Visitation needs of families who have a member as a patient in a critical care unit
by Susan Diane Simmons

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
Visiting policies were initially established for the critical care unit, with the purpose of providing rest for the critically ill patient; however, evaluation of these policies has not taken place. Additionally, visitation restrictions have been established and enforced with little input from the families of patients in these units. Therefore, the purpose of this descriptive study was to determine the visitation needs of families who had a family member hospitalized in a critical care unit. A questionnaire was used to ascertain visitation needs of families. The sample consisted of 1 participant from 30 different families who had a member hospitalized in a critical care unit. The study was conducted in a rural hospital in the southeastern United States from November 1987 through February 1988.

This study findings suggest that the emotional aspects of family visitation ranked most important to family members. Statements related to visitation frequency ranked next in importance. The family member's perceived severity of illness affecting the hospitalized relative was found to significantly influence visitation needs pertaining to visiting whenever the family member wanted and having visiting hours start on time. Demographic variables were also noted to influence visitation needs.

Open-ended questions concerning specific visitation times and frequencies revealed a variety of responses.

Nearly all participants wanted to be able to visit 7 days a week. Family members also want to be able to see their relative from 3 to 5 times per day, or as needed; and to spend from 10 or 30 minutes at a time with the relative.

Visitation policies need to be developed with the entire family system in mind. The nurse can be instrumental in maintaining family unity during the hospitalization of seriously ill patients. The critical care nurse is in an optimal position to evaluate policies and recommend appropriate changes by conveying the findings of this study along with evaluation of specific family visitation needs to administrators who establish institution visitation policies.

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ABSTRACT

Visiting policies were initially established for the critical care unit with the purpose of providing rest for the critically ill patient; however, evaluation of these policies has not taken place. Additionally, visitation restrictions have been established and enforced with little input from the families of patients in these units. Therefore, the purpose of this descriptive study was to determine the visitation needs of families who had a family member hospitalized in a critical care unit. A questionnaire was used to ascertain visitation needs of families. The sample consisted of 1 participant from 30 different families who had a member hospitalized in a critical care unit. The study was conducted in a rural hospital in the southeastern United States from November 1987 through February 1988.

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Open-ended questions concerning specific visitation times and frequencies revealed a variety of responses. Nearly all participants wanted to be able to visit 7 days a week. Family members also want to be able to see their relative from 3 to 5 times per day, or as needed; and to spend from 10 or 30 minutes at a time with the relative.

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CHAPTER 1

INTRODUCTION

Often staff or family members who have relatives in the critical care unit will comment about the nurse having two patients; the identified patient and the patient's family. This description of the family also being the "patient" may be accurate. The precipitating event that brings a person into the critical care unit is usually unexpected and may precipitate a crisis for the family with the result being a family in a state of disequilibrium (Olsen, 1970). Since the patient is actually a subset of the family system rather than a separate entity, responses of family members to the crisis must be considered in developing a nursing care plan for the patient in the critical care unit.

With the advancement of medical technology, critical care units are able to accept and maintain the lives of critically ill patients in greater numbers. Technological advancement has produced a situation where patients with radically poor prognosis continue to live for indefinite periods of time. The stress placed on families lingers, and may create a delay in resolution, the fourth step of crisis theory (Jillings, 1985).

Critical care units can create a threatening environment for the patient's family. The physical layout of a critical care unit, the machinery, and the restrictive visitation policies create barriers between the patient and the family. Visitation restrictions can include the number of times per day, the specific hours of day, and the number of minutes allowed during each visit. Restrictions are also placed on the type of visitors (family only, age) and the number of visitors at one time. In addition, many units do not provide privacy during family visits.

In the capacity of a registered nurse in critical care units, this researcher has noted inconsistencies among institutions regarding visitation policies. Additionally, many problems for the patient and family are created by restrictions on visitations. Most patients enter the critical care unit seriously ill and frightened. The fear experienced by the patient is created by the uncertainty of the illness and by unfamiliarity with the machinery and the environment of the critical care unit. During admission procedures, patients frequently ask to see their families. Families of newly admitted patients can be observed standing as near to the entrance of the unit as possible. When finally allowed in, both the patient and family relax. Acceptance of the diagnosis, prognosis, and treatment by the patient and family is easier when explained to them as a unit.

Family members often ask if they can participate in the patient's care. The patient may also ask the same question. Both the patient and the family appear less anxious if they are allowed to assist in some manner.

If the patient's condition deteriorates, the family often wants to be with the patient more frequently than allowed. The family can be found sleeping in the waiting room and never leaving the hospital. If visiting policies are enforced, increased stress in the family may be observed.

Both the family and the patient may become angry and/or hostile towards the staff when visiting restrictions are strictly enforced. This anger can create a barrier between the staff and the family unit, with the resulting stress jeopardizing the patient's outcome.

