THE LIVED EXPERIENCE OF PATIENTS DURING FAMILY VISITS IN THE CRITICAL CARE SETTING

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This thesis was prepared under the direction of the candidate's thesis advisor, Dr. Rozzano Locsin, College of Nursing, and has been approved by members of her supervisory committee. It was submitted to the faculty of the College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

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ABSTRACT

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This study described the lived experience of patients during family visits in the critical care setting. Using Colaizzi's method of phenomenology interviews were conducted on six critical care patients in their homes two days after discharge from the hospital. From the transcribed interviews, three themes emerged: a) Family visits enhance patients' well-being; b) Family visits provide patient support systems; and, c) Family visits facilitate communication among patients, the health care team, and members of the family. Implications for nursing practice, nursing education, and research are presented.

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DEDICATION

To my parents for their love and support. To Lucy and her husband for their inspiration, encouragement, and moral support especially when I wanted to quit and also for being good friends for the last fourteen years.

CHAPTER I

INTRODUCTION

Hospital visitations have significant effects on patients, emotionally and physiologically, both positive and negative (Stillwell, 1984). In the past, hospital visits by family and friends were seen as stressful rather than beneficial to patient care (Stillwell, 1984). Today, however, hospitals encourage visitations, and nurses generally view the family presence as supportive and healing. The setting in which the visits take place is a significant factor. Most nurses who practice in critical care settings agree that hospitalization in an intensive care unit (ICU) or critical care unit (CCU) often precipitates a crisis situation for both patients and families (Stillwell, 1984). During this time, nurses are often confronted with distraught patients and family members, which can create stressful relationships among the nursing staff, patients, and their families. In such a setting, family visits can indeed be crucial to patient well-being, the primary focus of the nursing staff. With the severity of patients' needs at this time, it is important for nurses to understand the patients' lived experience of family visitations so that caregiving may be

enhanced and contribute to overall healing and personal renewal (Schulte, Burrell, & Gueldner, S., et al, 1993).

Admission to a (CCU is known to be both physiologically and emotionally stressful. Nurses have the responsibility to include not only the patients, but also their families, in daily care management. Such inclusion eliminates conflicts which lead to problems and multiple demands (and therefore stressors) as nurses interact with patients and their families during this trying time (Simpson& Shover, 1990).

Currently several studies have focused on the effects of family visits on patient care in the critical care setting (Burrell, & Gueldner, et al, 1983; Brickert, et al, 1993; Helm, Titler, 1990). In response to family visits, CCU patients in these studies exhibited a variety of physiological and emotional responses to visits from friends and family members: a significant increase in heart rate, blood pressure increase or decrease, and heart rhythm changes (Schulte, Burrell, & Gueldern, et al, 1993). In response to admission and initial visits, increased physiological effects were followed by a calming feeling and a gradual return to base-line dynamics as the visits proceeded (Kleman, Brickert, & Karpenski, et al, 1993). In another study, however, it was not clear whether or not

family visiting was harmful or beneficial to the psychophysiological status of patients in critical care setting (Simpson, & Shover, J. 1990).

Phenomenon of Interest

The phenomenon of interest is the lived experience of patients during family visits. The experience of family visits in health care institutions is different from each patient's perspective. To understand the experience of having family visits during hospitalization in a critical care setting, a phenomenological study was conducted in which patients' descriptions of the lived experienced was generated and analyzed using Colaizzi's (1978) phenomenological approach.

Only the patient, lying sedated in a hospital bed connected to tubes and surrounded by whirring machines can dictate a question such as the following: What is the meaning of being visited by friends and family members? This proposed study will investigate the meaning of the experience of family visits during hospitalization in a critical care setting.

Purpose of the Study

This qualitative study examined the phenomenon of the lived experience of the patient during the family visit in the critical care setting. The essential understanding of this phenomenon was identified through a phenomenological analysis of the verbal descriptions of six participants who had experienced family visits in the critical care setting.

The interviews were conducted two days after discharge from the hospital to facilitate better recall on the part of the participant.

Significance of the Study

Nurses are aware of the various aspects of visiting protocols set up by their health care institutions. These aspects include frequency of visits, the duration of the visit, and the number of visitors allowed during each visit. The lived experience of patients in critical care settings during family visits facilitates the nurses' understanding of the most appropriate environment that will enhance patients' well-being, provide support, and minimize stress. Within the visiting protocol, visitors contribute to patient care through their living presence, and in their way extending the caregiving of the nurses and staff.

Family members can be a major source of social support for the patients which can protect the patients from a wide variety of pathologic states (Cobb, 1976). Family visiting can provide comfort, support, and reassurance to the patient and enhance their own adaptation to a critical illness (Dunkel & Eisendrath, 1983). An understanding of the experience of the patient receiving visitors during hospitalization is important in order to enhance nurses' sensitivity in caring for patients. Critical care nurses are often the "critical" link between family members and the

patient during this crisis and therefore need an empathetic awareness of the situation to best meet the needs of the patient.

In addition, nurses are the most visible health care professionals in critical care units and assume a major role in meeting the needs of critically ill patients. The regulation of visiting hours is one way the nurses try to reduce possibly stressful or over-stimulating situations. Currently the regulation of visiting hours is dependent on the nurses or administrators, rather than on patient-related rationalization (Kirchhoff, 1982). However, through investigating the lived experience of this phenomenon, we can see the effects of visitations thus allowing nurses to better evaluate the situation and its effect on patient well-being. Although restrictions on visiting in ICU have been the norm, through this investigation, nurses and administrators may be led to reconsider this issue in terms of patients' needs. If visiting is restricted, this may affect the care of the critically ill patients and interfere with their coping mechanisms during a stressful time.

