12-2013

Meeting the Needs of Family Members of ICU Patients.

Kalie Nolen
East Tennessee State University

Recommended Citation

Nolen, Kalie, "Meeting the Needs of Family Members of ICU Patients." (2013). *Undergraduate Honors Theses.* Paper 120. https://dc.etsu.edu/honors/120

EAST TENNESSEE STATE UNIVERSITY
COLLEGE OF NURSING
HONORS-IN-DISCIPLINE PROGRAM

University Honors-In-Discipline Program
East Tennessee State University

Meeting the Needs of Family Members of ICU Patients

Kalie Brooke Nolen

An Honors Thesis
submitted in partial fulfillment
of the requirements for the
University Honors-In-Discipline Program
East Tennessee State University
December 2013

Signature of HID Mentor Date

Signature of Second Reader Date

Signature of Third Reader Date

Meeting the Needs of Family Members of ICU Patients

Introduction

The intensive care unit is an extreme environment which houses the most critically ill patients in a hospital. As a result, an array of equipment, IV lines, medications, and sounds that are unfamiliar to the general public can be found. These factors, added to the fragile emotional state of families and friends who have recently admitted a loved one, can be overwhelming. This rush of unforeseen stimuli often leads to feelings of fear and powerlessness (Farrell, Joseph, & Schwartz-Barcott, 2005).

The patients in Intensive Care Units (ICU) are the primary focus of staff; some need virtually continuous care. As a result, the needs of family and friends often go unnoticed. Reasons for this include the supposition that family is bothersome, disruptive, and a distraction from the patient’s care (Farell et al., 2005). Factors such as high patient acuity or limited staffing contribute to this phenomenon as well (Farell et al., 2005).

This lack of attention to family members is often overlooked in the health care environment as families are not given high priority. However, families are expected to make essential decisions regarding their loved one’s care, as well as provide the patient with continuous love and support. The family’s ability to provide love and support for the patient, as well as make decisions about the patient’s care is hindered during periods of emotional distress, especially in situations where patients cannot speak for themselves (Bailey, Sabbagh, Loiselle, Boileau, McVey, 2009). When arriving on the unit for the first time, family and friends are exposed to a high acuity environment as well as circumstances foreign to them, with little education by the nursing staff. For nurses who work in this type of environment daily, it is easy to become desensitized. Desensitization results in a lack of sensitivity to patients and their families, causing increased anxiety due to fear of the unknown. Without effective orientation to the unit, family and friends may assume the worst (Azoulay et al. 2002). Previous research has shown that family satisfaction and understanding of patients' treatment leads to a better experience for the family, encouraging them to be present and supportive of the patient (Azoulay et al., 2002)

Research Aim

The aim of this study was to explore the perceptions of family members of intensive care patients. Much research exists on identifying the needs of this population; however, a gap was identified in how to better meet the needs of families who have loved ones in the ICU.

Assumptions

Throughout the course of this research study, I expected to uncover a disconnect between patient care and the education of family members. I believe the responses from many family members who participated in this study demonstrated an overwhelming need to be informed about their loved ones' tests and treatments and the root cause of their illnesses.

Conceptual Framework

The comfort theory developed by Kolcaba in the 1990s provided the underlying conceptual framework for this study. Kolcaba uses a Taxonomic Structure of Comfort to demonstrate three forms of comfort: relief, ease and transcendence. Relief is described as "The state of having a specific need met." Ease is "the state of calm or contentment,' and transcendence is defined as "The state in which one can rise above problems or pain (Kolcaba

2010).” The three forms of comfort exist in four different contexts: physical, psychospiritual, environmental, and sociocutural (Kolcaba 1996).

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL	Pain		
PSYCHOSPIRITUAL	Anxiety		
ENVIRONMENTAL			
SOCIOCULTURAL			

This model argues that if the needs for the three forms of comfort are met in all four contexts, the patient experiences true holistic care (Kolcaba 2010). Kolcaba (2010) expands the Comfort Theory to not only include the patient, but family members as well; therefore, the Comfort Theory was relevant to this study

Each one of the contexts for comfort can easily be applied to family members of ICU patients. If families do not perceive that each of the three levels of comfort are met in their own experience, they are not fully strengthened and available to attend to their loved ones needs. This situation can cause stress and fatigue not only for the patient who is trying to heal, but also by their support system. Assumptions of comfort care are that when the patient's and family's comfort needs are met in full, they are strengthened and better able to cope with the treatment process.

Research Question

The primary questions for this study were:

1. How well do ICU patient family members perceive their needs are being addressed?
2. What strategies can be implemented to better meet ICU patient family member needs?

Research Statement

It is hypothesized that a gap exists between identified needs of family members visiting intensive care patients and needs that are actually being met.

Study Design

This study was a triangulation mixed method design which used both quantitative and qualitative means to assess the research question. Participants were given the Needs Met Inventory (NMI), a forty-five item tool created by Warren (1993). This tool uses a four-point Likert scale, allowing participants to rank how well their perceived needs are being met during their current hospital experience. After completing the NMI, participants were offered the opportunity to complete the second part of the study, an in-depth interview guided by ten open-ended questions asked by the principal investigator. The interview allowed participants the opportunity to discuss their perceptions of these needs, how well they were currently being met, and how to implement change. The results of the two data collection methods were analyzed and integrated to explicitly identify the needs of family members and relevant interventions that nursing and other healthcare professionals could implement.

