

In a systematic review of medical and nursing periodicals and books, some acknowledgement of the family is

¹⁵Ibid., p. 13.

¹⁶Lambertson, op. cit., p. 3.

¹⁷Sharon Roberts, "The Patient's Adaptation to the Coronary Care Unit," Nursing Forum, IX, No. 1. (1970), p. 57.

being made. Meltzer, Pinneo and Kitchell state

. . . the nurse should give a general description of the unit and its purpose to the family . . .¹⁸

In the Canadian Nurse, Pat Wallace states

. . . there is a need to prepare relatives of patients in the intensive care unit beforehand for what they will encounter . . . they deserve some knowledge of what to expect on entering an intensive care area.¹⁹

This is preparation of the family for what they might expect to see but it is not an input for the nursing staff regarding expectations of the purpose and function of the intensive care unit that the family may have.

SUMMARY:

Review of the literature indicates that patients and their families are interacting groups. What affects one does affect the other and has implications for the nursing profession. Nurses need to be alert to cues from the family that will assist them in caring for the critically ill patient in the intensive care unit.

¹⁸Lawrence E. Meltzer, M. D., Rose Pinneo, R.N., M. S., J. Roderick Kitchell, M. D., Intensive Coronary Care: A Manual for Nurses, (Philadelphia: Charles Press, 1968), p. 89.

¹⁹Pat Wallace, "Relatives Should be Told About Intensive Care--But How Much and by Whom?" The Canadian Nurse, (June, 1971), p. 33-34.

CHAPTER 3

METHODOLOGY

THE PROBLEM

The problem of this study was to investigate families of patients in intensive care units to determine:

1. Their expectations of the purpose of intensive care units.
2. Their expectations of the function of intensive care units.
3. Their feelings about intensive care units.

EXPERIMENTAL DESIGN

A non-experimental design was selected for use by the investigator because independent variables could not be manipulated nor could any number of extraneous variables be controlled. As Abdellah and Levine point out, the non-experimental design is especially suited to studies about human beings, "since description implies natural observation of the characteristics of the research subjects without deliberate manipulation of the variables or control over the research setting."¹

¹Faye G. Abdellah and Eugene Levine, Better Patient Care Through Nursing Research, (New York: Macmillan Co., 1963), p. 140.

Independent variables considered but not controlled or manipulated included: the age of the patient in the intensive care unit and the age of the immediate family member interviewed; the relationship, both legal and emotional, of the patient and immediate family member; the socioeconomic status of the family member interviewed; previous exposure to an intensive care unit; severity of the condition of the patient in the intensive care unit; the time of admission to the intensive care unit; activity of the immediate family member between the time of admission and the time of the interview.

THE SAMPLE SOURCE

The intensive care units of two selected general hospitals in different geographical locations in Montana were utilized. The intensive care units were a four bed and a nine bed unit accepting both medical and surgical patients. The four bed unit was a specific area of the hospital designed and constructed for the purpose of an intensive care area. It consisted of four sound proofed, glass-enclosed, private rooms within a large area. All patients could be visually monitored from a central nursing station. The nine bed unit was a segregated section of a general care area. It consisted of a three-bed ward and three semi-private

rooms. The nursing station was located in the three bed ward. Visual monitoring of the three semi-private rooms was not possible from the nursing station.

THE SAMPLE

To insure a random selection, blocks of time one week in length were established and each admission to the intensive care unit in the time period was included. The intensive care unit of each hospital was used for two weeks. A total of four blocks or weeks was utilized. Patients in the intensive care unit at the beginning of the data collection period were not considered. There was a total of nineteen admissions to the intensive care units during the data collection periods.

The nineteen patients admitted to the intensive care unit were admitted for any reason other than recovery purposes after the post anesthesia room was closed. An immediate family member of each of fourteen patients was interviewed for the purposes of this study. The remaining five patients were excluded because of unwillingness of the family to participate in the study or lack of availability of the family. This gave the investigator a total of fourteen subjects.

THE INTERVIEW

The approach to each family member was the same. The investigator introduced herself as a graduate student in nursing at Montana State University and with the aid of a face sheet (sample in Appendix) explained the purpose of the study and asked the cooperation of the interviewee. All the interviews were conducted with the investigator wearing a white uniform in a conference room close to the intensive care unit area. Only the family member and the investigator were present. Each question was read as written with no attempt to further clarify or interpret. Each response was recorded verbatim with no attempt to interpret at that time. The interviews lasted from twenty-five to forty minutes.