Researcher's Perspective

This topic became of interest to the researcher after observing patients' reactions to family visits. As a critical care nurse for 18, the researcher believes the patient's well-being and recovery are positively affected by visitations, particularly those by family members. This

investigation explored the phenomenon of patient experiences when visited by family members in a critical care setting.

Summary

In this chapter the purpose and significance of the study were discussed. The purpose of this study was to identify the lived experience of family visits in the critical care setting. This study will contribute to the understanding of the importance of family visits to the critically ill patient in the critical care setting.

CHAPTER II

REVIEW OF THE LITERATURE

The subject of patient visitation in the critical care setting is one that has received considerable attention in recent years. As we are aware, greater emphasis is now being placed on a more individualized approach to nursing care, with increased patient and family participation in health care decision making (Gardner, 1989; Sinha & Scher, 1987). Along with the growth of the "consumer" movement in health care (Carter & Mowad, 1988) has come an increasing realization that critically ill patients and their families have psychological as well as physical needs (Hickey, 1990). As a result of all these developments in patient care, the subject of patient visitations has become one that we need to become more sensitized to as nurses and care givers.

Bouman (1984) found that the greatest emotional concern immediately following admission to an intensive care unit seemed to be for the quality of the patient's care and suggested that this need takes priority. During a stay in ICU, a patient is expected to experience a variety of physical and emotional stressors in the process of treatments, tests, and evaluations. The modern technologically advanced laboratory of the ICU room can be

overwhelming to the solitary patient in its midst. But the complexity of care given in the intensive care unit may indeed also create stress and new needs among family members (Stillwell, 1984; Roeter, 1979; Leshe, 1986). Cipriano (1987) examined the stress and anxiety of hospitalized patients and their families and found that major surgery often causes as much stress for the family as for the patients.

In addition, the ICU/CCU visiting protocols may also cause stress for families (Ritchie, 1981; Hickey, 1988). Families are forcefully separated from their loved one at this initial time, distanced by rules and requirements set by the hospital. Such restrictions may be valued by staff as an expression of power over the vulnerable patients (Kirchhoff, 1982), and indeed such rules do allow the staff to have a rest from contact with families (Daly, 1984). In fact, policies for visiting were originally established so that the patients themselves would be allowed sufficient rest.

Surveys carried out by Kirchhoff (1982) and Younger et al. (1989) revealed that severe restrictions still exist. The findings of Griffith (1988) and Shaw (1989) concerning restrictions included the intensive and critical care environment. Therefore, it would appear that the "open visiting" ideal enthusiastically promoted by many authors (Chamel, et al, 1988; Hammer, 1990) is far from reality.

Kirchhoff (1982) suggested that visiting policies have been implemented and maintained by the nursing staff with no attempt to evaluate their effectiveness. Her survey showed that in intensive care units and critical care units, visiting restrictions were related to the unit rather than the needs of the patients and their families. The effort to involve the family in the care of the critically ill (Dunkel & Eisendrath, 1983; Stillwell, 1984; Boykoff, 1985; Bay et al, 1988; Simpson, 1989) is not being reflected in practice when there are restricted visiting hours.

Nurses working in the highly complex biomedical environment of an ICU/CCU have unique technical skills which require a stable and supportive environment to be maximally effective. However, nurses must also have the ability to identify and deal with the emotional impact of the patient's experience being in ICU, which includes the effect of visiting on the patient and the family (Dracup, 1988). Ideally, when friends and family members visit patients, they bring support, comfort, and even distraction from hospital procedures and routine. However, the actual experience as lived by patients, visitors, and also nurses has brought forth many contrasting views and attitudes.

Studies have established that relatives are helped by identifying their own needs in the ICU setting, rating them on a scale ranging from "not important" to "very important" (Watler, 1979; Daly, 1984; Bouman, 1984). Interestingly,

ranking these needs has been found not to correlate with demographic variables such as age, sex, socio-economic class, social support, and religion. Dividing needs into six categories, Daly (1984) found that the category concerned with being with the patients was rated as less significant to relatives than those related to the relief of anxiety and the supply of information. Although, the patients' "needs" to be with the family and for them to stay near the intensive care unit rated high at other times.

A study by Stillwell (1984) revealed a significant correlation between the family's perception of the severity of the patient's condition and the ranked importance of visiting frequently. She suggested that in such a situation, families might experience shock and denial; repeated visiting would help them to come to terms with the situation. Quite commonly, families seem to value "being there" as a kind of coping mechanism, according to Geary (1979). This suggests that patient visits may do more to relieve the anxiety of the visitor than of the patient. The families also considered that it was important to be allowed to visit at any time.

Studies have found that several factors may affect critical care unit nurses' attitudes toward families of critically ill patients: a) the amount of time available for the nurse to deal with families, b) the nurse's knowledge of the psychosocial aspects of dealing with families in crisis,

and c) the nurse's stress level (Dunkel, Eisendrath, 1983).

In other studies, families themselves have been identified as a stress for critical care unit nurses (Bilodeau, 1973; Cassen, Hackett, 1975). In fact, Michaels (1971) noted that nurses find many acceptable reasons for not interacting with family members. Furthermore, she proposed that critical care unit nurses may be so emotionally taxed in their work that they may themselves be in need of support and unable to offer support to others.

Engel's study of nursing and patient experiences (1980) affirms that patients are the best source of information about themselves, including their experience of visitation.