Review of the Literature

Identifying the needs of family members of critically ill patients is a popular topic in research. Several studies have been conducted in various parts of the world to identify these needs. The first groundbreaking study was conducted by Molter (1979) in which he created the Critical Care Family Needs Inventory (CCFNI) (Kinrade, Jackson, & Tomnay, n.d.). The CCFNI is a tool of forty-five self report questions pertaining to specific family needs of critically ill patients (Molter & Leske, 1995). A scale of one to four is used to rate the importance of these questions to respondents; the items are categorized into five basic themes: the need for support, comfort, information, proximity, and assurance (Molter & Leske, 1995). The CCFNI has been assessed for test-retest reliability and construct validity in multiple studies (Takman and Severinsson 2006; Lee and Lou 2003; Lee et. al 2000; Bijttebier et al 2000; Coutu-Wakulczyk and Chartier 1990). The internal consistency for the tool is between 0.88 and 0.98 in five studies (Molter and Leske, 1991).

Since the identification of Molter’s five themes of family needs in 1979, multiple studies have used the tool or conducted similar studies to identify family needs (Buckley & Andrews, 2011; Kinrade et al.; Bailey et al., 2009; Verhaeghe et al., 2005; Yang; Omari, 2009; Miracle, 2006; Kosco & Warren, 2000). Some studies identified additional themes such as anxiety reduction and accessibility among their particular populations (Kinrade et al., n.d.)(86). Additional family needs not included in the CCFNI are the family’s psychosocial need to protect and provide reassurance and support the critically ill patient (Verhaeghe, Defloor, Van Zuuren, Duijnstee, & Grypdonck, 2005).

Although many studies identify family needs, a gap exists between identification of these needs and learning how to construct interventions that improve family satisfaction (Henneman & Cardin, 2002). Perhaps this gap begins with the difference in family members' and healthcare providers' perception of their needs (Kinrade et al.). To bridge this gap, the Needs Met Inventory was created as a modified version of the CCFNI (Kosco & Warren, 2000). The NMI consists of the same questions used in the CCFNI, but rather than using the questions to identify needs, a 4-point Likert scale was used to identify whether the needs were never met,1; sometimes met,2; usually met,3; or always met,4 (Kosco & Warren, 2000). Even though the NMI gives some insight as to what family members feel their unmet needs are, it does not aid in identifying strategies to meet these needs.

Very few studies have explored ways to meet the five basic family needs of support, comfort, information, proximity, and assurance. One strategy that has been proposed is the administration of informational leaflets to families when their loved one is first admitted to the ICU. Inside theses leaflets, families could receive information on unit policies, job specific information for healthcare staff, equipment, procedures, and resources available (Bailey et al., 2009). This method has been found effective in establishing communication between family and unit staff. The leaflets increase the families' comprehension of the current situation, which in return increases their feelings of satisfaction with the staff (Azoulay et al., 2002).

Other possible strategies for meeting the needs of families of ICU patients are informational videos, beepers for communication, daily meetings with the patient's healthcare team, and staff members designated to care for family members (Miracle, 2006). The latter two strategies are of the utmost importance as studies show families consider being informed about their loved one's condition and treatment plan as most important (Kinrade et al., n.d.; Omari, 2009; Verhaeghe et al., 2005; Yang, n.d.).

Methods

A triangulation mixed method design was used for this study which combined quantitative and qualitative methods. A mixed method design was beneficial for this study because the goal was not only for participants to identify their needs as either met or unmet, but it was crucial to gain the participants' perspectives on how to better meet these needs. To gain a complete understanding of how to improve this area of healthcare, both quantitative and qualitative means were necessary.

Setting

This research study was conducted by a baccalaureate nursing honors student with the assistance of a faculty mentor at a university nursing school in the southeastern region of the United States. IRB approval was obtained through the university supporting the research as well as the hospital where the research was conducted. The healthcare system in which the participating hospital belonged has its own Institutional Review Board (IRB). This study was deemed by both boards to have minimal risk to participants, thus a full review was not required. Approval was granted after minor changes were made to research documents.

Population/Sample

The participants were family members of intensive care patients at a local hospital. Inclusion criteria included the patients were admitted to the ICU for a minimum of twenty-four hours, participants were eighteen years of age or older, and participants were family members of the patient (biological or by marriage). Convenience sampling was used as participants were approached in the ICU waiting rooms by the principal investigator and asked if they would participate in the study. The participating hospital had three intensive care units with three separate waiting rooms: cardiac, medical, and surgical. Each of the three waiting rooms contributed participants to the study; however, the least number were recruited from the surgical ICU waiting room.

Instrument

Participants were first given the Needs Met Inventory (NMI), a modified version of the Critical Care Family Needs Inventory (CCFNI) created by Molter and Leske in 1983 (Kosco & Warren, 2000). Permission to use the NMI was granted by the author of the tool, Dr. Nancy Warren via telephone. A copy of the tool was sent to the researcher by email. The NMI measures how well the needs identified in the CCFNI are met. The second phase of the study included a structured in-depth interview in which participants answered questions regarding their current experience in the intensive care unit. Questions focused on their opinion about what changes should be made to better meet their needs. In addition, they were asked to identify the interventions currently in place that successfully meet their needs. The interviews were recorded and evaluated for accuracy. The third phase of the study consisted of interpreting both sets of results and integrating them to identify areas where change is needed.

Data Collections

Questionnaires containing the NMI were distributed to willing participants in each of the three critical care waiting rooms at the participating hospital. After learning about the study, participants were required to sign an informed consent prior to answering any questions. Participants in this study remain anonymous as no identifiable information was obtained when administering the questionnaires or interviews. Once participants completed the NMI, they were given the opportunity to participate in an interview guided by ten open-ended questions pertaining to their perceptions of needs met. The interview questions gave participants more freedom to discuss in detail specific pros and cons of their current experience. For accuracy, the interviews were audio recorded and transcribed. The transcriptions were then analyzed by the principal investigator for recurring themes.

