Meeting Family Needs---
What Critical Care Nurses Perceive
and How They Respond to
the Needs of Family Members
of Critically Ill Patients

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Introduction

Hospitalization for a critical illness will usually cause a great deal of distress for the family members of critically ill patients. Meeting needs of family members of critically ill patients can have a significant impact on a patient's ability to cope during his or her stay in an intensive care unit. In the critical care setting, families have a profound impact on the critically ill patient's response to illness. Families can be buffers against patient stress and act as valuable support resources to a patient. However, when families have high levels of stress, they may be unable to support the patient and may even, transfer their stress to the patient. Thus, in holistic nursing care, it is important that the critical care nurse is able to identify the specific needs of family members, and apply appropriate intervention to those in need of support.

Critical care nurses are at the patient's bedside 24 hours a day. Numerous studies agree that nurses are qualified to identify and meet family needs. However, family needs are anticipated only when known. If the nurse is unaware of family needs, the critically ill patient's health status can be negatively affected. So, three questions emerge: (1) What personal needs do family members of critically ill patients identify? (2) What do critical care nurses perceive and how do they respond to the family needs? (3) How can critical care nurses meet family needs based on the literature's recommendations?

Literature Review

Ogden Tanner (1986) in his book, Stress, mentioned "The Chinese use a word to express crisis stress: while it can be a brush with disaster, a potential loss, it can also be a chance for gain; oddly, it is often both things at the same time." (p.81) In China, our ancestors had many sayings which encourage us and help us to look at the positive and optimistic parts of an experience. Our ancestors tried
to teach us to understand "Crisis is crisis, but, it also is a turning point for you
to be better, to improve yourself. You are the master of your own life. What you
think of yourself can be what you will be in the future." This Chinese saying gives
us some hint that no matter who is in crisis he or she can turn it into a better situation.
So, if critical care nurses can identify family needs and intervene properly, the patient's
family not only can go through the crisis, but can also return to a higher level
of functioning.

Brenda O'Keeffe (1988) studied family care in a coronary care unit, she said
"Intervention in families of critically ill patients should be both focused and
supportive—meeting family needs can reduce family stress." (p.192) She used a case
study analysis to show how a clinical nurse specialist working in the CCU setting
intervened in a complex family system during the course of a critical life-threatening
illness, to improve patient care and supporting the health of the family group. She
found, "Stress is an inevitable feature of daily living. Hospitalization for a critical
illness can throw even the most highly organized and functional family into
disequilibrium... intervention in families facilitates family absorption of informa-
tion, encourages use of coping skills, reduces stress and anxiety, and facilitates
improved and timely patient care. These processes enhance the potential for patient
recovery" (p. 198). Furthermore, Dorn (1990) studied the relationship between
unmet needs and distress in family members and she found that there was a significant
(P < .05) positive relationship between unmet needs and five emotional distress
symptoms; somatization (r =.33), anxiety (r=.30), depression (r=.40), interpersonal
sensitivity (r=.37), and total symptom distress (r=.30). So, even if it is unrealistic
to expect the critical care nurse to deal with all aspects of the family members'
psychological state, it is contended that stressors associated with the hospital
experience of the patient can be significantly reduced if appropriate intervention
is provided.

The first question is: "What personal needs do family members of critically
ill patients identify?". The following two research studies identified some family
needs.

In Bedsworth's study (1982), she tried to figure out the psychological stress
of spouses of patients with myocardial infarction. She used a nonexperimental design
to investigate the theoretical components of psychological stress by a semistructured
interview addressing her major research questions. She found the threats identified
by spouses were: loss of mate; change in own goals or motives; loss of the health
of a mate; financial insecurity; new roles within the family unit; separation from
mate; functional family into disequilibrium. ... intervention in families facilitates
family absorption of information, encourages use of coping skills, reduces stress
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enhance the potential for patient recovery” (p.198). Furthermore, Dorn (1990) studied the relationship between unmet needs and distress in family members and she found that there was a significant (p < .05) positive relationship between unmet needs and five emotional distress symptoms; somatization (r=.33), anxiety (r=.37), and total symptom distress (r=.30). So, even if it is unrealistic to expect the critical care nurse to deal with all aspects of the family members’ psychological state, it is contended that stressors associated with the hospital experience of the patient can be significantly reduced if appropriate intervention is provided.