As we can see, families are very important to the patients in the critical care setting. Family members are part of the patients' lives and they don't consider them visitors, in contrast to the perception of most critical care nurses (Molter, 1994). The families' desire to get involved in the patient's care is not unusual. For family members to be effective, however, the critical care unit nurse should be ready to prepare them for the demanding intensive care unit environment and identify the parameters of their new caring role (Hammond, 1995).

Establishing visiting hours that are supportive of the patient and family is an important nursing intervention that nurses in the critical care unit can implement. Role-Modeled and Restricted visiting have thus been investigated

for their effects on patients' well-being as measured by perceived social support, perceived control, anxiety and pain. The results of the study determined that Role-Modeled visiting has a statistically significant effect on the patient (Holl, 1992). Another study investigated visit preferences of middle-aged versus older patients. The results demonstrated that middle-aged and older patients differed so significantly in their visit preferences to warrant tailoring visits to the unique preferences of patients based on age and clinical setting (Simpson, 1993). Determining intensive care unit visiting hours is still a controversial issue, but visiting loved ones plays an integral role in the family is offering of support and comfort to patients during critical illnesses. Nurses, however, often view visiting hours as intrusive and time consuming (Gurley, 1995). Lately more hospitals advocate open visiting in intensive care units so that families can visit whenever they like. In this situation, critical care unit nurses must learn to adapt to benefit the patient and the family alike (Daniels, 1996).

Most patients hospitalized in intensive care units are frightened and ill-prepared for the experience and find that few nurses are aware of how to help them adapt to the strange environment (Rosenthal, 1996). These experienced critical care unit nurses are overloaded so that they are unable to spend time with their patient, which leaves

patients feeling frustrated (Nursing Times, 1996). In another setting, out-patient surgery, patients undergoing same day surgery found their experience a fulfilling one because nurses spent time to prepare, educate, and care for them (Same-Day Surgery, 1995).

Throughout this review of the literature we have seen that some nurses view visitors as potential stressors and that visitors themselves may receive more comfort from visiting than the patients. However, it still remains to be seen how patients perceive and experience visitations. Do visits contribute to comfort and healing? Do they add to the hospital experience or create added and unnecessary stress for patients?

This study will explore the perceptions of visitation during the intensive care experience from the points of view of patient in the critical care setting. From the conclusions, perhaps we can gain an understanding of what visitation means to patients. As a result, nurses can begin to assimilate this understanding into their caregiving to enhance and enrich the well-being and personal growth of patients.

CHAPTER III

METHODOLOGY

This chapter presents the general method of phenomenological inquiry and analysis according to Colaizzi (1978). Also included is information pertaining to selection of participants, setting, data generation, and ethical considerations.

General Method of Inquiry

Qualitative research methodologies first appeared in nursing in the 1960's, but not until the 1970's did the phenomenological approach to such research start to gain interest in the field. At this time, nurse researchers looked to phenomenology as a way of investigating questions about the lived experience of patients and their families. Phenomenology was seen as a way to provide a better conceptual fit regarding the functions of clinical nursing, as well as the research questions which arose from clinical practice (Morse, 1991).

The philosophical foundations for phenomenology for this research were drawn from the works of Edmund Husserl (1859-1938), a 19th century philosopher, considered the

founder of phenomenology. He believed that we can only know what an individual experiences by attending to perceptions and meanings that awaken our conscious awareness.

Husserl (1965) also believed that the term "intuiting" translates as the ultimate test of all knowledge. He believed that philosophy must begin with the phenomena and problems themselves, and the study of theories was secondary. Furthermore he proposed that reductive phenomenology, which includes suspending belief in the reality or validity of a phenomenon, be accomplished through the use of bracketing or detaching the phenomenon of everyday experience from the context of our natural living.

The phenomenological description was further supported by Colaizzi (1978), who stated the importance of first disclosing what is the phenomena before any other cognitive steps can be taken to understand that phenomena. He believed that experience is objectively real and is reflected in the way we relate to the world and act towards others. He developed a data analysis method for phenomenology that consists of in-depth dialogic interviews with participants who have experienced the phenomenon. He realized that the participant is more than a data source; he or she is exquisitely a person. In this dialogic interview the researcher makes contact with the verbalized experiences of the participant only when listening with his/her total being and entirely of personality.

Munhall and Oiler (1986) described phenomenology as an approach that concentrates on the subjects' experiences rather than solely the subjects themselves. Phenomenology is a particular way of focusing, thinking, and acting which provides a broad view of experience. Munhall and Oiler go on to assert that the phenomenological baseline in nursing is the real world of being and experiencing for the client and the nurse. This baseline is accomplished in nursing research by a rough description of our nursing world as it is experienced by the participants. These descriptions are then returned to practice as developed nursing concepts which will be true to the real world of lived experience.

Colaizzi's Method of Phenomenology

The transcribed interviews were analyzed using Colaizzi's approach to phenomenology. Colaizzi's (1978) seven step procedure is as follows:

1. All of the participants' descriptions are read in order to obtain a feeling for them.
2. Significant statements are extracted from each description. Statements containing the same or nearly the same data are eliminated.
3. Meaning is formulated by spelling out each significant statement. The original protocols are again re-read to ensure the accuracy of the formulated meanings.

4. Clusters of themes are organized from the formulated meaning, allowing for themes common to all the subjects to emerge.
5. Integration of the cluster themes results in an exhaustive description of the phenomena. The researcher also validates the theme clusters back to the original protocols.
6. The exhaustive description is reduced to a fundamental statement of identification.
7. The final validating step is taken by returning to the participants and asking the following question: "What aspects of your experience have been omitted?"