Data Analysis

The data collected using the NMI was entered into SPSS to generate a census, comparing each participant's responses. Each of the forty-five items on the NMI was analyzed by category [physical, spiritual/emotional, need for preparedness, honesty/communication, and routine] based on the type of need the item addressed. Once questions were categorized, these categories of needs were compared to determine which ones were perceived as being well met and which ones fell short. Thematic analysis was conducted on the interview data to identify common central themes.

Results

Quantitative

Thirty willing participants completed the NMI. One additional participant began the tool but was unable to finish. She was included with the demographic information as one of the participants with “missing” information. However, none of her responses were included in the statistical analysis used to analyze the results of the NMI. Participants were also asked to document their age, sex, relationship to the patient, and how long their family member had been cared for in the ICU. This information is displayed in Tables 1 to 4. However, not all participants completed the demographics information entirely. Despite screening participants before asking them to participate in the study, two individuals completed the NMI and marked that their family member had been in the ICU less than twenty-four hours. The data for these participants were included in the data analysis; however it should be noted that their limited experience could slightly alter some results.

Table 1: Age of Participants

Age	Frequency	Percent
21	1	3.2
25	1	3.2
33	1	3.2
34	1	3.2
37	1	3.2
43	2	6.5
46	1	3.2
47	1	3.2
49	1	3.2
50	1	3.2
51	1	3.2
52	2	6.5
54	1	3.2
56	1	3.2
57	1	3.2
58	2	6.5
61	4	12.9
65	1	3.2
66	1	3.2
67	1	3.2
70	1	3.2
78	1	3.2
Total	28	90.3
Missing	3	9.7
Total	31	100.0

Table 2: Sex of Participants

Sex	Frequency	Percent
Male	11	35.5
Female	17	54.8
Total	28	90.3
Missing	3	9.7
Total	31	100.0

Table 3: Relationship to ICU Patient

Relationship	Frequency	Percent
Spouse		
Wife	2	6.5
Husband	4	12.9
Children		
Daughter	6	19.4
Son	4	12.9
Daughter-in-law	1	3.2
Parents		
Mother	2	6.5
Extended Family		
Sister	2	6.5
Brother	2	6.5
Uncle	1	3.2
Niece	1	3.2
Sister-in-law	3	9.7
Total	28	90.3
Missing	3	9.7
Total	31	100.0

Table 4: Current ICU Stay

Length of family members current ICU stay	Frequency	Percent
Less than 1 day	2	6.5
1-3 days	16	51.6
4-7 days	5	16.4
1 week	0	0
Greater than 1 week	5	16.1
Total	28	90.3
Missing	3	3
Total	31	100.0

Participant responses were divided by gender in order to compare the p-value for these groups. Items 12 and 20 (To have friends nearby for support and to have comfortable furniture in the waiting room) were significant with a p-value of 0.028. Item 38 (To help with the patient's physical care) also showed significance with a p-value of 0.030. Responses were also divided into two categories based on age. The average age of participants was 52; group 1 consisted of participants 52 and under and group 2 consisted of participants older than 52 years of age. The only item showing significance between age groups is 11 (To know which staff members could give what type of information) with a p-value of 0.092.The NMI was also assessed for reliability. These results revealed a Cronbach's alpha of 0.988 for the 46 items on the tool individual scores for each of the five categories of needs (physical, spiritual/emotional, preparedness, honesty/communication, and routine) were also tested and are displayed in Table 5.

Table 5: Reliability Analysis for 5 Categories of Needs

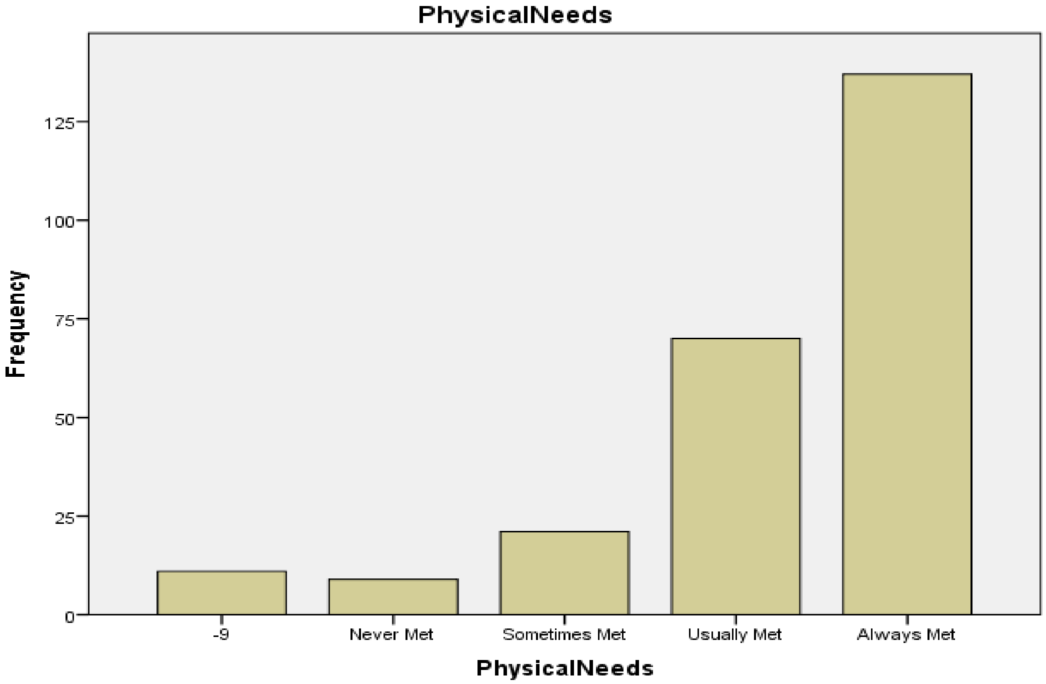
	Valid N	Number of Items	Cronbach's Alpha
Physical Needs	27	8	0.766
Spiritual/Emotional Needs	27	15	0.902
Need for Preparedness	28	6	0.778
Need for Honesty/Communication	30	8	0.839
Need for Routine	28	8	0.775

To analyze what the needs perceived as being met most frequently and met the least, the 45 items on the NMI were categorized into five groups based on commonalities in each question. Table 6 shows the percentages of needs met. For example, under the "Physical Needs" category, 3.75 % of these needs were marked as “Never met,” 8.75 % marked “Sometimes met,” 29.2 % “Usually met,” 57.1 % as “Always met,” and 1.67 % were not answered, indicated in the “Unknown” column. Graphs 1 to 5 further display these results with -9 representing items with no response or marked “NA”.