The interviews were conducted no earlier than two hours after the patient was admitted to the intensive care unit and no later than eighteen hours after admission. In selecting this period of time, the investigator allowed for some family adjustment to the new environment but not a complete resolution of the probable crisis situation. Little and Carnevali's criteria for timing of interviewing for nursing histories was considered. The criteria were: (1) the information should be obtained soon after admission so it can be utilized, and (2) the ability of the family member to

respond verbally and appropriately and the willingness to respond needs to be considered.²

THE INTERVIEW GUIDE

An eighteen question structured interview guide (sample in Appendix) was devised by the investigator as an attempt to elicit information from immediate family members of patients in intensive care units. The information collected was an expression of their feelings about intensive care units and their expectations of the purpose and function of intensive care units. A pilot study to test the tool was conducted using three subjects. One question was added and four reworded. The tool was then found acceptable to the investigator for purposes of data collection.

DEVELOPMENT OF THE INTERVIEW GUIDE

The interview guide was comprised of eighteen open form type questions. The first question, "Have you ever had a relative or close friend in an intensive care unit before _____ was admitted?", was to determine if the family member had had any previous experience with an intensive care unit. The investigator felt that previous knowledge

²Dolores E. Little and Doris L. Carnevali, Nursing Care Planning, (Philadelphia: J. B. Lippincott Co., 1969), pp.

of intensive care units could alter the expectations of the family member. The second question, "When did you first learn that _____ would be admitted to the intensive care unit?", and the third question, "Did you suspect before this time that _____ would probably be in the intensive care unit?", were asked to determine if the patient's admission to the intensive care unit was a planned or emergency admission. The investigator felt if it were a planned admission (e.g. admission after extensive surgery), the family member could have made himself familiar with the intensive care unit and the nursing staff. The fourth question, "Can you describe what you felt when you first heard that _____ would be admitted to the intensive care unit?", and the fifth question, "Has this feeling changed at all since that time?" and "In what way?", were to elicit information about the family member's feelings about the intensive care unit.

Questions six through ten were designed to determine the family member's knowledge of intensive care units. These questions were:

6. From your point of view, what kind of patients are admitted to the intensive care unit?
7. Can you say why you think the patients are admitted to

the intensive care unit rather than the general ward?

8. To your knowledge, have the people who work in the intensive care unit had any extra or special education or training?
9. Can you tell me how many people you think work in the intensive care unit on each shift in relationship to the number of patients?
10. Are all the nurses who work in the intensive care unit Registered Nurses?
Do licensed practical nurse ever work in the intensive care unit?
Do nurse aides ever work in the intensive care unit?
Did you expect a physician to be present within the intensive care unit at all times?

Questions eleven through seventeen were designed to elicit the family member's expectations of the purpose and function of intensive care units. These questions were:

11. How would you describe the people you would like to see working in the intensive care unit and caring for _____?
12. Do you think the care that _____ received in the intensive care unit might be different than the care on the general ward?
13. What do you think might differ in the equipment used in

the intensive care unit than that used on the general ward?

14. How do you think the medical treatments used in the intensive care unit might differ from those used on the general ward?
15. Do you think the patient in the intensive care unit might be treated differently by the people working there than by those working on the general ward?
16. What do you as relative expect from the people who work in the intensive care unit?
17. When you wish information about _____'s condition, to whom do you go?

Question eighteen, "What suggestions do you have for the people who work in the intensive care unit that could make things easier for other people who might find themselves in the situation that you are in today?", was asked to elicit the family member's needs. Family members have needs of their own that may have been delayed or rejected since the critical event. They need support in realistically evaluating and meeting these needs.³

³Janet M. Lee, "Emotional Reactions to Trauma," ed. Janet Pinnegan Carrol, The Nursing Clinics of North America, V., No. 4. (Philadelphia: W. B. Saunders Co., 1970), p. 587.