Purpose and Research Questions

While visiting policies were initially established for the critical care unit with the purpose of providing rest for the critically ill patient, evaluation of these policies has not taken place. Additionally, visitation restrictions in critical care units have been established and enforced with little input from the families of the patients in these units. Therefore, the purpose of this study was to determine the visitation needs of families of patients hospitalized in a critical care unit. Specific questions

which were addressed in this research study consisted of the following: (1) What visitation needs are identified by families 24-36 hours after admission of the family member into a critical care unit? (2) How does the family's perception of the severity of illness affecting the patient influence visitation needs? and (3) What is the association between the demographic variables (relationship to the patient, gender, education, employment, and religion) and the family member's identified visitation needs?

Significance to Nursing

Little research has been done to study the visitation needs of families with a member as a patient in the critical care unit. As stated earlier, it has not been determined whether current visiting policies and practices adequately meet visitation needs of families. Additionally, the inconsistency of visitation policies noted around the country suggests that there is no theoretical basis on which visitation policies are derived. Visitation is an area in which nursing can use its knowledge related to systems and crisis theories to determine policies that will lessen the stress associated with illness.

The findings of this study can help nurses provide total patient care by incorporating the visitation needs of the family into the patient care plan. The patient's recovery time could be decreased if the stress of illness is

lessened when family members are allowed to be near the patient and to participate in patient care.

Definitions of Terms

1. Family informant: Spouse, relative, or significant other (if the patient has no family member) at least 18 years of age who can read and understand English.
2. Critical care unit: Ward in the hospital where the patients require constant monitoring because of potentially life threatening medical conditions.
3. Need: "A requirement which if met, relieved the immediate distress and restored well being" (Hampe, 1975, p.114).
4. Severity of illness: (Florida Hospital Association, 1982).
    a. Good - vital signs are stable and within normal limits. The patient is conscious and comfortable. The chances for recovery are excellent.
    b. Fair - vital signs are stable and within normal limits. The patient is conscious but may be uncomfortable. Chances for recovery are favorable.
    c. Serious - vital signs may be unstable and not within normal limits. The patient may be

unconscious. Chances for recovery is questionable.

d. Critical - vital signs are unstable and not within normal limits. Chances for recovery is unfavorable.

5. Vital signs: Blood pressure, heart rate, temperature, and respirations.

Assumptions

Two assumptions were identified prior to the institution of this study. The first assumption was that the family informant was aware of and able to identify visitation needs. The second assumption was that the time period prior to participation in the study, paired with at least one visitation, would reduce the participant's stress level enough to allow for valid responses.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

A review of literature related to the needs of families of patients in the critical care area indicated few studies devoted to the identification of those needs. Only one research study was found that related specifically to identifying visitation needs of families. Other literature concerning the implementation of visitation policies for critical care areas discussed differences related to the rationale for the development of visiting policies and the practices of various institutions related to visiting policies. This chapter reviews literature related to the rationale for visitation policies, patient responses to visitation, and the family's need for visitation. Also included in this chapter is a conceptual framework which utilizes crisis and systems theories as a foundation for the development of visitation policies.

Rationale for Visitation Policies

A review of visitation policies for the critical care areas disclosed a variety of practices with little commonality (Kirchoff, 1982; Younger, Coulton, Welton, Juknialis, & Jackson, 1984). Younger et al. reported that

there was an enormous amount of variation with regard to frequency and length of visits among the intensive care units of 78 hospitals from which they collected data. In a study of the visiting policies of 240 intensive care units throughout the country, Kirchoff found that visitation policies were dictated by institution and unit variables such as the size of the hospital, the number of beds in the critical care unit, the geographic location of the hospital, and hospital ownership. She noted that visiting policies tended to be based on institutional needs or "power of control" as reflected by administration, nurses, and/or physicians, rather than reflecting the needs of the patient and family.

In a study of 78 head nurses of critical care units, Younger et al. (1984) reported that 56% of the nurses interviewed thought that visitation by families was a right rather than a privilege. Seventy-eight percent of the nurses did not think that visiting policies should be changed, even though they acknowledged that existing policies did not fully meet the needs of patients or their families.

As noted in Chapter 1, visitation restrictions included the timing of visits, who can visit, and privacy during visitation. Younger et al. (1984) indicated that the rationale for the development of visiting policies in critical care units consisted of the following: "(a) visits

are too upsetting for the visitors, especially children; (b) visits may be physiologically disruptive and damaging to the patient, particularly those with cardiac problems; (c) visitors or patients run the risk of infection; and (d) visiting disrupts the unit, draining staff time and energy" (p. 606). Kirchoff (1982) found that the reported rationale for the development of visiting policies was to provide rest for the cardiac care unit patient. She concluded that if patients' needs were the primary concern when developing visiting policies, then the institutional patterns observed in her study would not have been so diverse.

Patient Response to Visitation

The principle rationale reported for instituting restrictive visitation policies in critical care areas can be broadly classified as protecting the patient from stress. Fuller and Foster (1982) observed that studies have been implemented to determine if visitation by family members is a source of stress for the patient. They found that the data suggested conflicting findings in regard to stress experienced by the patient during visiting hours and to stress experienced by the patient when stimulated by the nurse. Fifteen minute visits by the family did not induce more stress on the patient than shorter, 5 to 10 minute periods. Fuller and Foster also concluded that any form of patient arousal should be expected to cause an increase in

blood pressure and heart rate. In a study of visitation of families with a member as a patient in a critical care unit, Stillwell (1984) determined that inflexibility in visitation policies was identified as a source of stress for both the patient and the family.