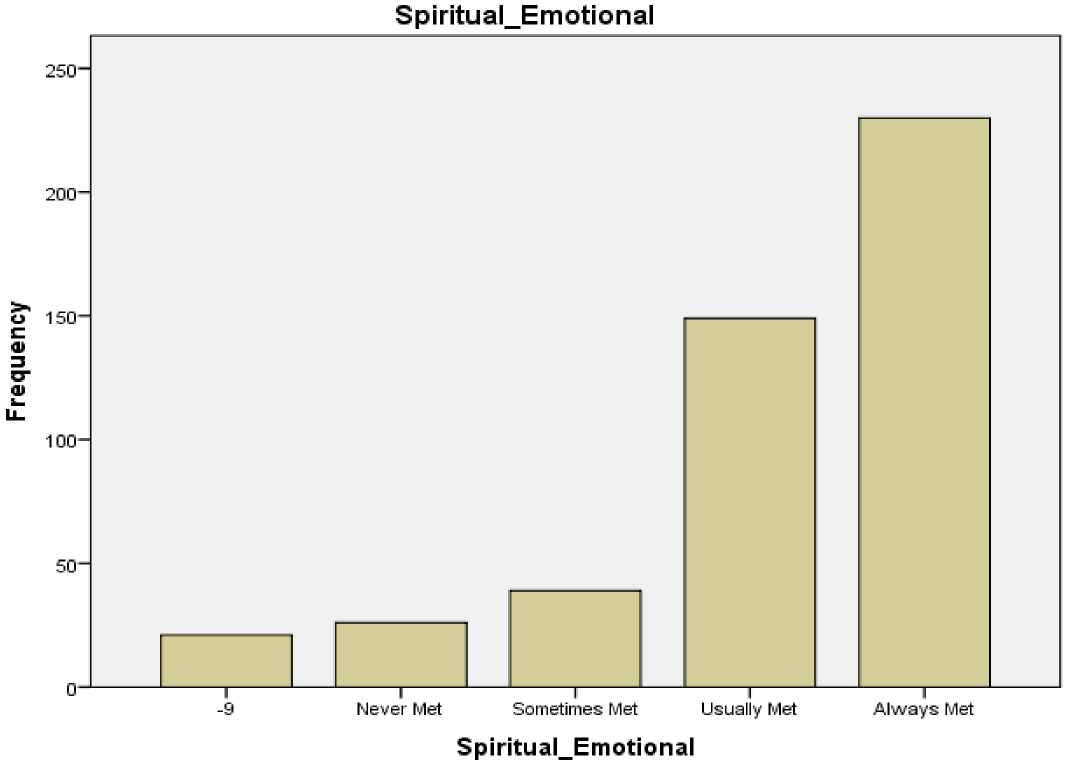
Table 6: Percentages of Needs Met by Category

	Never Met	Sometimes Met	Usually Met	Always Met	Unknown
Physical Needs Questions 8,20,22,23,31,32,38,45	3.75% (9)	8.75% (21)	29.2% (70)	57.1% (137)	1.67% (3)
Spiritual/Emotional Needs Questions 6,7,10,12,14,18,21,24,26,27, 28,30,33,34,37	5.78% (26)	8.67% (39)	33.11% (149)	51.11% (230)	1.33% (6)
Need for Preparedness Questions 2,9,25,35,39,40	2.78% (5)	6.1% (11)	30% (54)	60% (108)	1.1% (2)
Need for Honesty/ Communication Questions 1,5,13,16,17,19,42,43	0.42% (1)	5% (12)	27.1% (65)	67.5% (162)	0% (0)
Need for Routine Questions 3,4,11,15,29,36,41,44	1.25% (3)	10.42% (25)	30.42% (73)	57.1% (137)	0.83% (2)