CHAPTER 4

ANALYSIS OF DATA

This study was an attempt to determine the expectations of the purpose and the function of intensive care units. The expectations solicited were those of immediate family members of fourteen patients admitted to the intensive care units of two selected general hospitals in Montana. The expectations were elicited from an immediate family member during interviews using an eighteen question structured interview guide. The interview was done no sooner than two hours after the patient was admitted to the intensive care unit and no later than eighteen hours after admission.

Nineteen patients were admitted to the intensive care units during the data collection periods. Fourteen immediate family members of these patients were included in the study.

Table 1

Family Member Interviewed	
Husband	4
Wife	6
Son	1
Daughter	2
Mother	1
Total	<u>14</u>

Six wives and four husbands were interviewed. Two daughters and one son were included in the study as well as one mother. One daughter was a health professional.

RESPONSES TO THE QUESTIONS

Question 1: Have you ever had a relative or close friend in an intensive care unit before _____ was admitted? If yes, who? In what hospital?

Table 2

Previous Exposure to the Intensive Care Unit	
Yes	6
No	8

Eight family members had not had any previous experience with a friend or relative being hospitalized in an intensive care unit. Five of those interviewed had had a relative in an intensive care unit prior to the current admission. One had visited a friend in the intensive care unit. Of the six with previous experience with intensive care units, four were involved with the same intensive care unit. One had had another daughter in an intensive care unit in a university hospital. One family member had had a sister in an intensive care unit in another city in Montana.

The investigator thought that previous experience with an intensive care unit could alter the expectations of the family member. When the responses of the six family members with previous experience in intensive care units were analyzed separately, the trends were similar to those without experience so will not be dealt with separately.

Question 2: When did you first learn that _____ would be admitted to the intensive care unit?

All fourteen family members interviewed learned of the patient's admission to the intensive care unit at the time of admission. There was no opportunity to acquaint themselves with the facility or the nursing staff before the patient was admitted. Four of those interviewed, however, did know the facility and some of the nursing staff because of previous experience with the intensive care unit.

The investigator thought that if the family had an opportunity to adapt to the environment of the special care area prior to the patient's admission, feelings and expectations might be different.

Question 3: Did you suspect before this time that _____
would probably be in the intensive care unit?

Table 3

Anticipation of Admission to the Intensive Care Unit	
Yes	6
No	8

Six family members interviewed thought the patient would be admitted to the intensive care unit. These patients all became ill at home with chest pain or difficulty with breathing. Of these six, one family member was hoping the doctor would put the patient in the intensive care unit. Eight family members responded "no" to this question. Two of the patients were admitted following surgery that was more extensive than anticipated. Two of the patients were admitted to the intensive care unit for observation following automobile accidents.

Question 4: Can you describe what you felt when you first heard that _____ would be admitted to the intensive care unit?

Table 4

Feelings About Admission to the Intensive Care Unit	
Relief	7
Anxiety	6
Indifference	1

Of the fourteen family members, seven were relieved when they learned the patient would be admitted to the intensive care unit. Six stated they were frightened or had some anxiety about the admission to the unit. Two of these stated the fear was relieved almost immediately when it was evident the patient would be observed more closely. One family member stated that he felt no different about this admission than several other admissions by the patient.

With only four family members expressing some prolonged anxiety about the patient's admission to the intensive care unit, the investigator speculated about the reasons for less anxiety about the other ten patients admitted.

These were:

1. The family thought the patient's condition was not critical

2. The orientation of the family to the intensive care unit was thorough
3. The family member was able to obtain information about the patient's condition
4. The family member was receiving support from the nursing staff

Question 5: Has this feeling changed at all since that time? If yes, would you describe in what way this feeling has changed?

Table 5

Changes in Feelings About Admission to the Intensive Care Unit	
Yes	4
No	10

The ten family members who responded "no" to this question were the family members who stated they were relieved when the patient was admitted to the intensive care unit. Of the four who responded "yes, the feeling has changed," all expressed relief and security in knowing the patient was "receiving the best possible care."

The investigator interpreted this "relief as an expression of a need being met. The nursing staff was

apparently supporting these family members and instilling confidence in the staff.

Question 6: From your point of view, what kind of patients are admitted to the intensive care unit?