Visitation policies have also been instituted to protect the immunosuppressed patient from acquiring infections from the family. Younger et al. (1984) found no studies supporting risk of infection as a legitimate reason for restricting visitation. They surmised that appropriate measures such as hand washing and isolation protocols should minimize potential infections.

The presence of the family has been shown to influence the patient's attitude towards his illness and thus the patient's adaptation to the illness (Bedsworth & Molen, 1982; Gardner & Stewart, 1978; Potter, 1979). Potter studied the family's perception of sources of stress encountered while having a member of the family hospitalized in a critical care unit and found that family support influenced the patient's ability to adapt to illness.

In a study conducted to determine psychological stresses experienced by spouses of patients in cardiac care units, Bedsworth and Molen (1982) cited previous research showing that the attitudes of the family members notably influenced the patient's adaptation to the illness. In their sample of 20 subjects, they found that the most common

source of perceived threat for the spouse was the potential death of their mate. Bedsworth and Molen suggested that early assessment by the nurse with regard to the spouse's perceived fears and stresses can result in the planning of appropriate measures which help the family deal with the stress. In addition, they suggest that if the family is able to deal with the stress, they will be more able to help the patient deal with the illness.

Gardner and Stewart (1978) conducted a study concerning staff involvement with families of patients in intensive care units. They suggested that the family's presence can help to comfort and reassure the patient at a time when the patient may be feeling helpless, isolated, and dependent on strange people and equipment. Gardner and Stewart determined that families can help the staff plan the management and care of the patient by providing important information about the patient's idiosyncrasies, habits, fears, and medical history. In addition, they indicated that the family's presence can assist with interpretation of behavior or language of the patient which is unfamiliar to the staff.

Families Needs for Visitation

Hampe (1975) began work on the assessment of the family needs for visitation by working with families of dying patients. In her study, "needs" were divided into

eight categories; two of the need category labels were "being able to visit whenever the family wanted" and "helping with the physical care of the patient". Molter (1976) expanded on Hampe's work by developing a "needs" assessment tool. The tool consisted of 45 need statements derived through a literature review and a survey of 23 graduate nursing students. Molter then used the tool to identify the general needs of 40 families who had a family member in an intensive care unit. Other researchers (Daley, 1984; McMahon, 1985; Rodgers, 1983; Stillwell, 1984) have used and validated Molter's assessment tool as a means of evaluating the needs of families of patients in the critical care area.

Molter (1976) found that the need of family members to "see the patient frequently" was ranked important or very important by 90% of her sample (N=40). Daley (1984) utilized Molter's tool to evaluate the needs of 40 families with a member as a patient in a critical care unit and found the "greatest" need category to be "the need for relief of anxiety". She classified the identified needs of families according to six categories: (1) the need for relief of anxiety, (2) the need for information, (3) the need to be with the patient, (4) the need to be helpful to the patient, (5) the need for support and ventilation, and (6) personal needs. Needs were measured using a Likert-type scale that ranked responses from 1 (not important), to 4 (very

important). All need statements in the category "the need for relief from anxiety" received a ranking of 3.224 or higher. Daley's respondents gave the single need statement "to be able to be with my family member in the intensive care unit" a ranking of 3.825. Combining Daley's finding of the "need for relief of anxiety" with the most important need identified in Daley's, Hampe's, and Molter's studies, "to be with the ill family member", it could be postulated that visibility may reduce the family's experienced anxiety.

In 1978, Dracup and Breu conducted research to identify needs of families who had a member as a patient in a coronary care unit. They proposed to incorporate the needs they identified into the nursing care plan of the patient. When strict visiting hours were enforced, Dracup and Breu found that only 24% of the families (N=26) felt that their need to be with the ill family member was met; however, when flexible visiting hours went into effect, 92% of the families felt that the need to be with the ill family member was met.

In a study of families (N=30) of patients in a critical care unit, Stillwell (1984) found the most important visitation need of these families was to be able to visit the patient whenever the family member desired. Stillwell expanded Molter's (1976) work to determine the existence of visitation needs and their importance so that appropriate rationale could be used when developing and/or revising

visitation policies. The family's requirement to see the patient frequently was evident in her study. Additionally, she found that as the perceived condition of the patient deteriorated, the need of the family to see the patient increased. Stillwell concluded that visitation should be open and flexible and also reflect the needs of the patient and family.

Dracup and Breu (1978) found that prior to instituting a care plan that included the family's needs, families did not feel that their need to be helpful was met. After instituting a care plan that individualized the family's needs, 54% of the families (N=26) felt that their need to be helpful was satisfied. They further noted that allowing family participation in patient care alleviated the nurse's guilt related to inability to complete some aspects of care.

