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Need Satisfaction of Families of Emergency Department Clients

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NEED SATISFACTION OF FAMILIES OF EMERGENCY DEPARTMENT CLIENTS

by

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VITA

Patricia Marie Rovelli, is the daughter of Joseph Rovelli and Margaret Manning Rovelli. This author was born December 12, 1951 in Jersey City, New Jersey.

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CHAPTER I

INTRODUCTION

The admission protocol of emergency departments are generally devised to render prompt service to the client, however family members who accompany the ill or injured individual often receive delayed and limited care. The relative is asked to provide pertinent information, and then requested to stay out of the way. Often, the family members are directed to a waiting area where they anxiously wait to be informed of the client's condition. The time passed in this confined area can vary from one to several hours and generally precipitates a multitude of overt feelings and behavior related to the crisis. Such feelings include shock, anger, panic, separation anxiety, guilt, and remorse. Furthermore, a period of prolonged waiting often without adequate information about or personal contact with the client can intensify these feelings.

Undoubtedly, the client's family has a number of needs requiring intervention; however, these needs are often ignored or inadequately attended to by the professional staff. Frequently, the emergency department professionals only become aware of the plight of their client's relatives when the relatives demand information or request some personal contact with their sick kin.

Recently the needs of family members have been documented and health care professionals have begun to realize that parallel

efforts must be directed toward meeting the adaptive needs of relatives who also experience suffering due to the trauma of their sick family member (Bunn & Clark, 1979; Cruz, 1982; Eggland, 1975; Epperson, 1977; Farber, 1978; Groner, 1978; Hoover, 1979; McKnight, 1973; Yoder & Jones, 1982). The American Nurses' Association's Standards for Emergency Nursing Practice (1982) state that emergency care nursing should encompass activities conducted toward the care of clients and supportive measures for their family. However, recent studies have documented that some emergency department nurses have contrary beliefs regarding supportive interventions for relatives in the emergency department. Specifically, Yoder and Jones (1982) investigated the psychosocial skills of nurses working in the emergency department. These researchers reported that some nurses regarded the clients' families as "being in the way". Other emergency department nurses viewed the families as "being time-consuming" and believed that the focus of nursing intervention belongs to the ill client. Thus, the clients' relatives may be thought of as an additional burden, distracting from the care of the clients, as opposed to being thought of as individuals who also suffer from the crisis and who can serve as a vital support system for the clients.

A. Statement of the Problem

In view of the multitude of emotional responses (i.e., shock, anger, panic, separation anxiety, guilt, and remorse) of family

members to an emergency situation, and in light of the attitudes of some emergency health caretakers toward these individuals, this investigation examined the degree to which needs of families waiting for emergency department clients have been met. In addition, an attempt was made to ascertain the role category (i.e., nurse, physician, secretary, self) of the individual(s) who assisted the relatives to meet their needs. The two major assumptions of this study were: 1) serious illness or injury of a famliy member affects the entire family, and 2) nursing intervention can assist family members to adapt to their crisis.

B. Definition of Terms

1. Need -- the feeling of a want or desire by the relatives for some necessary aid, which, if supplied, relieves or diminishes their immediate distress and provides an immediate sense of comfort and well-being necessary for optimal coping abilities.

2. Satisfaction -- the fulfillment of needs.

3. Need Satisfaction -- the extent to which desires or wants are fulfilled. This has been operationally defined by asking the relatives of seriously-ill emergency clients to respond to a 32 statement, 6 point scale instrument of broadly classified intra-personal, interpersonal, and environmental needs defined by families of seriously-ill clients (Molter, 1977; Rovelli, 1980). These needs were assessed via a Likert-type scale. The scale measuring the degree of need satisfaction consists of strongly agreeing

(i.e., definite need satisfaction) to strongly disagreeing (i.e., the need not being satisfactorily met) with respect to the extent that each need was met.

4. Family -- an adult, 18 years of age or older, related to the client by ancestry, marriage or within the community of one's household. This significant adult family member accompanied the client or was summoned to the client in the emergency department. This relative waited during the emergency visit, performed admitting procedures and generally accompanied the client to his or her hospital room.