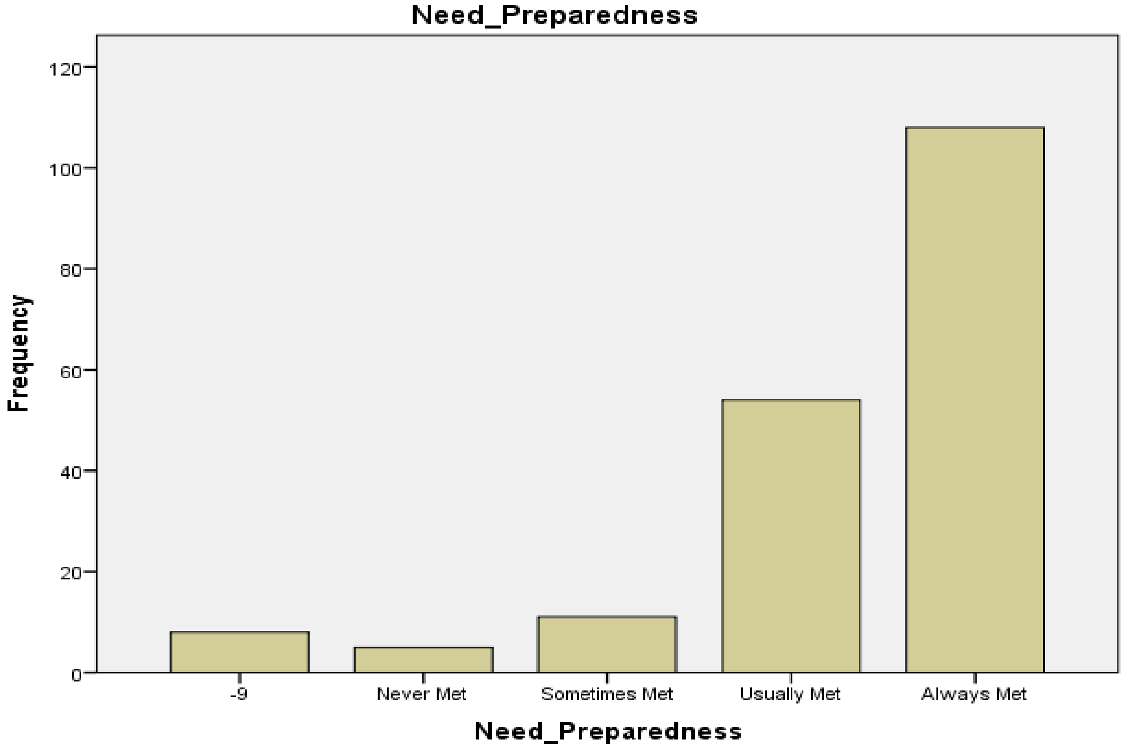
Graph 1: Physical Needs



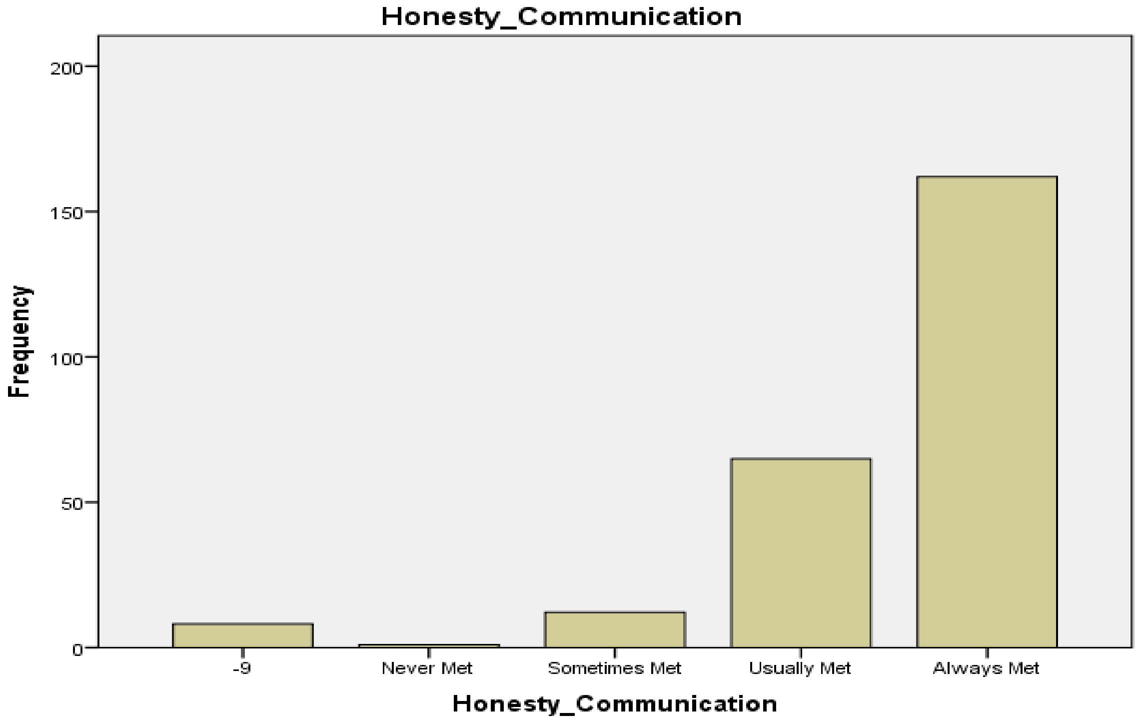
Graph 2: Spiritual/Emotional Needs



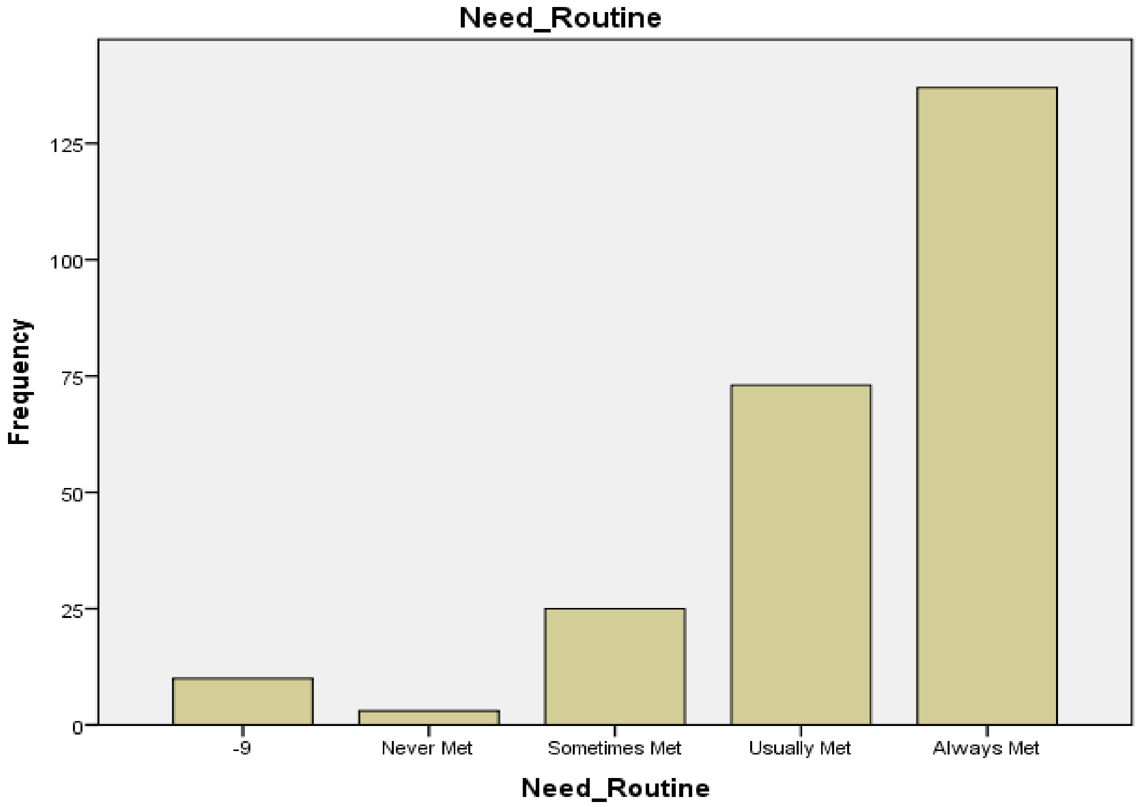
Graph 3: Need for Preparedness



Graph 4: Need for Honesty and Communication



Graph 5 : Need for Routine



In addition to completing 45 items on the NMI, a 46th item labeled “other” followed the 4-point Likert scale format. Any additional comments were recorded under this item. Three of the thirty respondents marked the “other” category. The uncle of one patient placed a check in the “Usually met” category under this item and commented “Waiting room needs better seating.” The second “other” line was checked in the “Usually met” category with no additional comment and the third was checked in the “Always met” category with no additional comments.

Qualitative

Of the thirty-one participants that completed the NMI, only four were willing to complete the interview portion of the study**.** Many expressed feelings of anxiety or being overwhelmed as they awaited more news regarding their loved one's condition. It is also possible that some felt uncomfortable being audio recorded. Of the four who did complete the interview, each one showed excitement about the opportunity to talk more in-depth about their experiences, good or bad.

All four interviews were completed by women, ages ranging from 51 to 61 years with a mean age of 56.5. Two participants were the sisters-in-law of ICU patients, one was the sister, and one the daughter. Both sisters-in-law were accompanied by their husbands or brother of the patient during the interview. Lengths of ICU stay for the family members of those participating in the interview were 3 days to 14 days with an average stay of 6.75 days.

Participants generally rated their overall experience with the intensive care unit as positive. However, the interviews also exposed deficits in meeting the physical and communication needs of family members. To differentiate between the four interviews, participants are referred to as Participant 1,2,3, or 4.

Physical needs: "Comfortable zone." Of the four interviews, two exposed a need for an enhanced physical environment. The three waiting rooms differered in size, furniture, and updates. Some had slightly better seating than others; however, complaints were raised about the lack of comfortable chairs in all three rooms. Participant 1 had comments such as:

> They should maybe have like cots or something, or better sleeping habits. We've been having a hard time getting blankets or pillows. They said they wouldn't be

> giving them out no more but we found out last night they was. So they told us two different days in a row that they weren't going to give out any more pillows or blankets.

This statement is contradictory to the experience of participant 3 who indicated, "They've made sure we've had pillows and quilts because we've been staying the nights." This lack of continuity in care can lead to further complaints as some families may see that others are receiving what they consider "better care" than they are receiving. Participant 1continued discussing the lack of quality furniture for family spending significant time at the hospital with their loved ones stating:

> Just for example, if my mom stayed over here, there's no way she could come because she's 82 years old. She would be, you know, she couldn't do it if she had to. If she had to stay…just a better comfortable zone.

Participant 4 shared that she and her husband were two and a half hours away from home visiting their loved one. They were able to use one of the services of this particular hospital called the hospitality house. This was a facility across the street from the hospital where family members who were a long way from home could stay to remain close to the hospital without driving back and forth constantly. She expressed great appreciation for this service but admitted that if she could change one thing about her experience it would be this: "I would just say that perhaps, an increase in space if possible in the hospitality house."

Communication needs: "Not what we wanted it to be." In addition to the physical needs identified above, the interviews identified a lack of communication with some families. This deficit in information was not from the nurses, but from physicians. A theme in all four interviews was how well the nursing staff relayed information and answered questions honestly as perceived by the families. This was not true when communicating with physicians. The daughter of one patient (participant 3) confessed:

> I just don't feel like communication with the doctors that are seeing him in the ICU because there are several different ones. If you're not there when they're there, you don't get to talk to them. And then they're usually not there when the visiting hours are. So we've been able to catch them periodically and then we've found, found out that where we thought they were going to be, we sat and wait on them. We just don't feel like communication between the doctors and us is been that great…just as far as them checking him in a day and something else has developed, we don't know about it unless we ask. Like what was the results of the x-ray, you know. We just don't seem to be getting the information we would like to have, as much information we would like to have. Because we're aware that he's having an x-ray and unless we just ask the nurse about it, nobody's been calling us about it.

Feelings such as this were also expressed during the completion of the NMI by many participants. As they came to questions regarding communication about treatments provided for their loved one or their progress, many would comment that they often times did not get to speak with the physician or that a great deal of time would pass before they would learn the results of a test or procedure. If the collection period of this study was lengthened and data collected from multiple hospitals, this could be a disturbingly common theme. A testimony such as the following, also from participant 3, is unfortunate and is not congruent with providing holistic healthcare:

> The communication was just not what we wanted it to be or expected it to be. He's just been very critical for a while and we're just very anxious and we'd just like better communications with specific doctors that have seen him for specific things.