Jillings (1981) and Potter (1979) asserted that contributing support and providing personal care to the family member may assist the family in dealing with its own crisis. Families may then be observed "as a component of total care required by the patient" (Kirchoff, 1982, p. 576).

Family members can assist nurses in interpreting the patient's needs. According to Younger et al. (1984), the family is able to provide important information for the planning of patient care, since they alone can best identify

the personal needs of the patient. Younger et al. further suggest that the family can act as the patient's advocate.

Conceptual Framework

Concepts related to the idea of supporting family needs concerning visitation include those found in crisis and systems theories. A brief overview of the two theories describe how they can be useful in identifying family needs for visitation.

Fuller and Foster (1982) state that nursing has a responsibility to lessen the amount of stress placed on the critically ill patient. These authors further stated that "knowledgeable management" of visiting policies is an area in which nursing can reduce stress. The family member who wants to see the patient frequently may use this need as a coping mechanism to come to terms with the seriousness of the relative's condition and thus, achieve resolution. The nurse must recognize that patients are members of a family system and that after the crisis of serious illness resolves, the patient will be reintroduced into that system. The patient's recovery may be influenced by the behavior of the staff and family. Restricted visitation may be a stress for both the patient and the family.

A system can be defined as a whole which is greater than the sum of its parts but functions as a whole because of the interdependence of its parts. The family can be

identified as a system (Braden, 1976; Fawcett, 1975; Olsen, 1970). Two terms related to systems theory that help explain family function are negentropy and synchrony. "Negentropy" is a term used to describe the mechanism by which a family attempts to maintain homeostasis. Fawcett (1975) describes the family as negentropic or leaning toward increasing order, complexity, and heterogeneity. "Synchrony" within the family system describes the system as dependent upon the state of the system and its environment at any given time.

Systems are identified as being either open or closed. Three criteria that must be met in all open systems include: (a) intake and output of both matter and energy; (b) achievement and maintenance of a homeostatic state so that intrusion by outer energy will not seriously disrupt internal order; and (c) a general increase in order, negentropy, that occurs over time (Braden, 1976). The family can be seen as an open system constantly exchanging energy in the form of matter and information within itself and between itself and the environment. The action of any member of the system will affect the entire system and its equilibrium. Loss of a family member from the immediate system, by hospitalization, changes the integrity of the system. Environmental variables, including the demographic variables of the family, also affect the integrity of the system, which is now missing a portion. How the family

perceives the severity of the illness affecting the missing member may also influence the integrity of the system.

Crisis theory describes a crisis situation as any event which disrupts the equilibrium of a system. Crisis can be viewed as having four phases: shock, disorganization, reorganization, and resolution (Jillings, 1985). Two types of crises can occur: maturational and situational. A situational crisis is defined as an event that is unexpected and overwhelmingly threatening to an individual. It is an event in which present coping mechanisms may be rendered useless (Williams, 1974). Loss of security and control is experienced. Helplessness may ensue.

Illness often occurs without warning, especially illness requiring the individual to be hospitalized in a critical care unit. A crisis may develop depending on how the individual and the family view the hospitalization as well as the effectiveness of current coping mechanisms. Factors that can influence current coping mechanisms include the family's perceived severity of illness afflicting the ill member and the demographic characteristics of the family. The suddenness of the event may initially cause the family to experience shock, fright, disbelief, numbness, guilt, helplessness, and powerlessness (Gardner & Stewart, 1978).

Hospitalization may be the initial stressor of the crisis situation. A variety of other sources of stress may

act to compound the situation. These can include potential death, permanent disability, fear of chronic pain, inability to perform usual roles, role changes, dependency on others, financial concerns, being away from home, and loneliness (King & Gregor, 1985).

When family members are not able to deal with the stress of hospitalization, various behaviors indicating crisis may become evident. In response to the crisis, family members may show somatic symptoms including sleeplessness, depression, inability to concentrate, restlessness, or loss of appetite (King & Gregor, 1985).

Williams (1974) categorized a family's reaction to a crisis situation into several phases. Initially the family may experience denial, followed by periods of confusion and anxiety, and finally recovery and reorganization. Kuenzi and Fenton (1975) have stated that the period of shock, denial, and disbelief is most pronounced when the impetus is unexpected hospitalization. Depression may be experienced by the family as reality of the situation becomes apparent. During the anger/anxiety phase, the family may try to blame itself, the patient, or the staff for what has happened. The final stage of recovery and reorganization occurs when the family begins to move on towards the future, returning to a state of equilibrium. The family system experiencing disequilibrium through crisis needs to reorganize itself in order to continue to exist as a system (Olsen, 1970).

"Entropy" is a systems theory term that can be used to describe a family system in crisis. The term describes a physical quality in which matter has a tendency to go into disequilibrium, characterized by a decrease in usable energy. Increasing entropy can lead to death of a system. There is a certain degree of resistance to any incoming energy, but if the system's entropy increases, resistance also increases. As the family becomes more disorganized by the hospitalization crisis, entropy increases. If the patient's condition deteriorates and causes increased family stress, entropy can also increase. As entropy increases, the feasibility of accepting positive energy by the system decreases.