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Molter studied the needs of relatives of critically ill patients. She identified 45 statements of needs and the relatives ranked them according to perceived importance (45 statements of needs ranking from most important to least important. See appendix A). They also were asked if the need was met and, if so, by whom.

The most important need identified was the need for hope. Other important needs were concerned with receiving adequate and honest information and feeling that the hospital staff members were concerned about the patient. And she also found that the majority of psychosocial, physical, and emotional needs were perceived as being met by the nurses. Only 7 of the 45 needs were perceived as being met by the physician. Her study clearly delineates specific family needs of which critical care nurse should be aware in order to intervene.

These two studies address important issues for critical care nurses to consider.
In Bedsworth's study, she used interviews to let subjects speak freely and found the family members' major concern was the threat of loss. In Moller's study, she used a questionnaire listing 45 items of family needs and she asked family members to rank the importance of these needs. The first ten needs showed that family members were most concerned with the patient's condition and prognosis, and obtaining clear information. These two studies provide critical care nurses with a guideline to begin to assess family needs.

The second research question is: What do critical care nurses perceive and how do they respond to the needs? The research of Lynn-McHale, O'Malley, Hickey and Lewandowski explored critical care nurses' perceptions and responses to family needs.

Lynn-McHale (1988) studied the "needs satisfaction levels of family members of critical care patients and accuracy of nurses' perceptions". She modified Moller's questionnaire to obtain need statements. The questionnaire was also designed to seek information about the level of satisfaction that the respondent associated with each need statement by using a five-point Likert-type format to identify from "strongly disagree" to "strongly agree". (For ranking of need satisfaction of family members and critical care nurses see appendix B).

The study showed that the ten least satisfied needs identified by families clustered around these themes: not enough emotional support, unknown intensive care unit environment and unawareness of resources in hospital. The critical care nurses were moderately accurate at identifying the extent to which family members perceive their needs as being met. However, numerous items that were identified by family members and nurses showed disagreement. Some needs ranked relatively low in satisfaction for family members and relatively high by critical care nurses. Those needs included "to have someone encourage me to cry," "to be told about religious services," "to have food available in the hospital," "to have comfortable waiting rooms," "to have someone to talk to about the possibility that the patient may not recover." Lynn-McHale asserts that "whether unmet needs are accurately or inaccurately identified they constitute a prescription for nursing interventions and deserve consideration in the care plan" (p.452).

O'Malley et al. (1991) tried to identify nurse perceptions of family needs in critical illness and the perceived importance of these needs, and also studied nurse perceptions of time available to meet family needs and who was the best care giver to meet the need. The researchers used Moller's questionnaire to assess the nurse's perceived importance of family needs. They then adapted the same tool to assess nurses' perceptions of who was best able to meet a particular family need. The result of this study was that the majority of the nurses perceived family needs as important, if not very important, and 85% of the nurses indicated that nurses were able to meet
family needs and had the time to do so. However, there were some disagreement between nurses' and families' perceptions of which family needs were important. For example, "to be assure that relatives will be notified if condition changes", "to have explanations given in terms that are understandable", "to talk about death", were needs perceived as more important by the critical care nurses and relatively less important by families. The disagreement between critical care nurses and families is similar to Lynn-McHale's findings.

The study found that the majority of the sample (86%) agreed that they would still become involved with families. The study used a questionnaire to explore: (1) How do critical care nurses view their own roles with families of critically ill patients? (2) What factors do critical care nurses believe most influence their involvement with families of critically ill patients?