The common answer that nine of the family members gave was "those who are critically ill." Other responses included:

1. Those who need special attention
2. Those who need monitoring
3. Those requiring respirators
4. Heart patients
5. Those having extensive surgery

It was not possible to interpret the family members' definitions of "critically ill." The response to this question was apparently oriented to the patient's diagnosis and that of other patients present in the unit at the time of the interview. The investigator could not determine if the family member had any knowledge about the type of patient the health professional would consider a candidate for the intensive care unit.

Question 7: Can you say why you think the patients are admitted to the intensive care unit rather than the general ward?

The fourteen family members' responses were varied but contained some common elements. Only one family member stated she thought the patient was admitted to the intensive care unit because "he is dying. They put dying people in here." One respondent said he really did not know why the patient would be admitted to the intensive care unit rather than the general ward unless it was more convenient for the staff. The remaining twelve respondents had the following comments to offer:

1. The arrangement makes it possible to observe the patient at all times
2. Equipment is readily available
3. The staff is specially trained for caring for critically ill patients
4. The monitors

Patients with life threatening illnesses are commonly placed in intensive care units.¹ Current media (e.g. television; women's monthly periodicals) seems to stress this

¹N. H. Cassem, et al, "Reactions of Coronary Patients to the CCU Nurse," American Journal of Nursing, LXX, No. 2, (February, 1970), p. 319.

and the investigator thought more family members would identify this point.

Question 8: To your knowledge, have the people who work in the intensive care unit had any extra or special training or education?

Table 6

Knowledge of Special Education of Staff	
Yes	12
No	2

Twelve of the family members thought the staff members, particularly the registered professional nurses, had received special training or education prior to working in the intensive care unit. Two family members stated they did not know if the staff had special training, but thought not.

The emphasis today in treatment in intensive care units is early detection of complications and prompt control, using specially qualified nurses and other highly trained hospital personnel. The nurse in the unit is trained to give artificial ventilation and external cardiac

massage. She must know how to use other specialized equipment.²

Question 9: Can you tell me how many people you think work in the intensive care unit on each shift in relationship to the number of patients?

Table 7

Staff-Patient Ratio	
I don't know	3
1 nurse to 1 patient	3
variable	5
2 per shift	2
6 per shift	1

A variety of responses was obtained from this question. Three family members stated they did not know how many people staffed the intensive care unit in relationship to the number of patients. Three stated they thought there was one nurse for each patient. Two family members interviewed thought the nurse-patient ratio was variable, depending on the needs of the individual patients in the unit.

These responses indicated to the investigator that a difference in actuality and expectations might occur

²Maurice S. Rawlings, "Trends in Therapeutic Management," American Journal of Nursing, LXVII, No. 11, (November, 1967), p. 2321.

because of staffing patterns. In the two intensive care units used in this study, staffing was variable, but generally less than what the family members anticipated. For optimum effectiveness one nurse should be responsible for only two or perhaps three patients.³

Question 10: Are all the nurses who work in the intensive care unit registered nurses?

Do licensed practical nurses ever work in the intensive care unit?

Do nurse aides ever work in the intensive care unit?

Did you expect a physician to be present within the intensive care unit at all times?

Table 8

Staffing of the Intensive Care Unit			
	I don't know	Yes	No
Only Registered Nurses	3	4	7
Licensed Practical Nurses	2	8	4
Nurse aides	2	4	8
Physician always present		1	13

Four family members thought only registered nurses worked in the intensive care units. Seven family members thought others worked in the intensive care unit to assist

³Meltzer, op. cit., p. 49

the registered professional nurse. Eight family members named the nursing assistants as licensed practical nurses and not nurse aides.

Only one family member expected a physician to be present within the intensive care unit at all times. It is interesting to note that this family member was the individual with experience with an intensive care unit in a large university teaching hospital. Of the thirteen who responded "no" to this question, three qualified their responses by stating "but one is readily available."

In the opinion of Meltzer, Pinneo, and Kitchell, hospital should refrain from using licensed practical nurses in the intensive care unit. "The professional nurse at the bedside is invaluable for repeated clinical observations and for the patient's feeling of security."⁴ Both intensive care units utilized non-professional assistants.

In neither unit was a physician physically present at all times nor "readily available" as indicated. The investigator anticipates a departure from actuality and expectation in regard to this. Clarification would be most important for all family members in the event of a crisis with the patient.

⁴Ibid., p. 50.

Question 11: How would you describe the people you would like to see working in the intensive care unit and caring for _____?