The concepts of crisis and systems theories can be useful in all phases of the nursing process. From the data gathered, interventions for the patient care plan will include the family as a whole, and the patient as a subsystem of the family system. Hospitalization of a family member is a specific stressor that can place a family into disequilibrium. This disequilibrium may influence the family's need to visit the patient. The institution's critical care unit's visiting policies may increase the stress experienced by the family if the practices of the institution do not meet the specific visitation requirements of the family. The possible increased stress caused by restrictive visitation policies may add to the

disequilibrium experienced by the family. Specific nursing interventions are directed toward decreasing stress and thereby decreasing the disequilibrium experienced by the family. This could then restore the family system to a new state of equilibrium. Meeting the visitation needs of the family may assist the family and the patient in satisfactory adaptation to the illness.

CHAPTER 3

RESEARCH METHODOLOGY

The purpose of this chapter is to describe the methods that were employed in the study. Included are discussion of the design, setting, sample, instrument development, protection of human subjects, procedure, and data analysis.

Design

An exploratory, descriptive study was used to determine the visitation needs of relatives who had a family member in the intensive care unit. This design was appropriate for the purpose of this study, since little research has been done in the past regarding family visitation needs (Polit & Hungler, 1978). This study used the exploratory component in order to investigate variables which may influence family visitation needs.

Setting

The research setting was a for-profit, certified, 169 bed hospital, located in the southeastern United States. The hospital was located in a rural town with a population of approximately 25,000 people in which the major economic base was tourism. The clientele of this hospital were

patients who lived in the community and who also visited the area. The general economic make-up of the patient population ranged from the poor, medicare dependent, to the upper-middle class; educationally, the range was from grade school through more than four years of college. The religious preference of the group was variable, due in part to the tourist population.

The mean hospital census during the study was 100. The critical care area, composed of ten beds, had patients with surgical, medical, and/or coronary conditions. Admissions to the critical care unit originated from the emergency room, physician's office, or from another patient care area in the hospital. The usual nurse:patient ratio was 2 patients per nurse. Staffing was dependent on the patient census.

Visits, limited to 15 minutes, were scheduled four times a day at 11am, 1pm, 5pm, 7pm. Only 2 family members were allowed to visit at one time. However, visitors could switch during the 15 minute period. A waiting room for the critical care area was located directly across from the entrance to the unit.

Sample

The sample consisted of 1 participant from 30 different families who had a family number hospitalized in a critical care unit. Parameters for the family member's

participation included the following: (1) the patient was directly admitted to the critical care unit through the emergency room or the physician's office, or the patient was transferred to the critical care unit from another patient care area in the hospital; (2) the admission was the person's first experience in a critical care unit; (3) the family member visited the relative and was approached by the researcher within 24-36 hours following admission; and (4) the family member who volunteered to participate in the study was at least 18 years of age and able to read, write, and comprehend the English language. If the patient had no family member available but considered a visitor a significant other, that person could participate in the study if all other criteria were met.

The designated time frame for collecting data, 24-36 hours after admission, was based on previous research by Stillwell (1984) and Rodgers (1983). Both researchers found that families interviewed before 24 hours after patient admission had difficulty in answering questions. Interviewing subjects after 36 hours could lead to retrospective distortion. Additionally, using the 24-36 hour time period provided for consistency across studies.

The sample consisted of the first 30 individuals who were willing to participate in the study and met the participant criteria. Data were collected from November, 1987 through February, 1988. This 3 month time-frame was

based on the critical care unit's daily census of 8-10 patients. Patient length of stay in the unit averaged 3 days. First time, direct admissions comprised approximately one-half of all admissions.

Instrument

The questionnaire used in this study was developed from the work of Molter (1976), Stillwell (1984), and Rodgers (1983) (Appendix B). Molter's original questionnaire consisted of 45 "need" statements pertaining to the needs of relatives of critically ill patients. Stillwell shortened the tool to nine statements when she partially replicated Molter's study in order to examine the specific visitation needs of relatives of critically ill patients. Rodgers also used Molter's tool in her research of family visitation needs, adding questions related specifically to family members' desired activities during their visits with the patient. Permission to use questions from Molter's and Stillwell's tools was obtained (Appendix C). Rodgers was unable to be reached, so specific questions from her questionnaire were not used.

Molter's (1976) questionnaire was derived using crisis theory and Maslow's hierarchy of needs. The needs list was developed through a review of literature, Molter's professional experience as a staff nurse, and input from Molter's graduate classmates. Content validity, the

ability of the questionnaire to represent all questions which might be related to the subject of family needs, was established by comparing the graduate students' needs lists with professional critical care unit nurses' needs lists. Content validity has been further established in studies by Mathis (1984), McMahon (1985), Rodgers (1983), and Stillwell (1984). Each researcher found that study participants could not identify additional needs from those identified in the questionnaire.