The study found that the majority of the sample (86%) agreed that they would still become involved with families. However, more than three quarters (77%) of the sample agreed that it is emotionally exhausting to become involved with families who are in need of support. The critical care nurses strongly agreed "although it is upsetting for me to become involved with the stress of families of my patients, I still do", "being supportive of families of critically ill patients is more the role of the staff nurse than of the social worker" (critical care nurses' perceptions about their roles with families, see appendix C). Mandel (1981) suggested that nurses may feel frustration and confusion when they don't know how to be helpful to families. The data from Hickey and Lewandowski's study showed that more than one third of the sample agreed that they didn't have the knowledge to meet the psychosocial and emotional needs of families. This fact may also be the reason for the finding that 77% of the sample said that it is emotionally exhausting to repeatedly become involved with families in need of support. The factors most influencing critical care nurses' involvement with families were: (1) those relating to patient's actual or impending death, and (2) those relating to the nurse's subjective feelings about (like or dislike of) the patient and family. Patient's critical condition always is the focus of nursing care. Although nurses are often encouraged not to let their subjective feelings get involved in care, this may not be a realistic expectation. Other factors that tended to decrease critical care nurses' involvement were a busy unit where continual response was necessary, and situations where the nurse was unsure what information the physician had given the family. This study tells us more from a nurse's perspective than the family's. How do nurses think of their role with families and what reasons make them think so? It helps us to consider critical care nurses' real feelings and know how to help critical care nurses to meet family needs.

These three studies showed critical care nurses also had motivation to meet family needs. However, there is a difference between critical care nurses' perceptions
and families’ real needs. Thus, based on this understanding, critical care nurses can identify the gap between their perceptions and families’ to improve patient care to meet family needs.

Research question three is: how can critical care nurses meet family needs based on the literature’s recommendations?

It is important that family needs are accurately delineated so that nursing interventions can be developed to meet those needs. Lynn-McHale (1988) suggested three strategies: (1) “family needs can be identified by using a family assessment form” (2) “a standard of care may be developed by the critical care unit for families who have potential for ineffective coping related to admission of their family member to the critical care unit” (3) “interventions for this standard should include: orienting the family to the critical care unit, reviewing the critical care family brochure, keeping the family aware of the patient’s status, encouraging family expression of feelings, providing family support, and encouraging use of the family support system” (p.452). Lynn-McHale’s suggestions are crucial to standardize assessment and intervention in meeting family needs. Mikhail asserted a similar opinion and designed a tool to be a reference.

Mikhail (1990) developed a family assessment-intervention nursing protocol (see Appendix D attached). She mentioned that “Early assessment and intervention by the nurse can help avert the emotional disequilibrium that may follow the acute illness or serious injury of a loved one. ... Nurses assess and process large amounts of information from families during a period a loved one stays in a critical care unit. Unfortunately, much of this information is lost or distorted from shift to shift because of the lack of a designated place to quickly document such information in an organized fashion.” Mikhail’s protocol is a good beginning to try to have a standard form to keep a record the family needs, what had been done, and what still needs to be done for the family.

Woolley (1990) used crisis theory to develop a framework for preventive, supportive and therapeutic intervention for family members at risk. She subdivided family needs into four categories: 1. initial anxieties and informational concerns; 2. emotional support and interfamilial contact; 3. involvement with care; and 4. personal needs.

Because following an acute admission to a critical care area, many family members present a shocked and confused state, and are unable to make sense of exactly what has happened, initial anxieties can be relieved by helping such individuals gain a clear understanding of the crisis. Explanations should be offered using simple terminology, free of medical and nursing jargon. For emotional support and interfamilial contact, intervention should include the reduction of tension by providing the means for individuals to recognize and ventilate present feelings. It
is sometimes necessary to encourage emotional catharsis in order to accomplish this aim effectively. Previous coping behaviors which have proved successful in the past can be explored to establish appropriate and useful strategies for the present situation. For involvement with care, once the patient’s condition has been stabilized, families should be offered the opportunity to play some part in the nursing care, and not be made to feel as if they are intruding in matters which do not concern them. By involving family members as much as possible, the nurse can promote the development of a trusting relationship, whilst allowing individuals to feel that their efforts are of some value in assisting the patient’s recovery. Personal needs such as having tea, coffee or food available should also be considered. Although families appear least worried about their own needs, many of these needs are, nevertheless, important. If family members are to remain an effective means of support both for the patient and each other, they must receive adequate rest, sleep and nutrition themselves. The final phase in the problem-solving process involves evaluating whether the individual or family has returned to a normal, or possibly higher, level of emotional equilibrium. Evaluation is an ongoing aspect of the intervention process, and the time it takes to resolve the problem will obviously vary with each individual case. The degree of disequilibrium experienced, the effectiveness of techniques employed to restore ego integrity, and the availability of therapeutic and support resources are all determining factors.