By means of these steps and the phenomenological approach, the lived experience of ICU patients receiving family members as visitors during their hospital stay were descrubed. Actual responses and comments from patient interviews were analyzed for their meaning and significance.

Procedures

The informed consent was discussed with the perspective participants. This was signed prior to each interview. The participants were selected from the combined intensive/critical care units from a hospital in Southeast Florida. However, each interview took place in the participants' homes, two days after their discharge from the hospital. These participants were alert and responsive to

the interviews which were tape recorded using sixty-minute tapes. These interviews lasted 30-40 minutes without interruption. The tape recorder was kept out of sight and only a small microphone was visible during each interview. The following questions were asked: "What was it like to have family members visit you while you were in the ICU/CCU? Please share all your thoughts and feelings that you can recall until you don't have anything more to say about these thoughts and feelings."

The researcher utilized the concept of active listening and asked questions only to clarify the participants' statements. The researcher kept written notes of observations during the interview. The researcher's notes were put aside as a potential reference during the data analysis. All participants' taped interviews and notes were kept anonymous. When the participant had nothing more to say and the researcher had no further questions, the interview was concluded.

Participants

Consent to participate in the interviews was obtained from each of the participants. Six participants met the criteria set for selecting participants. This was necessary to meet the rigor of qualitative analysis. Parse, Coyne, and Smith (1985) stated that as few as two to four subjects

have been found to produce data redundancy or saturation, another consideration in qualitative research is necessary to establish significant statements regarding the phenomenon.

The demographic data of the six participants who participated in the study are provided in Table 1:

TABLE 1

Demographic Data of Participants

Age	Sex	Race	Work-Status	Residence
82	F	Caucasian	Retired	Lives with husband
76	M	Caucasian	Retired	Lives with daughter
68	M	Caucasian	Retired	Lives with wife
74	F	Caucasian	Retired	Lives with significant other
82	F	Caucasian	Retired	Lives with sister
78	F	Caucasian	Retired	Lives with husband

Another criterion that was used in selecting the participants was the participant's ability to articulate thoughts and feelings and willingness to participate in the study. All participants met this criterion.

Setting

The participant selection was conducted in a private hospital with a total bed capacity of 222, located in Southeast Florida. This hospital is equipped with a

combined intensive/critical care units of 14 beds and one progressive care unit with 40 beds and 6 beds in intermediate care unit.

After the participants were selected, interviewing schedules were arranged for mutual avaialability. The participants were interviewed in their own homes. These interviews were done in a quiet environment, with only the participants and researcher present.

At the last step of Collaizzi's method, the researcher went back to the participants for a second time to validate their descriptions of the lived experience and asked if anything was accurate. All participants validated the lived experience and claimed nothing was inaccurate.

Ethical Considerations

Permission to conduct this study was granted by the Florida Atlantic University's Human Subjects' Committee (see Appendix A). The informed consent form was given and explained to all participants in the study (see Appendix C). These participants were informed about the purpose of the study and their exact involvement. Permission to conduct initial interviews of the participants in the hospital was obtained from the respective hospital administrators (see Appendix B).

Rigor of Qualitative Research

Credibility in a research study is achieved when participants have lived the experience and are able to

relate to the findings. This allows others who may have experienced similar phenomenon to recognize the experience as their own. This compares to the concept of internal validity in quantitative research (Sandelowski, 1986; Beck, 1993). By providing excertps of the interviews, evidence of credibility of the study was enhanced. The description of the phenomenon would be considered credible if found to be a true expression of the participants' lived experience (Sandelowski, 1986). Additionally, credibility was enhanced in this study with the belief that all participants had met the criteria for selection.

Auditability compares to reliability in quantitative research, is achieved when another investigator is able to follow the decision or audit trail (Guba & Lincoln, 1981) from beginning to end. Beck (1993) identified ways to evaluate auditability such as the use of a tape recorder, field notes, and even another researcher. The study has met this criterion by making available all field notes, transcriptions, and coding instructions to her thesis advisor and excerpts of interviews using participants' data which were used to describe themes. Similarly, audit trails were used to trace the results of the study.

In addition, the researcher ensured fittingness by remaining true to the research and staying within the data generated. Fittingness is compared to the generalizability of the findings in quantitative research (Beck, 1993;

Sandelowski, 1986, 1993). The data must be representative of the participant's descriptions. Sandelowski (1986) pointed out that a study meets the criterion of fittingness when its findings can "fit" into the contexts outside of the study situation. Beck (1993) suggested one way to help the reader to assess the degree of fittingness is to determine if the study fits the data from which it was generated.

In this study fittingness was achieved by participants lived descriptions of their experiences in the critical care setting and the resulting data, which was representative of both the lived and the external experience. Further, the description of the lived experience of patients visited by family members during hospitalization in a critical care setting was verified and confirmed by all participants. This procedure of verification responds to Collaizzi's steps of phenomenological analysis.

CHAPTER IV

INTERPRETATION OF DATA

This chapter describes the analysis of data using Colaizzi's methodology. These findings describe the participants' responses to the research question: "What is it like to have family visits while you are in the ICU/CCU? Share all your thoughts and feelings that you can recall until you don't have anything else to say about that experience."

After the interviews, the researcher transcribed the six audiotaped interviews into written notes. The researcher then began with Colaizzi's first step of reading and re-reading the protocols to acquire a feeling for the material. A sample transcription of the interviews follows.