Reliability of Molter's (1976) tool, the tool's degree of consistency to measure family needs, was determined by Rodgers (1983) and Mathis (1984). The Cronbach's Alpha test of internal consistency performed by both researchers was at the .90 level or greater.

The readability of the present tool, with special attention to the section covering "patient condition" was evaluated using Mouse Write (1986). Readability was found to be at the sixth grade level.

Stillwell (1984) extracted eight questions pertaining to visitation needs from Molter's (1976) questionnaire when she studied visitation needs of relatives of critically ill patients. She added a ninth question related to privacy. This addition was based on the fact that curtains separated patient areas in the setting of her study. While patients used for this study had private rooms, privacy was often limited because of the presence of medical personnel in the

room during visitation. Therefore, Stillwell's ninth question was included in this study.

Rodgers (1983) replicated Stillwell's study, adding two questions to Molter's tool (1976) to determine what family members wish to do during their visits. Two similar questions were included in this study.

For consistency with the previous studies, the 4-point Likert scale was used for ranking participant responses to each visitation need statement. The 4-point Likert scale ranks responses from 1, not important to 4, very important.

The participant's perception of patient condition was elicited to establish if there was an association between the perceived condition and the ranking of visitation needs. Stillwell (1984) added a question to her tool in order to evaluate the participant's perception of the patient's condition but did not define categories related to patient condition. She believed that the informant's perception of the terms may differ from the health professional's perception (personal communication, July 15, 1986). It was the belief of this researcher that the participant's educational background and previous experiences with the health care system could influence his/her definition of the severity of illness. Therefore, definitions related to the severity of illness affecting the patient were included in this study. The definitions (Chapter 1, page 5) were based on the information that hospitals give to the press related

to a patient's condition (Florida Hospital Association, 1982).

Since closed-ended questions were used for ease in ranking needs, the identification of specific family needs associated with time and frequency of visits may have been limited. Therefore, three open-ended questions were added to the questionnaire to elicit information related to day(s), time(s), and number of visits per day that would be most appropriate for the family member. Content validity for these questions was established through review by the researcher's thesis committee and professional critical care nurses at the institution used for the study.

Information including gender, age, relationship to the patient, education, occupation, and religion were also obtained for the purpose of analyzing data corresponding to demographic variables. A question requesting ethnic background was included in this study's questionnaire. However, at the request of the hospital used for the research, this question was deleted.

Procedure

Contact was made with potential participants in the adjacent visitors waiting room between visitations. Participants were approached after the first visitation and within 24-36 hours following patient admission. The researcher introduced herself to the potential participant,

inquiring about his/her relationship to the patient. If family criteria were met, the researcher explained the purpose of the study. If the family member appeared interested, a letter explaining the project, the consent form, and the questionnaire along with two unmarked envelopes were provided. Contents of the letter and consent form were explained and time was allotted for questions. The participant was given information on how to contact the researcher should there be additional questions or concerns. The family member was instructed that the questionnaire was to be completed within 24-36 hours after the relative was admitted. The participant was then instructed to place the signed consent form in one unmarked envelope, the completed questionnaire in the second unmarked envelope, and to seal both envelopes before returning them. Both envelopes were placed in a mailbox at the nurse's station in the critical care unit for pick-up by the researcher.

Protection of Human Subjects

Informed consent was obtained from all participants. The requirements for protection of human subjects was met prior to the initiation of this project. Approval by the Montana State University Human Subjects Review Committee was obtained. Consent for the project was also obtained from the institution used for the study (Appendix D).

Data Analysis

The sample and findings from answers to structural questions were described using measures of central tendency. Responses to open-ended questions were tabulated by frequency of responses. The 11 structured need statements were ranked from most important to least important and compared with each independent variable (perceived condition of the patient and the demographic variables of the participant: relationship to the patient, gender, education, employment, and religion) using Kruskal-Wallis ANOVA by Ranks and Spearman Rank Order Correlation. Level of significance accepted for each nonparametric measure was $p<.05$.

CHAPTER 4

RESULTS

A nonexperimental study was conducted to investigate the perceived visitation needs of families who had a family member in the critical care unit. This chapter describes the responses of the families who returned the questionnaire. The description of the responses is presented in the following order: (a) analysis of the visitation needs identified by families 24-36 hours after admission of the family member into a critical care unit, (b) analysis of the relationship of the family member's perception of the severity of illness and visitation needs, (c) analysis of the association between demographic variables and identified visitation needs, and (d) analysis of open-ended questions.

Sample

The first 30 individuals who met the predetermined criteria and returned the questionnaire comprised the sample. Twenty-one of the participants (70%) were female and 9 (30%) were male. The relationship of the participants to the patient included 15 spouses (50%), 4 parents (13%), 4 siblings (13%), 6 offspring (20%), and 1 was an aunt (4%).

Analysis of Visitation Needs

The first research question asked what visitation needs were identified by families 24-36 hours after admission of a family member into a critical care unit. Responses to the 11 need statements were measured on a Likert-type scale from 1 (not important at all) to 4 (very important). Using the mean of each statement (N=30), the needs were ranked from the most important to the least important (Table 1).