5. Client -- an individual with a perceived physical or emotional alteration which is undiagnosed and may require prompt intervention. This person employs the services of the health care professionals in an emergency department.

6. Emergency Department Clients -- Rutherford et al. (1980) has defined areas of classification for emergency department clients: life-threatening and/or severe, major, and minor. The life-threatening classifications include cardiac and respiratory arrests. Severe problems include acute respiratory distress; burns; head, neck and thoracolumbar spine; fractures of the facial bones; chest and pelvic injuries; injuries from guns; shock; and unconsciousness. Major conditions encompass chest pain, dyspnea and cough, abdominal pain, rectal bleeding, extremity pain with vascular or neurogenic etiology, and psychiatric emergencies.

The last category, minor problems, consists of wounds; musculo-skeletal problems; foreign bodies; and eye, ear, nose, and throat disorders; and dermatological conditions. This investigation utilized families of emergency department clients with alterations of the severe and major category who were treated in the emergency department and admitted to the medical center. This study eliminated those relatives with minor problems as defined by Rutherford et al. (1980) as well as families of sudden death victims (i.e., those clients who are dead on arrival, die during the time in the emergency department or during the admitting procedure).

CHAPTER II

REVIEW OF LITERATURE

A. The Impact of a Relative's Sudden and Serious-Illness or Injury on the Family System

The concept of the family as a system implies that a change in one member will bring about a corresponding change in the rest of the members of the system (Dixon, 1979). It can thus be safely assumed that illness in an individual disrupts the whole network of family relationships. Olson (1970) states that "serious illness is a family affair, and the family not just the client has the illness" (p. 172). Olson bases this statement on the fact that family members occupy and function in roles defining relationships to one another (e.g., father-husband, daughter-sister, etc.). Family members seem to function in these roles according to the expectations of the whole family and the action of any individual member affects all, producing reaction, counteraction and shifts in family equilibrium. According to Jackson (1965), families operate within certain sets of rules which define and govern relationships and maintain equilibrium in the system. In the event of a serious illness or injury, Olson (1970) remarks that old roles and rules may be insufficient to maintain sensible organization when a family member is removed from the home. The nature of the illness or injury, the outcome of the crisis and the absence from the home all

create new demands of the family. As a result, these authors propose that serious illness of one member often precipitates a crisis within the family, transforming the highly organized family system into disequilibrium (Jackson, 1965; Olson, 1970).

Health professionals increasingly are becoming aware of the concept of a family as a system and observations of this group attempting to adapt to a serious illness or injury in the family have been investigated and reported. These coping mechanisms vary widely from person to person and from one crisis situation to another.

Geary (1979) described the coping behaviors most common to families of patients in the intensive and cardiac care units of the hospital. The behaviors or mental processes families have used to come to terms with the illness or injury of a family member were: minimization, intellectualization, repetition, acting strong and competent and remaining near the patient.

The most prevalent coping mechanism, minimization, was characterized by reducing or attempting to ignore the significance of the event. This mechanism takes on several forms, one of which is a cheerful demeanor while visiting the patient. Another form of minimization was demonstrated as an inability to understand or remember information about the patient's condition. Even after several explanations, these families stated they were never given information and constantly requested knowledge of the illness and prognosis (Geary, 1979).

The use of intellectualization implies the adoption of an overly rational attitude accompanied by a de-emphasis on feelings involved in this experience. A select group of relatives spoke quite frequently about the intensive care machinery with little mention of how they felt about their family member's dependence on those machines. This method seems to have as its purpose the avoidance of painful feelings (Geary, 1979).

Some subjects in Geary's study repeated the same statement over and over, as if trying to convince themselves of the event. Repetition seems to have more than one meaning. Some relatives appeared to be working-out a solution or convincing themselves of the crisis events.

Family members also presented themselves as strong, competent, and able to deal with the illness. This role of "the strong one" seemed to serve as an individual and family function. Wives acted brave and calm so as not to disturb their patient-husband. The wives focused on concrete areas of strength: care of the children and work outside the home. As substitute for the ill family-leader, they describe themselves as stable and dependable at an emotional time for the family members (Geary, 1979).