All fourteen family members interviewed responded in a similar manner. They gave the following qualities:

1. Specially trained
2. Personally interested in the care of patients
3. Conscientious
4. Competent
5. Friendly
6. Pleasant
7. Helpful to the family

"Personally interested in the care of the patient" was given by six of the family members interviewed.

In addition to these qualities, Meltzer, Pinneo, and Kitchell suggested intelligence, emotional stability, and social maturity.⁵

⁵Ibid., p. 50-52

Question 12: Do you think the care that _____ receives in the intensive care unit might be different than the care on the general ward? If yes, explain how it might differ.

The fourteen family members interviewed answered "yes" to the question. They expected the following differences:

1. Mechanical monitoring
2. Closer observation
3. Better and more modern equipment
4. Specially trained staff

Rose Pinneo discusses the care given in intensive care units in the February, 1965, American Journal of Nursing. She says nursing care focuses on the individual patient and seeks to identify and meet his psychological and physical needs.⁶ This was not identified by family members and might have implications for the nursing staff.

⁶Rose Pinneo, "Nursing in a Coronary Care Unit," American Journal of Nursing, LXV, No. 2, (February, 1965), p. 77.

Question 13: What do you think might differ in the equipment used in the intensive care unit than that used on the general ward?

The fourteen family members offered the following differences during the interview:

1. Monitors and defibrillator
2. Suction equipment
3. Complicated equipment
4. Respirators

One family member stated he knew the monitoring equipment was utilized in the intensive care unit, but felt it could be satisfactorily used on the general ward.

In certain instances all the equipment generally found and used in the intensive care unit is used on the general ward. For economy of time and personnel, however, it is concentrated within the intensive care unit.

Question 14: How do you think the medical treatments used in the intensive care unit might differ from those used on the general ward?

Two family members felt the treatment would not differ. Two family members stated they did not know how the treatment would differ in the intensive care unit compared to that on the general ward. The remaining ten family members gave the following differences:

1. The care cardiac patients receive
2. Nurses give emergency treatment without the doctor being there
3. It is more complicated

These expectations are essentially the differences suggested by Maurice S. Rawlings in Trends in Therapeutic Management.⁷

⁷Rawlings, op. cit., p. 2321-2328.

Question 15: Do you think the patient in the intensive care unit might be treated differently by the people working there than by those working on the general ward? If yes, can you explain this difference?

Table 9

Difference in Treatment by Staff	
Yes	12
No	2

Twelve of the respondents thought the patient in the intensive care unit would be treated differently by the people working there while two replied "no." The differences in the care they expected included:

1. Care would be more personalized
2. Closer observation
3. More compassion

David E. Sobel in Personalization on the Coronary Care Unit says the nurse is the most important person responsible for the patient's emotional well-being while the patient is in the intensive care unit. The nurses' efforts toward personalization are particularly significant.⁸

⁸David E. Sobel, "Personalization on the Coronary Care Unit," American Journal of Nursing, LXLX, No. 7, (July, 1969), p. 1439-1442.

These responses raise a question in the mind of the investigator. Do the patient and his family not expect personalization and compassion in the general care area, and if not, why?

Question 16: What do you as a relative expect from the people who work in the intensive care unit?

One family member expressed the feeling that she wished the staff to be kind and considerate of her but to remember the patient comes first. The other thirteen respondents included the following considerations:

1. The care the patient receives should reflect the expertise of the staff
2. The best available medical and personal treatment
3. Close and continual observation
4. Continuation of the present high caliber of care

These comments are an expansion of Esther Lucille Brown's nursing interventions for the family: (1) recognition of the family as individual persons by the staff; (2) interest in and sympathetic understanding of their difficulties; and (3) assistance in making the hospitalization of the patient as non-frustrating as possible.⁹

⁹Brown, op. cit., p. 18.

Question 17: When you wish information about _____'s condition and progress, to whom do you go?

Table 10

Source of Information About Condition of Patient	
Nurse	5
Doctor	9

Five of the family members would question the nurse about the patient's condition. Nine family members interviewed would seek information concerning the condition and progress of the patient from the physician.