The need statement ranked by the participants in this study as being most important was, "I need to tell my relative how much I care for him" (M =3.667, S.D.=0.471). Twenty of the participants ranked this statement very important and 10 participants ranked this statement important.

The statement which ranked as being the second most important was, "I need to touch my relative during my visit" (M=3.567, S.D.=0.616). Specific participant responses included very important (n=19), important (n=9), and slightly important (n=2).

The statement, "Because there are limited visiting hours, I need to have them start on time", ranked third in importance to the participants in this study (M=3.467, S.D.=0.718). The participants ranked this statement very important (n=17), important (n=11), slightly important (n=1), and not important at all (n=1).

Table 1. Ranking of need statements by family participants from most important to least important. (N=30)

	Statement	Mean	Standard Deviation
1.	I need to tell...how much I care...	3.667	0.471
2.	I need to touch my relative...	3.567	0.616
3.	Because (of) limited visiting hours, I need to have them start on time.	3.467	0.718
4.	I need to see my relative frequently.	3.267	1.998
5.	I needed to have someone explain... about the sounds and equipment...	3.000	1.033
6.	I need to...visit whenever I want.	2.867	1.176
7.	I need direction...as to what is expected of me...at (the) bedside.	2.800	1.077
8.	I need...the visiting hours changed...	2.400	1.332
9.	I need to have privacy provided...	2.333	1.106
10.	I need...to do some of the physical care of my relative.	2.100	1.165
11.	I needed...another person with me...	1.733	1.031

The next statement of importance to the participants was, "I need to see my relative frequently" (M=3.267, S.D.=1.998). Specific participant responses included very important (n=12), important (n=10), slightly important (n=4), and not important at all (n=4).

The statement that ranked fifth in importance was, "I needed to have someone explain to me about the sounds and equipment in the critical care unit before I went in for the

first time" (M=3.000, S.D.=1.033). Participants ranked this statement as very important (n=12), important (n=10), slightly important (n=4), and not important at all (n=4).

The statement that ranked sixth in importance was, "I need to be able to visit whenever I want" (M=2.867, S.D.=1.176). Participants ranked this statement as very important (n=13), important (n=6), slightly important (n=5), and not important at all (n=6).

The seventh most important statement to the family members of this study was, "I need direction from the staff as to what is expected of me while I am at my relative's bedside" (M=2.800, S.D.=1.077). Participants ranked this statement as very important (n=10), important (n=9), slightly important (n=6), and not important at all (n=5).

The eighth most important statement was, "I need to have the visiting hours changed because of special conditions (work, other obligations, etc.)" (M=2.400, S.D.=1.332). Participants ranked this statement as very important (n=10), important (n=5), slightly important (n=2), and not important at all (n=13).

The statement, "I need to have privacy provided for me and my relative when I am visiting", ranked ninth in importance (M=2.333, S.D.=1.106). Participants ranked this statement as very important (n=6), important (n=7), slightly important (n=8), and not important at all (n=9).

The tenth most important statement was, "I need to be able to do some of the physical care of my relative" (M=2.100, S.D.=1.165). Participants ranked this statement as very important (N=6), important (N=4), slightly important (N=7), and not important at all (N=13).

The statement least important to the participants in this study was, "I needed to have another person with me when I visited my relative for the first time" (M=1.733, S.D.=1.031). Three participants ranked this need as very important, 4 participants ranked this need as important, 5 participants ranked this need as slightly important, and 18 participants ranked this need as not important at all.

Influence of the Severity of Illness and Visitation Needs

Of the 30 participants, 7 of the participants (23%) perceived their relative's condition as "good", 14 of the participants (47%) perceived their relative's condition as "fair", 3 of the participants (10%) perceived their relative's condition as "serious", and 6 of the participants (20%) perceived their relative's condition as "critical". Chapter 1, page 5, defines each condition category.

In an attempt to answer the question, "How did the family's perception of the severity of illness influence visitation needs?", responses were analyzed using Kruskal-Wallis ANOVA by Ranks (Table 2). Two need statements carried a significance level of $p=<.05$. These two

statements are, "Because there are limited visiting hours, I need to have them start on time", and "I need to be able to visit whenever I want". The two statements show a difference between the four perceived condition variables but due to the categories' diverse sample sizes and the conservative nature of multiple comparisons, it cannot be determined which category accounted for the difference.

Table 2. Influence of perceived condition of the patient and visitation needs using Kruskal-Wallis.