Lynn-McHale (1988) suggested an assessment form to pinpoint family needs, and then to have a standard of care for families who have potential for ineffective coping related to admission of their family member to the critical unit. Mikhail (1990) designed a family assessment and intervention protocol to give critical care nurses a real example for reference. Woolley (1990) used crisis theory as a framework to intervene with families of critically ill people. Combined these three studies give critical care nurses a more complete idea about how to assess, intervene to meet family needs by using standard form, and finally, evaluate whether families return to equilibrium status or not.
Summary

I. Gaps in existing research:

Bedsworth's (1982), Molter's (1979), Lynn-McHale's (1988), O'Malley et al.'s (1991), Hickey and Lewandowski's studies, all have good face and content validity and reliability. This means that they used good instruments to conduct their research. Nevertheless, there are still some gaps.

Molter (1979) pointed out, “many relatives have similar needs, the use of a group process to deal with them should be investigated” (p.339). Bedsworth (1982), Molter (1979), Lynn-McHale (1988), O'Malley et al. (1991) all identified some common family needs when a family member is critically ill. Can a group process deal with these similar needs? If so, what is the effect? This needs further study.

In Lynn-McHale’s study, she suggested “the identification of characteristics of patients and their family members that might be related to specific needs likely to be viewed as important and perceived by them as being unmet” (p.452) needs further investigation. Individual’s different age, social status, religion, and other personal characteristics will result in very different needs. This information would help critical care nurses to identify and fulfill specific needs of family members.

In O’Malley et al.’s study, they indicated that further research is necessary to assess the influence of education. Nurses’ responses to family needs are affected by perceptions of importance and ability to meet the need. They pointed out that “further research can clarify how family needs are related to patient outcomes and can provide directions for nursing practice and education.” (p.201). A similar recommendation appeared in Hickey and Lewandowski’s study. They mentioned that staff nurses agreed that they didn’t have enough knowledge to meet the psychosocial and emotional needs of families. O’Malley’s study had the same result. Nurses ranked the need to talk about death as the fifth most important family need, and identified the physician and the chaplain as the best care givers to meet this need. It is regrettable that this important family need is referred to a less accessible care-giver. The nurses care for the patient on a 24-hour-a-day basis and have the most frequent contact with the family. However, discussion of subjective aspects such as grief, and loss are difficult. This study indicates that further education is needed for nurses to respond to grief and loss to meet family needs. So, if critical care nurses are to meet the needs of families, they should have educational preparation to engage in these activities and the ongoing educational, practical, and emotional resources and support available to them in the workplace. More studies to assess the influence of education on nurses’ abilities to meet family’s psychosocial
Hickey and Lewandowski revealed that the nurses’ subjective feelings toward the patient and family will influence involvement with families. Therefore, how a critical care nurse’s subjective nature influences his or her nursing practice needs to be explored.

Besides these gaps, in Bedworth’s study, she utilized a qualitative methodology, the open-ended interview schedule that allowed subjects to express their threat, coping, and affect. The open-ended interview can prevent bias in predetermining family’s stress and coping. However, the sample size was too small (20 subjects), and the subjects in this study were all female. So, a larger sample of spouses of patients with myocardial infarction, comparing male and female subjects would be useful in drawing more meaningful conclusions. Furthermore, the sampling of all of these studies was accidental. Random sampling is the most powerful method to represent the whole population. Hence, no matter what results these studies present, remember they might need more investigation.

From the literature review, some researchers tried to identity the family needs, some researchers tried to assess family needs from a nurse’s perspective, some researchers tried to make a comparison between a nurse’s and the family’s perception of family needs, and some researchers tried to apply crisis theory to develop assessment—intervention to meet family needs. All of these studies are very valuable. However, studies such as these should be done more narrowly but longitudinally. In other words, conduct the research in a specific population, such as patients immediately following myocardial infarction and admittance to medical CCU, using standard protocol to assess family members’ needs, intervening with those needs, and then evaluating need satisfaction levels of family members, and finally, evaluating whether the family returns to equilibrium or precrisis state or not.