The last coping mechanism encountered was "being there". This remaining with the client was manifest by spending long hours in the waiting room because relatives felt better being there, and this "being there" was seen by some ethnic families as a necessary element in the care/cure of the patient. Geary (1979) states this

knowledge of families' behavior at the time of a crisis can assist nurses to determine how well they are coping with the client's illness and how nurses might support effective coping.

In the case of trauma, the client's injury often occurs without any warning to the other family members. Gardner and Stewart (1978) recognized that these relatives initially feel shock, fright, disbelief, and numbness. Some feel responsible for the client's condition because of something they did or failed to do. They may feel guilty about their anger at the client for being injured.

After the client's admission to a trauma unit, these relatives feel painfully helpless about their inability to influence the client's recovery. They are disturbed by the foreign sights, sounds and smells of the unit. They are forced to trust strange nurses and physicians who use mysterious equipment and procedures to treat the client. They respond with anxiety, anger, fear, depression, and loneliness, to the physical separation from the client and having to contend with the uncertain prognosis. Furthermore, family members may experience unpleasant feelings and memories from the past activated by the client's current plight. These include feelings and memories related to illness of self or important others, separation and death of loved ones (Gardner & Stewart, 1978).

The families of emergency department clients suffer similar feelings that have been associated with multi-causal variables.

The pictorial representation described by Eggland (1975) of families in the emergency waiting area demonstrates increased familial anxiety. Anxiety created by their crisis is often increased rather than decreased by the physical and emotional atmosphere in the emergency department and lack of communication with professional personnel.

Specifically, the family, confined to the waiting room, is often ignorant of the degree of seriousness of the client's condition, diagnostic studies being performed, proposed treatment, progress and sometimes even plans for hospitalization. In the absence of facts, anxiety feeds upon their imagination. Often, the family feels tied to the waiting area for fear of missing information. Waiting, no matter for how short a time, can seem almost intolerable to the family. It is generally after long periods of waiting that families begin to raise their voices and demand information about the client and an opportunity to see him (Eggland, 1975).

The frequency of stressful events which require prompt intervention and sometimes elicit bewildering routines contribute to the urgency of the emergency department atmosphere. This hectic environment often serves to create apprehension for the family. In addition, the anxiety of the family members in the waiting area may be intensified by their view of staff who may often appear tense while working in confined areas with seriously-ill clients (Eggland, 1975).

Eggland (1975) agrees that a sudden acute illness or injury is not only a threat but also a disruption to the family system. Interfering with family association and threatening emotional and economic security, it causes dread of the crisis outcome, and anxiety over recovery.

This disruption to the family system manifests itself daily in trauma centers equipped to give intensive, comprehensive treatment to severely-ill and multiple-trauma victims. Within such a trauma setting, Epperson (1977) postulated that families experience severe stress when confronted with threatened or sudden death of one of their family members. She studied families of individuals who had suffered multiple injuries after a road, industrial, or recreational accident and identified six phases of the recovery process. These six phases include the following: high anxiety, denial, anger, remorse, grief, and reconciliation. Although there may be some diversity in their reaction and recovery, most families in crisis appear to go through or experience some phase of this recovery model before the family system is able to reorganize, reintegrate and regain its homeostatic state. She suggests that differences in regard to the sequence of the phases, the rate of passing through the stages and sometimes elimination of a stage or more should be noted in the families' reactive and adaptive process. She also believes that all family members do not pass through the phases at the same time and each member is unique in completion of the process. Despite these

variations, Epperson's (1977) phases describe a distinct, identifiable method of family recovery (see Figure 1).