N=30 (good=7, fair=14, serious=3, critical=6)

Statement	H	p
1. Because (of) limited visiting hours, I need to have them start on time.	8.897	.030
2. I need... to visit whenever I want.	8.830	.031
3. I need direction... as to what is expected of me... at (the) bedside.	7.228	.064
4. I need... the visiting hours changed...	5.009	.170
5. I need...to do some of the physical care of my relative.	4.568	.205
6. I need to see my relative frequently.	4.291	.230
7. I need to have privacy provided...	4.279	.232
8. I need to touch my relative...	3.533	.31
9. I needed...another person with me...	3.474	.324
10. I needed to have someone explain... about the sounds and equipment...	2.092	.557
11. I need to tell...how much I care...	1.864	.605

Relationship of Demographic Variables and Visitation Needs

The third question in this research study asked about the association between demographic variables and identified visitation needs. For this study the demographic variables of the participant's relationship to the patient, gender, educational level, employment, and religion were explored. Kruskal-Wallis ANOVA by Ranks was used to determine if a relationship existed between the variables and the ranking of need statements. Each variable will be analyzed separately.

Relationship

The demographic variable of relationship to the patient was divided into the categories of spouse, parent, sibling, offspring, and other. Initial analysis determined only the statement, "I need direction from the staff as to what is expected of me while I am at the bedside", to carry a level of significance ($p=.041$). This analysis demonstrated that relationship to the patient and ranking of importance of visitation needs could not be established due to the small sample size within the categories (15 spouses, 4 parents, 4 siblings, 6 offspring, and 1 aunt). Therefore, the data was reanalyzed using only two categories of relationship; spouse and other (Table 3). McMahon (1985), in her research on the general needs of families with a family member in the critical care unit, also identified the need to code her

data related to family relationship into the two categories identified above.

Table 3. Influence of relationship to the patient and visitation needs using Kruskal-Wallis.

N=30 (spouse=15, other=15)

Statement	H	p
1. I needed to have someone explain... about the sounds and equipment...	3.271	.050
2. I need...the visiting hours changed...	3.541	.057
3. I needed...another person with me...	1.223	.269
4. I need...to do some of the physical care of my relative.	.806	.373
5. I need to tell...how much I care...	.580	.453
6. Because (of) limited visiting hours, I need to have them start on time.	.407	.531
7. I need to have privacy provided...	.387	.541
8. I need to touch my relative...	.374	.548
9. I need to see my relative frequently.	.120	.727
10. I need direction...as to what is expected of me...at (the) bedside.	.119	.728
11. I need...to visit whenever I want.	.806	.373

The previously significant statement, "I need direction from the staff as to what is expected of me while I am at the bedside", did not demonstrate significance (p=.728) after consolidating the participant's relationship to the

patient into two categories. Interpretation of this finding suggested that the category of "spouse" did not establish the significance demonstrated initially.

The statement which may be related to the statement above, "I needed to have someone explain to me about the sounds and equipment in the critical care unit before I went in for the first time", did demonstrate significance (p=.050) when two categories of participant's relationship to the patient were analyzed. This need was more important to the "other" category than to the "spouse" category as demonstrated by the Sum of the Ranks which totaled 276.5 for "other" and 188.5 for "spouse".

Gender

The significance of the variable of the gender of the participant in relationship to the importance of the need statements was analyzed using the Kruskal-Wallis ANOVA by Ranks. Table 4 summarizes the influence of gender of the participant and the 11 need statements.

The only need statement of statistical significance was, "I need to be able to do some of the physical care of my relative" (p=.050). Females (n=21) ranked this need as being more important than did males (n=9). The Sum of the Ranks for females and males for this need statement was 366.0 and 99.0 respectively.

Table 4. Influence of gender of the participant and visitation needs using Kruskal-Wallis.

N=30 (female=21, male=9)

Statement	H	p
1. I need... to do some of the physical care of my relative.	3.747	.050
2. Because (of) limited visiting hours, I need to have them start on time.	1.598	.203
3. I need to see my relative frequently.	.968	.327
4. I need to... visit whenever I want.	.822	.368
5. I need to tell...how much I care...	.690	.411
6. I needed to have someone explain... the sounds and equipment...	.229	.638
7. I need to have privacy provided...	.120	.727
8. I needed... another person with me...	.169	.684
9. I need to touch my relative...	.120	.727
10. I need... the visiting hours changed...	.084	.765
11. I need direction... as to what is expected of me... at (the) bedside.	.014	.873

Education

Responses to the variable of education were originally divided into the following categories: less than sixth grade, grade school, middle school/junior high, high school, 2 years college, 4 years college, and more than 4 years college. Due to the small sample size and the large diversity of responses, the categories for education were

collapsed into three categories: less than 12 years (n=2), 12 years (n=16), and more than 12 years (n=12) of education. McMahon (1985) found the same diversity to be true in her sample (N=29) and condensed her data into the above three categories.

Using Kruskal-Wallis ANOVA by Ranks, Table 5 summarizes the relationship of the educational level of the participant and the ranking of the 11 need statements. Only the need statement, "I need to be able to do some of the physical care of my relative", was found to near statistical significance (p=.053). However, due to the differences in the sample size of each of the three categories it could not be determined which category accounted for the difference.

Since education and importance ranking can be placed on an ordinal scale, further analysis of the 11 need statements associated with the education variable was accomplished using Spearman Rank Order Correlation. Summary of the Spearman Rank Order Correlation related to the educational level of the participant and the rankings of visitation need statements is shown in Table 6.