Table 2

Participants Verbatim Response

Participant 1.	Being in critical care unit is not a pleasant experience but when your family is there, I feel relieved.
Participant 2.	I thought I am dying but when I saw my family it gave me a lift emotionally.
Participant 3.	After surgery I have the breathing machine, so I can't talk, my hands are tied, I can't move but when my wife held my hands it's comforting.
Participant 4.	I'm sick losing blood, a lot of blood, then they have to give me blood because I am sick but he is there he gives me support.
Participant 5.	I am tired of everything, too many things being done, I feel lonely and scared.
Participant 6.	Seeing my husband always there to visit me gave me the desire to live. Because I love him.

Extracting Significant Statements

The second step is to extract significant statements, phrases, and sentences which pertain to the phenomenon and eliminate statements that contain the same or similar statements. The significant statements were extracted from

the transcriptions by highlighting words, phrases, or statements that were significant to the study. The same or similar words, phrases, or statements which appeared more than once in an interview were eliminated to avoid duplication. Sixty statements from the six participants were reduced to twenty-six significant statements. These twenty-six statements were then placed on separate index cards to facilitate the conduct of the analysis.

Table 3

Significant Statements from the Participants' Interviews

Participant 1.	My family relays information to my other members of the family
Participant 2.	I feel relieved when my family is there
Participant 3.	Just their presence is enough, makes me feel better
Participant 4.	Someone cares for you
Participant 5.	Nice to see you have visitors especially family
Participant 6.	Someone is there to check if things are done right.

Formulated Meanings

Colaizzi (1978) suggested that this is the most difficult step of the analysis process. It requires the researcher to decide what the underlying meanings are of the

significant statements without losing the connection with the original description. The researcher referred back to the index cards and re-read all the phrases to derive the meanings which were hidden in the statements, in an attempt to describe what the participants meant by their descriptions. This step was undertaken only after bracketing original pre-suppositions pertaining to this phenomenon. This is a vital aspect to maintaining, sustaining rigor of qualitative analysis as such, a non-biased development of meanings and themes can be derived.

Table 4

Formulated Meanings From Participants Significant Statements

	Significant Statements	Formulated Meanings
Participant 1	My family relays information to my other family members	Family visits serve as a link between hospital and home
Participant 2	I feel relieved when my family is there	Family's visits makes patient feel at ease, secure takes away fears and gives emotional lift
Participant 3	Just their presence is enough to make me feel better	Family's presence helps patients in critical care unit better adjust to unfamiliar settings
Participant 4	Someone cares for you	Family visits are very helpful. Their meaning can be best captured by comments such as, "They make me feel better," "Someone cares"

Participant 5	Nice to see visitors especially your family	Family visits serve as a vital support system to the patient in critical care unit
Participant 6	Someone is there to check if things are done right	Family visits have a significant impact on patients' well-being by communicating effectively with the health care team

Clusters of Themes

The next step is to identify, recognize, and organize the themes into clusters from the formulated meanings. The researcher re-read the formulated meanings using the index cards and placed the cards into groups with related meanings. The themes were compared to the original transcriptions. No new significant themes were identified. Colaizzi (1978) stated that the researcher must rely upon tolerance for ambiguity and be careful not to ignore any new theme or data which does not fit into the existing data.

Table 5

Theme Clusters

1. Family visits enhance the patient's well-being
2. Family visits provide patient support system
3. Family visits facilitate means of communication among health care team members and the patient's family members

Participant descriptions of their experiences helped the researcher formulate these three themes.

Theme Number One

Family visits enhance the patient's well-being

Many basic needs of patients are met through their interaction within the family structure. Visiting allows family members to provide comfort, support, and reassurance

to the patient and enhance their own adaptation to a critical illness thereby promoting their well-being. A critical illness has long lasting repercussions both for patients and for their families. Families have a significant impact on the critical care patient's response to illness. Families can also serve as a buffer and assist the patient in maintaining psychological integrity in the critical care setting. Cognitive information may also assist family members in feeling more involved in patient care and prepared to expect normal patient reactions such as confusion, depression, and/or anger during visits. Family presence also helps patients better adjust to an unfamiliar environment such as the critical care unit.

The following are statements of participants describing their feelings under this theme:

> "I feel relieved when I saw my wife." "It's nice to know someone is concerned about you," "There is someone who cares for you," "Someone is there for me," "I feel a lot better if my family is there," "I know I'm, okay because my wife is there," "Someone is there to check if things are done right," "I thought I'm dying until I saw my family."

Theme Number Two

Family Visits Provide a Realistic Patient Support System

Before a family can provide support to their loved ones, health care should recognize and meet their needs so

they can effectively carry out this role. Studies (Mayou, Foster, & Williamson, 1978; Bedsworth, & Molen, 1982) have indicated that families themselves have needs and that they are not always prepared to provide an ongoing social support system for the patient during a crisis. Significant hospitalization problems have occurred as a result of a family's minimal understanding of the patient diagnosis and treatment, as well as the long term implication for the patient's continued care.

However, critical care nurses and the patient's physician addressing these needs could solve the problem of maintaining social support and relieving family stress. Many families who feel overwhelmed during the first few hours following the patients' ICU/CCU admissions may be insecure and in denial. Complete information about the patient's condition and treatment plan from caregivers may provide some sense of stability or control and assist family members in coping with their high levels of anxiety. This information will also assist the family in feeling more involved in the patient's care and prepare them to interact and support the care giving process.

As we can see, family members are the major source of social support for the critical ill patient. Such social support protects the patient from a wide variety of pathologic states (Cobb, 1976) and is crucial to the patient's desire and will to recover.

The following is a sample of participants' descriptions of their feelings about this theme:

> "Give me a lift emotionally," "Give me support to live," "Encourage me to move on," "Allay or takes away my fears," "You don't feel alone," "I feel secure with my family's presence," "Put me in a relaxed mood, instead of being scared all the times," "I didn't trust anybody except my family."