In contrast with the perceived poor physical accommodations in the waiting areas and communication with the physicians, the interviews also exposed several positive feelings. Many of these comments stemmed from the nursing staff catering to the emotional needs of participants. In all four interviews, the participants shared that they felt the nursing staff was compassionate toward their current situations and made themselves available to help in any way they could. Participants also stated that they perceived the staff as being honest when communicating information and did not try to manipulate the situation or misguide the family. When asked to respond to statements such as "Tell me about your current experience with the intensive care unit," comments included: "They've all been very nice, very helpful with us. Told us everything we need to know and, keep him very comfortable. It's been a good experience (participant 2)," and "All the people who have worked with him since he's been here have been very helpful, very concerned, and very knowledgeable and willing to share all of that with us so it's been good (participant 4)." When asking the sister-in-law of one patient to describe her experience, she commented, "It's been, you know, pretty good so far, they've been taking good care of him and stuff. If we ask them anything they usually tell us so that's, that's been no problem (participant 1)."

When asked questions such as "In what ways are the staff currently meeting your needs?" or "What steps is this facility taking to meet the needs identified on the Needs Met Inventory?" participant 2 replied, "Being here to keep us informed and keeping us comfortable, always asking if we need anything or if anybody can help us or anything like that." Also in response to this question, participant two stated, "They've even let us go back there when it's not been visiting hours, and told us we could stay with him. We've stayed the night with him, so they've been great." Participant 3 had the following to say in regard to this question:

> They always answer any question and they're very honest about that. They have a chapel or a courtyard you can go in if you need to, you know, have a moment…the telephones are always there, and then we have the pastors. We've had pastors visit us, we've had churches come in, bring in refreshments and put him on prayer lists and things like that. They're very good about letting us have our family here together. They accommodate us that way 'cause there was, there's been bunches of us here so they've been very good about that. I feel like they're always concerned about his health and we've had some great nurses that have just been really, gone out of their way. And of course the bathroom facilities, were able to just go and to clean up and all that. Like I said, we've had the chaplain, and they've been real good about his physical care so far.

And participant 4:

> My husband and I are not medically trained and they have been very good to explain what the procedures are and to put it on a level that we can certainly understand it and better able then to appreciate the information.

Throughout the course of the interviews, participants volunteered information regarding how they perceived their care or treatment during their loved ones ICU admission. In some areas they were grateful, and others they felt disappointed. To determine what kind of impact these feelings may have on not only their well being, but also that of the patient, participants were asked if they felt that the quality of care could or possibly already had impacted their ability to provide care and support for the patient. In preparing to answer this question, participants were able to reflect on their experience and to see exactly what effect their experiences in dealing with the ICU staff and facilities had on their ability to be completely available for any possible needs the patient had, both physical and psychosocial. The sister-in-law of one patient responded by stating:

> Well no. I mean I'm gonna do what I can do, don't make a difference whether I'm comfortable or not. It's up to the patient. You know, I can be uncomfortable…it's not going to help me, not taking care of the patient…my being uncomfortable is not the issue, it'd be his, you know, his state of mind.

Two of the other interview participants responded on the contrary with simple statements such as "Sure, yea," and "Certainly, you would be able to stay close enough to be available at anytime needed or wanted." The final participant did not feel that any changes could be made in her current treatment to improve the care she had received. In response to being questioned on this issue, she simply stated, "I can't think of anything."

Discussion

Family members visiting loved ones in the ICU had a wide range of emotions stemming from their current experiences. Some were excited at the opportunity to express their feelings and were intrigued by the research study but some were reserved and made statements indicating that they had nothing better to do to pass their time or that they wanted to help the "student" by participating in the study. A few individuals who were approached about participating in the study said that although they met the inclusion criteria to participate, they did not feel they were the best family member to interview. On many occasions, one representative of a family of several people would volunteer to fill out the NMI; in some circumstances two or three different volunteers from the same family completed the survey. Children of ICU patients comprised the largest group participating in the study with 35.5% or 11 children participating.

Overall, the statistics from the NMIs indicated that participants had a positive experience and perceived their needs as being adequately met. Over 50% of the needs were perceived as “always met” in each of the five categories of needs. At least 27% were perceived as “usually met” in all five of these categories with a combined total of less than 15% perceived as “sometimes” or “never met” in each category. Spiritual/emotional needs ranked the highest in “never” met needs with 5.78% claiming this on the NMI. Under this category were items such as “To have visiting hours changed for special conditions (item 6)” and “To talk about negative feelings such as guilt or anger (item 7).” Ranking the lowest in the “never met” category was the need for honesty and communication. Included in this category were items such as “To have questions answered honestly (item 5)” and “To know specific facts concerning the patient’s progress (item 43).” By looking at the statistics for these two categories, it can be presumed that the staff in this particular facility is efficient in providing families with information and keeping them updated about patients’ care so families feel they are being told the truth and not being misguided. However, they do not always make the extra effort to assess unmet emotional needs. The categories with the highest ranking for “never met” and “always met” items are spiritual/emotional needs and honesty/communication, respectively. This finding exhibits a directly inverse relationship with the first two rankings which further establish the previous conclusion.

While interviewing the four participants in the second part of the study, it was also concluded that generally, they all had good experiences up to that point. The topic that came up the most in discussion was the lack of comfortable seating in the waiting rooms. Participants felt that this was an important topic for this setting due to the length of time many family members spend in the waiting room, often at night. The most common praise that participants had for their experience in this facility was the nature of their relationship with the nurses. They were described as being extremely knowledgeable, caring, and informative. One woman who was interviewed did not have a single complaint but continually explained how she had been very pleased with her experience.