The family needs to be able to obtain information and counsel about the patient's condition.¹⁰ Traditionally, only physicians give this information. This also raises a question in the mind of the investigator. As the family becomes more secure and comfortable with the environment of the intensive care unit, will they request more information from the nurse concerning the patient? Nurses see education of the patient and his family as their role and within their realm.

¹⁰Ibid., p. 80.

Question 18: What suggestions do you have for the people who work in the intensive care unit that could make things easier for other people who might find themselves in the situation you are in today?

Only one family member interviewed had a suggestion for the staff members. This was "more and more explanation of what they are doing, and why, and what to expect as things change." The remaining thirteen family members' comments included:

1. I don't have any
2. Continue with the consideration and courtesy shown
me
3. Keep up the good work

TOOL

One of the purposes of this study was to provide a tool to be used by the nursing staff to identify specific expectations. The tool (sample in the Appendix) was developed from the responses of the family members and from the interview guide. It needs further evaluation to determine its effectiveness.

The tool developed by the investigator for data collection also needs further evaluation. The investigator

thinks the family members interviewed might have other expectations and suggestions not offered. A variation of the "Hawthorne Effect" is possibly evident in the results. The Hawthorne Effect is defined as:

. . . a term used to describe the way people who are put in a specialized research setting tend to respond psychologically to the conditions of the study. The psychological reaction to the study conditions can be mistaken for the effect of the explanatory independent variable manipulated by the experimenter¹¹ and can lead to spurious inferences¹¹

It raises a question in the mind of the investigator, "Did the family respond in the manner they thought the investigator wished?" If true, a similar effect might be found in responses to the tool developed for use by the nursing staff.

¹¹Abdellah, op. cit., p. 702.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

The purposes of this study were primarily:

1. To identify for the nursing staff of intensive care units the expectations of the purpose and function of intensive care units held by immediate family members of patients within these units.
2. To identify for the nursing staff of intensive care units the feelings about such care units as expressed by immediate family members of patients within the units.

A third purpose was to provide a tool to be used by staff members of intensive care units to further identify individual expectations of the purpose and function of intensive care units when it seems apparent that individual expectations are not being met.

The sample used in this study consisted of the immediate family members of fourteen patients admitted to the intensive care units of two selected general hospitals in Montana. The expectations of the purpose and function of intensive care units were elicited from the immediate family member during the interviews using an eighteen question structured interview guide. The interviews were

conducted no sooner than two hours after the patient was admitted to the intensive care unit and no later than eighteen hours after admission.

Family members experienced both relief and anxiety when the patient was admitted to the intensive care unit. The anxiety was alleviated when the family became aware of the environment. Families with previous experience with an intensive care unit are generally relieved when the patient is admitted to the intensive care unit.

The expectations of these family members were fulfilled in most instances. Points of departure between expectations and actualities that the staff might anticipate and clarify are:

1. The special training of the nursing staff
2. The basic preparation and education of the nursing staff (e.g. registered nurse; licensed practical nurse; nurse aide)
4. The presence or availability of a physician

Family members apparently do not seek information about the patient's condition and progress from the nursing staff unless all attempts to reach the physician fail.

The tool devised to assist staff nurses in identifying specific expectations needs further evaluation to determine its effectiveness.

CONCLUSIONS

Generalizations cannot be made from the findings of the study because of the limited sample. Some trends are apparent, however, that have implications for the nursing staff of intensive care units.

When it is known that a patient will be admitted to the intensive care unit, the staff should introduce the family to the environment and the nursing staff. The nursing staff needs to be sensitive to any anxieties the family might express, both verbally and non-verbally, and assist the family in dealing with these anxieties.

Possible points of departure between expectations and actualities need to be clarified for the family. This needs to be done as soon as possible after the patient is admitted and made comfortable to enhance family-staff communication patterns.

The family needs to be encouraged to question the nursing staff about the patient's condition and progress. In turn, the staff needs to be encouraged to be candid in giving information to the family, with the wishes of the physician in mind.