II. Relevance of topic to advanced practice:

The topic of family needs has been explored through understanding nurse’s perception, and responses to family needs, realizing the need satisfaction levels of family members, and by finding a paradigm by using crisis theory to assess and intervene family needs. From these studies we learned that family members’ needs can be identified and met by critical care nurses. However, critical care nurses need more education to adjust their perceptions so that they can accurately meet family needs. Thus, educators and administrators might begin to provide more training to prepare the critical care nurses to deal with the psychosocial needs of families. The staff nurses should intervene with families of critically ill patients through identification of what families perceive as their needs, to reduce families’ stress. Consequently, families can use effective coping skills, return to precrisis status, and
act as valuable patient care resources. This might benefit patient outcomes.

III. Population:

The population of family members of all critical care patients can be studied. However, studies can be narrowed down to specific kinds of patient families such as families of cardiac surgery patients, or myocardial infarction patients.
Conclusion

Stress is an unavoidable feature of daily living. Hospitalization for a critical illness can create chaos even for functional families. Family-focused care can mitigate family stress by providing support based on the unique needs of each family. Intervention for family needs when they are in a crisis period facilitates family absorption of information, encourages use of coping skills, reduces stress and anxiety, and facilitates improved patient care.

Therefore, the goal is to educate critical care nurses about the patient as a member of a family. The patient's health status in critical illness is not solely the result of physiologic failure, but is also the result of psychosocial, and emotional influences. The family can affect a patient's overall health status. Therefore, more preparation of critical care nurses is needed to deal with the psychosocial needs of families. Critical care units can use Bedsworth, Molter, Lynn-McHale, O'Malley's well-designed needs statement instruments as references to develop a family assessment form to identify family needs. Then, they can use crisis theory or other theories to build a framework to intervene with families who have potential for ineffective coping related to the admission of their family member to the critical care unit. The processes of meeting family needs based on correctly identifying and appropriately intervening with those needs will enhance the potential for patient recovery, and assist the family in returning to equilibrium.
References


Appendix A

Ranking of needs from most important to least important
1. To feel there is hope.
2. To feel that hospital personnel care about the patient.
3. To have the waiting room near the patient.
4. To be called at home about changes in the condition of the patient.
5. To know the prognosis.
6. To have questions answered honestly.
7. To know specific facts concerning the patient's progress.
8. To receive information about the patient once a day.
9. To have explanations given in terms that are understandable.
10. To see the patient frequently.
11. To feel accepted by hospital staff.
12. To have bathroom near the waiting room.
13. To be assured that the best care possible is being given to the patient.
14. To know why things were done for the patient.
15. To know exactly what is being done for the patient.
16. To have comfortable furniture in the waiting room.
17. To know how the patient is being treated medically.
18. To have friends nearby for support.
19. To be told about transfer plans while they are being made.
20. To be assured it is alright to leave the hospital for a while.
21. To visit at any time.
22. To have a telephone near the waiting room.
23. To have explanations of environment before going into ICU for the first time.
24. To have good food available in the hospital.
25. To have the pastor visit.
26. To talk to the doctor every day.
27. To have visiting hours start on time.
28. To talk about the possibility of the patient's death.
29. To help with the patient's physical care.
30. To have directions as to what to do at the bedside.
31. To know which staff members could give what type of information.
32. To talk to the same nurse each day.
33. To know about the types of staff members taking care of the patient.
34. To have a specific person to call at the hospital when unable to visit.
35. To be told about chaplain services.
36. To be told about other people who could help with problems.
37. To have someone be concerned with the relative's health.
38. To have a place to be alone while in the hospital.
39. To be alone at any time.
40. To be told about someone to help with family problems.
41. To be encouraged to cry.
42. To have another person with the relative when visiting in ICU.
43. To have visiting hours changed for special conditions.
44. To have someone to help with financial problems.
45. To talk about negative feelings such as guilt or anger.