This study revealed a surprising contrast to the initial assumptions about meeting the needs of family members of ICU patients. Although some participants did overtly express their lack of communication regarding treatment and prognosis of their loved one in the ICU, the majority were satisfied with the amount and frequency of information they were given, especially by the nursing staff. Conversely, other issues were discussed such as the need for more comfortable waiting room furniture and the desire to have less stringent visiting hours. Although these issues may not appear important to some, they are crucial if holistic care is to be provided to not only the patient, but the family who is there to support and encourage them in their recovery.

Significance

The intensive care unit is a high stress environment with many factors affecting patients, family, and facility employees. If the gap between indentified and met family needs could be reconciled, families, patients, and healthcare providers would have considerably less stress and consequently, a more favorable experience during this crucial time. Focusing on the patient's family is a component of providing holistic healthcare. If the family is cared for, they can better care for their sick loved one as well as be more available to the nursing staff, resulting in a more solid foundation for the nurse and family which can relieve stress on both sides. For this to occur, not only is it crucial for family needs to be recognized by facility employees, but strategies for meeting these needs must also be identified and implemented.

Limitations

This study lacks external validity because data were collected from only one hospital. A goal was set to obtain fifty completed Needs Met Inventory tools and ten audio recorded interviews. Due to a lower number of available participants than expected and a confined data collection period of ten weeks, those goals were not met. Convenience sampling was also used to access participants.

Conclusion

As healthcare continues to grow and evolve, it is crucial for the nursing profession to adapt to provide the best care possible. As seen in this study, two major areas for improvement in hospital care, especially in the ICU, are meeting spiritual and emotional needs of patient family members and providing a more comfortable and relaxing waiting area. For the patient to have the best healing environment possible, all aspects of care must be addressed to provide truly holistic health care. Nursing staff should look at facility specific practices to determine how to improve the process of meeting these needs. Only after the areas of weakness are identified can substantial changes occur.

References

Azoulay, E., Pochard, F., Chevret, S. Jourdain, M., Bornstain, C., Wernet, A., . . . Lemaire, F. (2002). Impact of a family information leaflet on effectiveness of information provided to family members of intensive care unit patients. *American Journal of Respiratory and Critical Care Medicine, 165, 438-432.*

Bailey, J. J., Sabbagh, M., Loiselle, C. G., Boileau, J., McVey, L. (2010). Supporting families in the ICU: A descriptive correlational study of informational support, anxiety, and satisfaction with care. *Intensive and Critical Care Nursing, 26, 114-122.*

Bijttebier, P., Delva, D., Vanoost, S., Bobbaers, H., Lauwers, P., Vertommen, H. (2000). Reliability and validity of the Critical Care Family Needs Inventory in a Dutch-speaking Belgian sample. *Heart and Lung-The Journal of Critical and Acute Care, 29(4), 278-286.*

Buckley, P., Andrews, T. (2011) Intensive care nurses' knowledge of critical care family needs. *Intensive and Critical Care Nursing, 27, 263-272.*

Chartier, L., Coutu-Wakulczyk, G. (1989). Families in ICU: their needs and anxiety level. *Intensive Care Nursing, 5(1), 11-18.*

Coutu-Wakulczyk, G., Chartier, L. (1990). French validation of the critical care family needs inventory. *Heart and Lung-The Journal of Critical and Acute Care, 19(2), 192-196.*

Farell, M. E., Joseph, D. H, Schwartz-Barcott, D. (2005) Visiting Hours in the ICU: Finding the Balance among Patient, Visitor, and Staff Needs. *Nursing Forum, 40(1), 18-28.*

Henneman, E. A., Cardin, S. (2002). Family-centered critical care: a practical approach to making it happen. *Critical Care Nurse*, 22(6), 12-19.

Kinrade, T., Jackson, A. C., Tomnay, J. E. The psychosocial needs of families during critical illness: comparison of nurses' and family members' perspectives. *Australian Journal of Advanced Nursing, 27(1), 82-88.*

Kolcaba, K. (2010). Conceptual framework for comfort theory. *Comfort Line.* Retrieved from http://www.thecomfortline.com/

Kolcaba, K. & Fisher, E. (1996). A holistic perspective on comfort care as an advance directive. *Critical Care Nursing* Quarterly, 23 (4), 66-76.

Kosco, M., Warren, N. A. (2000). Critical care nurses' perceptions of family needs as met. *Critical Care Nursing Quarterly, 23 (2), 60-72.*

Lee, I., Chien, W., Mackenzie, A. (2000). Needs of families with a relative in a critical care unit in Hong Kong. *Journal of Clinical Nursing, 9(1), 46-54*.

Lee, L. Lau, L (2003). Immediate needs of adult family members of adult intensive care patients in Hong Kong. Journal of Clinical Nursing, 12(4), 490-500.

Miracle, V. A. (2006). Strategies to meet the needs of families of critically ill patients. *Dimensions of Critical Care Nursing, 25(3), 121-125.*

Molter, N. C., Leske, J. S. Critical Care Family Needs Inventory. (1991).

Molter, N. C., Leske, J. S. Critical Care Family Needs Inventory (1995).

Omari, F. H. (2009). Perceived and unmet needs of adult Jordanian family members of patients in ICUs. *Journal of Nursing Scholarship, 41(1), 28-34.*

Takman, C., Severinsson, E. (2006). A description of healthcare providers' perceptions of the needs of significant others in intensive care units in Norway and Sweden. *Intensive and Critical Care Nursing, 22(4), 228-238.*

Verhaeghe, S., Defloor, T., Van Zuuren, F., Duijnstee, M., Grypdonck, M. (2005). The needs and experiences of family members of adult patients in an intensive care unit: a review of the literature. *Journal of Clinical Nursing, 14, 501-509.*

Warren, N. (1993). Needs Met Inventory

Yang, S. A mixed methods study on the needs of Korean families on the intensive care unit. *Australian Journal of Advanced Nursing, 25(4), 79-86.*