Theme Three

Family Visits Facilitate a Means of Communication Among Patient, Health Care Team, and Other Family Members.

Contact and communication during critical illness may offer an opportunity for personal growth and can provide valuable assistance in patient care. Explanations about the complex life support systems, intricate medical procedures, sophisticated assessment mechanisms, and different sounds from different equipment provide the patient with knowledge and a sense of control. Family members can assist the health care team by providing information about the patient's idiosyncracies so they can better serve the patient.

Important information communicated to the family by the health care team (such as the physician and nurses) reinforces the information given to the patient for better cooperation and understanding of both patient and family. Family members also can report back to other family members.

Therefore, they can act as advocates for the patients' dignity and their best interest (Dunkel & Eisendrath, 1983).

The critical care nurse is the person on the health care team who usually is responsible for communicating important information to the patients and their families, and also determining the extent of family involvement in the critical care unit. For this reason the critical care nurse is seen as a critical communication link between patient and family. This includes information about the present condition of the patient, laboratory tests, medical procedures, and future medical and home care plans. As do nurses, physicians also explain the diagnosis, treatment, and results to the patients and their families. The manner in which nurses and physicians relay information to families is also important; it must be clear, honest, and understandable with an expression of personal concern.

These sample statements describe the theme:

"When my wife visits, she relays information about me to my other family like my brother and sister," "My significant other calls and communicates how I am to my family in Georgia," "My daughter talks to the doctor and nurses and she asked about my condition and tests to be done," "Even though the doctor and nurses explain the test and procedures to be done, I don't fully understand, so I asked my wife to further explain it to me," "When I have tube in my throat, I can't talk. When

my hands are tied, I can't move. My wife keeps reinforcing to me this is necessary for my safety and helps me to breathe."

Exhaustive Description

The next step in this analysis requires integrating the significant statements, formulated meanings, and essential themes into an exhaustive description. This was accomplished by returning to the transcriptions and re-reading all of the statements from the participants. At this time, further significant statements, formulated meanings, or essential themes were noted. The words, statements, and themes were then integrated into a narrative exhaustive description.

The following is an exhaustive description of the lived experience of patients during family visits in critical care.

1. Family visits enhance the patient's well-being. Family presence in the critical care unit provides patients comfort, support, reassurance, adaptation to their illness and adjustment to an unfamiliar environment, and a will to live, therefore promoting their physical, emotional, psychological, and spiritual well-being.
2. Family visits provide a patient support system. After family expectations are met by the health care team, the families are prepared to carry out

an active role as a support system for the patients. Through the support provided by the families, the patient will be able to cope better with their illness, fears, and anxiety.

3. Family visits facilitate a means of communication among the patient, the health care team, and other family members.

   Through a knowledge base provided by the health care team, the family will be able to effectively communicate the information to the patients, therefore developing their sense of understanding and control of their health.

Statement of Identification

The final step in Colaizzi's method of data analysis involves collapsing the exhaustive description into a concise statement which integrates the components that have been identified.

The lived experience of family visits by patients in a critical care setting enhance patient's well-being, provide a support system, and facilitate a means of communication among patients, the health care team, and other family members.

Validating

Colaizzi's next step is validation. The statement of identification was presented to the six participants to establish validity. They were each asked to compare their

experiences with the following statement of identification: The lived experience of family visits by patients in a critical care setting enhances patients' well-being, provides a support system, and facilitates a means of communication among patients, the health care team, and other family members. All participants agreed that the statement of identification captured their experience.

Summary

In this chapter, the data were analyzed according to Colaizzi's method of phenomenology. After re-reading all the original transcriptions, the researcher extracted significant statements. From these statements, meanings were formulated and then grouped together as themes. The themes were then concisely explained in an exhaustive description, and a statement of identification was created. This statement of identification was then validated by the original participants. No new data were obtained, and all participants agreed to the identified description.

Learning and understanding this information would provide nurses with a greater sensitivity and knowledge to practice their nursing care, to meet patients' needs and their families', toward the goal of promoting well-being. Nursing education should be grounded in promoting the well-being of patients and their families. The best way to learn this is by experiencing nursing situations during their clinical rotations which will facilitate understanding of

the "Lived Experience of the Patient During Family Visits in a Critical Care Setting."

The issue of the educational preparation of critical care nurses to appropriately deal with families should be explored by educators and administrators alike. For nurses to meet the needs of patients and their families, education preparation should include these activities and offer ongoing educational practice, emotional resources, and support as available in workplaces.

CHAPTER V

RECOMMENDATIONS AND IMPLICATIONS OF THE STUDY

This chapter describes the recommendations and implications of the lived experience of patients during family visits in critical care settings as they relate to educational practice and research. Three themes emerged from the data analysis which can help critical care nurses better understand issues of care with family members and apply these in practice, research and education.

Recommendation for Education

Nurses in general, whether students or practicing nurses working in a hospital or community setting, should be taught the importance of culture and the dynamics of the family structure. In addition, nurses need to be aware of the impact of illness on the family, whether the patient is in acute care, hospice care, nursing home, or in the home setting.

Family dynamics guide the nurse in assessing and supporting the inner workings of the family as it confronts the hospitalization of one of its members. In fact, the family may be viewed as a system of interdependent parts where reciprocal behavior occurs. Furthermore, Minuchin's structural theory of family interaction (Hansen, J.L, Abate,

L., 1982) postulates that individuals do not live in isolation. Rather, family members are constantly interacting, each person adapting to pressure from within himself, or herself, from family sub-systems, and from society. Roles are readjusted as people and conditions change.