RECOMMENDATIONS

1. A similar study could be done using either a coronary intensive care unit or patients with a specific diagnosis hospitalized in intensive care units to determine specific expectations of the purpose and function of the special care area.
2. The study could be replicated using more intensive care units and enlarging the population. Such a study might identify expectations that could not be met or should not be met.
3. A similar study could be done at a later period in the hospitalization, comparing initial expectations and feelings with later expectations and feelings and determining the cause in the alteration if changes are evident.
4. A study could be done to determine how family members view their roles as family with a family member in the intensive care unit.
5. The tool could be utilized by the nursing staff of intensive care units to determine its value and effectiveness in identifying a specific expectations and feelings.
6. Nurses need to identify for family members the purposes and functions of each individual intensive care unit to

more closely correlate actuality and expectations. This could be done on an individual basis or if time does not allow, a printed pamphlet could be provided. This would need to expand upon the usual printed literature concerning visitors, visiting hours, flowers, etc.

7. Inservice education programs should be devised to educate all nurses about the concepts of anxiety and to assist her in understanding means of alleviating anxiety.

APPENDIX

FACE SHEET

_____, I'm Karen Eickhoff, a graduate student in nursing at Montana State Univesity. I'm very interested in caring for people who spend part of their hospital stay in an intensive care unit. Families are also of concern to those of us who work in intensive care units because patients have families.

I would like to talk with you for a while and ask you some questions. Hopefully the information we can share will make things a little easier for you and perhaps someone else who finds themselves in your position.

The things we talk about will be used in a study but your name and _____'s won't be used at any time.

Do you have any objections to talking with me?

Time of Patient's admission to the unit:

Time of interview:

Place of interview:

Relationship to patient:

Length of interview:

INTERVIEW GUIDE

1. Have you ever had a relative or close friend in an intensive care unit before _____ was admitted.
If yes, who?
In what hospital?
2. When did you first learn that _____ would be admitted to the intensive care unit?
3. Did you suspect before this time that _____ would probably be in the intensive care unit?
4. Can you describe what you felt when you first heard that _____ would be admitted to the intensive care unit?
5. Has this feeling changed at all since that time?
If yes, would you describe in what way this feeling has changed?
6. From your point of view, what kind of patients are admitted to the intensive care unit?
7. Can you say why you think the patients are admitted to the intensive care unit rather than the general ward?
8. To your knowledge have the people who work in the intensive care unit had any extra or special education or training?

9. Can you tell me how many people you think work in the intensive care unit on each shift in relationship to the number of patients?
10. Are all the nurses who work in the intensive care unit registered nurses?
Do licensed practical nurses ever work in the intensive care unit?
Do nurse aides ever work in the intensive care unit?
Did you expect a physician to be present within the intensive care unit at all times?
11. How would you describe the people you would like to see working in the intensive care unit and caring for _____?
12. Do you think the care that _____ receives in the intensive care unit might be different than the care on the general ward?
Can you explain how it might differ?
13. What do you think might differ in the equipment used in the intensive care unit than that used on the general ward?
14. How do you think the medical treatments used in the intensive care unit might differ from those used on the general ward?

15. Do you think the patient in the intensive care unit might be treated differently by the people working there than by those working on the general ward?
Can you explain this difference?
16. What do you as a relative expect from the people who work in the intensive care unit?
17. When you wish information about _____'s condition and progress, to whom do you go?
18. What suggestions do you have for the people who work in the intensive care unit that could make things easier for other people who might find themselves in the situation that you are in today?

TOOL

This is a tool devised from interviews with family members of patients in intensive care units to assist you in determining what family members expect from you as a staff member and from your intensive care unit.

Initially assess if the family has had any experience with intensive care units. If they have; "In what hospital?" and determine if it was a positive or negative experience. Previous experience can and will color their feelings about and expectations of you and the intensive care unit.

The following questions can be used as a questionnaire or in an interview to assist you in identifying areas where the family's expectations are not congruent with what will be found in your unit. These differences between expectations and actuality must be clarified to promote and maintain communication between the patient and his family. Effective communication is vital to effective nursing.

1. From your point of view, what kind of patients are admitted to the intensive care unit?
2. Can you say why you think the patient is admitted to the intensive care unit rather than the general ward?

3. To your knowledge, have the people who work in the intensive care unit had any extra or special training?
4. How many people do you think work in the intensive care unit on each shift in relationship to the number of patients?
5. Are all the nurses who work in the intensive care unit registered nurses?
6. Do you expect a physician to be present within the intensive care unit?
7. How do you think the care that the patient receives in the intensive care unit might differ from that in the general ward?
8. What do you, as a relative, expect from the people who work in the intensive care unit?

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