Recommendation for Practice

In the modern world of medicine, the rapid development of technology, changes in health care, and increasing patient load and patient-to-nurse ratio may become overwhelming for any practicing nurse. These factors influence the care of the patients and their families, especially in a critical care setting.

Most critical care nurses would agree that the hospitalization of a family member in an intensive care unit often precipitates a crisis for the family. The critical care nurse is confronted by distraught family members from day to day and it is important to be able to offer assistance. However, nursing intervention directed toward meeting the needs of family members frequently does not occur since critically ill patients demand much of the nurses' time. The needs of family members are often ignored. To appropriately intervene with these families during such critical times, nurses need to remember that they serve as a support system and contribute to family well-being as they help the patient recover from illness.

As this study has shown, family members visiting patients in critical care settings play a pivotal role in their well-being and in their ability to adapt to unfamiliar surroundings. Nurses must communicate with each other to gain insights into the meanings of their practice and how they affect the care of their patients and their families. Nurses need to have a better understanding that they make a difference for their patient's families and for nursing practice.

Recommendation for Research

To advance the body of nursing knowledge, nurses must learn more about the phenomenon of the lived experience of patients with family visits in the critical care unit. The process of nursing inquiry through the phenomenological method allows for a better understanding of the patients' lived experience in the critical care unit.

This data obtained from patient interviews indicate that family visits produce overall positive results for patients' well-being. As a result of this study, it would seem that family visits may need to be assessed, as they affect patients coping with illness during their stay in a critical care setting.

As has been seen, some nurses believe that visiting family members can have a negative effect on the patient's recovery (Brown, 1976; Walker, 1972). Research is needed to understand the effect of family visits on patients' recovery and adaptation to illness.

Another concern is the nurse's beliefs and attitudes about family members visiting in critical care units. For example, visiting by family members has been reported to be a source of stress to critical care nurses (Eisendrath & Dunkel, 1983). In the critical care setting, the nurses' focus is on the needs and care of the critically ill patient and consequently, the visiting needs of family members can appear to be a distraction and deter them from providing quality patient care. However, we have seen that family members are a major source of social support for the patient as described in this study, and adequate social support can protect the patient from a wide variety of pathological states (Cobb, 1976).

Implications of the Study

This phenomenological study has contributed to the body of nursing knowledge by describing the experience of patients during family visits in the critical care setting. Family visits enhance patients' well-being. Family visits provide a support system and facilitate an advocate role with the health care team.

Critical care units have existed for many years; as people age, they tend to be more critically ill when sick and often end up in a critical care units. Naturally, family members always want to be at their loved one's side. This occurrence happens on a daily basis in the Intensive Care Units.

Specially trained critical care nurses are able to provide the care needed by critically ill patients, as well as to interact with their families. These nurses must be very receptive, and understand the needs of both patient and family; however, no matter how demanding the nursing care and the use of high technology, nurses should not forget the patients who need care.

Carrying out task-oriented nursing care must be as important as meeting the needs of patient and family in a human caring way. This many-faceted care giving helps patients to adapt to the unknown environment, their illness, and to recover in less time.

Summary

In this chapter, the researcher has presented the recommendations and implications of the lived experience of patients during family visits in critical care settings as it pertains to education, practice, and research. The researcher also presented the importance of family visits and how they affect the patient's well-being and adaptation to illness in the critical care setting. This research

study will facilitate the development of a framework to understand the effects of family visits on patients in critical care settings and for nurses to practice effectively in critical care settings.

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APPENDIX A

FLORIDA ATLANTIC UNIVERSITY

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DIVISION OF SPONSORED RESEARCH
(407) 367-2318
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INSTITUTIONAL REVIEW BOARD
Human Subjects Review Committee

MEMORANDUM

DATE: March 20, 1996

TO: Rozzano Locsin,
College of Nursing

FROM: Deborah Richardson, Chair

RE: H96-6 "Lived Experience of Patients During Family Visits in Critical Care Setting"

The Institutional Review Board (IRB) has reviewed the above protocol. Under the provisions for expedited review, the proposed research has been found acceptable as meeting the applicable ethical and legal standards for the protection of the rights and welfare of the human subjects involved.

This approval is valid for one year from the above memo date. This research must be approved on an annual basis. It is now your responsibility to renew your approval annually, keep the IRB informed of any substantive change in your procedures and if you encounter any problems of a human subjects' nature.

Please forward copies of letters of agreement/support from your cooperating institution(s) before data collection begins. These letters can be forwarded to Elisa Gaucher in Sponsored Research.

Please do not hesitate to contact either myself (7-3365) or Elisa Gaucher (7-2318) with any questions.

DR:eg

APPENDIX B

HOLLYWOOD
Medical Center
Tenet South Florida HealthSystem

3600 Washington Street
Hollywood, Florida 33021
Tel 954.966.4500

September 23, 1996

Sonia Remonte, R.N.
ICU Nurse
Hollywood Medical Center

Dear Ms. Remonte:

This is in response to your request to interview ICU patients and their family visitors in order to complete your thesis, *"Living the Experience of Family Visits in Critical Care Settings"*.

Please be advised that in an effort to support your educational endeavors, Administration at Hollywood Medical Center is granting permission for you to approach the families of ICU patients to ascertain their willingness to participate in your study with the following stipulations.

- ❑ You must sign and return the enclosed Confidentiality/Agreement Statement.
- ❑ You agree to clearly define the purpose of your interview with the participants;
- ❑ as well as explain to the participants and verify their understanding that these interviews are being conducted in accordance with completion of a thesis and not as an HMC project.

Please do not hesitate to contact me if you have any questions or concerns. Please allow me to extend to you the best wishes of the Administrative staff for the successful completion of your educational program.

Very truly yours,

Leonard Freehof
Chief Operating Officer

LF:jer

Enclosure

Misc\Remonte.Approval

cc: Human Resources
Rachelle Zahniser
Janice Riley

TENET
SOUTH FLORIDA HEALTHSYSTEM

APPENDIX C

PARTICIPANT CONSENT FORM

Project Title: Living the Experience of Family Visits in the Critical Care Setting: A Phenomenological Study

Dear Client,

You are being asked to participate in a study to investigate the phenomenon of living the experience of family visits in a critical care setting. Because you have recently experienced this phenomena, your description may be of future benefit to both nurses and clients.

If you agree to participate in this study, you will be interviewed one or more times for a period of about 40 minutes. An interview will be scheduled at a mutually appropriate time and place and will consist of questions regarding your lived experience during family visits while you are in a critical care setting.

There are no risks to you from participation in this study. All information will be kept anonymous and confidential, and each transcript will be assigned a code number. The recorded interviews will be kept locked at all times and will be shared only with the researcher and her thesis committee. The tapes will be erased when the research is complete.

The benefits of this study are to expand the body of nursing knowledge concerning of the lived experience during family visits while in critical care setting. You will not be paid for your participation. There is no funding for this research.

Thank you for you time and attention in considering participating in this project.

Sincerely,

Sonia Remonte, R.N., BSN, CCRN

You agree to participate in this research project. You have reviewed the above information and discussed it with Sonia Remonte R.N. (Researcher), who may be reached at 305-753-2049 after 6 P.M. daily. You may address any other concerns about this research by calling the Office of Sponsored Research at Florida Atlantic University at 407-367-2310.

Signed:_____ Date:_____
Participant

_____ Date:_____
Researcher

APPENDIX D

SIGNIFICANT STATEMENTS

A. I feel relieved when my family is there.

B. Give me a lift emotionally.

C. Nice to see you have visitors especially your family.

D. Takes away my fears.

E. My family talks to the doctor and nurses to know about my care.

F. Encourage me to move on.

G. Give me a will to live.

H. Relays information to my other families.

I. Communicates to health care team.

J. Your family is concerned about you.

K. Someone cares for you.

L. You don't feel alone.

M. I feel good when they are there.

N. I feel secure.

O. They give me support.

P. I know I'm okay because my wife is there.

Q. Someone is there to check if things are done right.

R. Just their presence is enough, makes me feel better.

S. Puts you in a relaxed mood, instead of being scared at all times.

T. Family explained the care.

U. My family helps in cleaning after use of bedpan.

V. Be sure I'm being taken care of.

W. I didn't trust anybody except my wife, because she's a nurse.

X. I thought I'm dying until I saw my wife.

Y. It is a frightening experience when I can't talk, when my hands are tied; family presence helps me to be less scared.

Z. When my wife was holding my hands, I cried.

APPENDIX E

FORMULATED MEANINGS

A. Family's visit makes the patient feel at ease, secure, takes away fears, and gives emotional lift.

B. Family visiting patients in critical care unit helps them in a variety of ways, by their presence, by serving as patient advocate before the health team, and by serving as a link between hospital and home.

C. Family visits are very helpful. Their meaning can best be captured by comments such as, "They make me feel better," "It relieved my mind," "They raised my spirits," "They give me a feeling of security," "You are not alone," "Someone cares."

D. Family visits serve as a vital support system to the patient in a critical care unit.

E. Effects of family visits create an environment for better coping mechanisms and adaptability to their illness.

F. Family visits serve as a buffer and assist the patient in maintaining psychological integrity in a critical care setting.

G. Family visits have a significant impact on patients' well-being by communicating effectively with the health care team.

H. Family presence help patients in critical care unit to better adjust to an unfamiliar setting.

I. Family visits helped patients meet their physical needs like bathing.

J. Family visits foster feeling of hopefulness and desire to get better.

APPENDIX F

THEME CLUSTERS

1. Family visits enhance patient's well-being.
   - A. Family's presence puts patient at ease
   - B. Family's presence relieves patient's anxiety
   - C. Family's visit makes patient feel better
   - D. Family visits helps patient feel comfortable
   - E. Family visits show they are concerned about patient's welfare
   - F. Family visits acknowledge patient's desire not to be alone
   - G. Family assist in meeting their physical needs
   - H. Family checks the care given to the patient
   - I. Family visits gave patient reassurance
   - J. Family visits foster patient's desire to get better
2. Family visits provide patient support system
   - A. Family provide patient emotional lift
   - B. Family encourages patient's desire to live
   - C. Family instill hope in the patient
   - D. Family helped patient develop sense of confidence
   - E. Family understand patient's pain and frustrations
   - F. Family restore patient's SENSE OF CONTROL
   - G. Family LISTENS to patient's frustrations
   - H. Family treats patient with respect
   - I. Family visits create an environment of hopefulness
   - J. Family provide unconditional love

3. Family visits facilitate means of communication among patient, health care team, and other family members.

   A. Family kept patient informed

   B. Family provided information about the care of to be given

   C. Family spent time discussing the care given

   D. Family provided information to the patient

   E. Family relays information to other family members

   F. Family visits gave an opportunity for family to ask doctor and nurses questions about patient's care

   G. Family reinforced information about the care for better understanding

   H. Family visits create an environment of learning, teaching, and experience