It has furthermore been demonstrated that family members of emergency department clients also respond physiologically to the impact of sudden and serious illness or injury. Bliss, Migion, Branch and Samuels (1956) have reported a significantly increased corticosteroid level in relatives in response to the emotional stress of a family member's sudden injury or acute illness and admission to the emergency department. Although these levels characterize the mean of the sample (i.e., N = 26), these authors also report that there were several individuals whose values were normal despite considerable emotional disturbance. The latter may be related to the fact that individuals not only differ in their psychological response to a stressor but also in their physiological response, including adrenocortical secretion. This was demonstrated in a study of parents of hospitalized leukemic children (Wolf, Hofer, & Mason, 1964), some of whom responded to a crisis in the course of their child's illness with an increase in plasma cortisol whereas others did not. This difference in response is thought to be due to individual differences in adaptive coping mechanisms. Thus, effective coping mechanisms can minimize both the emotional and physiological response to a traumatic event such as the sudden and serious illness of a family member.

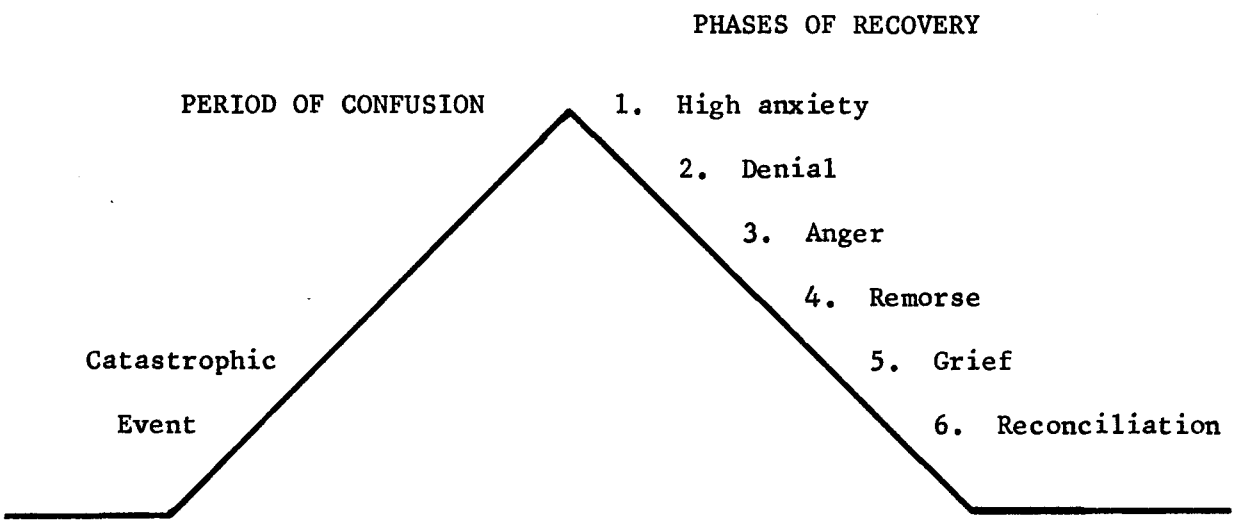


Figure 1.

Epperson's Six Phase Recovery Process

In summary, health professionals have recognized that "serious-illness or injury is a family affair and the family, not just the patient has the illness" (Olson, 1970, p. 172). It is the responsibility of health professionals to assist these families to utilize effective adaptive mechanisms in order to maintain a stable family system which is vital to the client's reattainment of health.

B. Toward Adaptation: Suggestions for Support of Families of Emergency Department Clients

When a client comes to the emergency department with a condition he, or his family, perceives to be urgent in nature, relatives have expressed certain needs which if met will assist the families' adaptation to the crisis. McKnight (1979) studied sixty families in emergency room waiting areas. Her results demonstrated that all the relatives waiting for clients who were being treated in the emergency department wanted to receive information about the clients' progress. It is interesting to note, however, that only 45% of these relatives initiated action to obtain information concerning this matter. McKnight also reported that 85% of the subjects requested some degree of personal contact with the client during the emergency visit.

McKnight (1979) concluded that the relatives' past experience, the nature of the client's condition and the environment are primary factors influencing the families level of anxiety and need for information. A relative's first encounter with an emergency

department results in a greater need for information than on subsequent visits. It is this initial visit when uncertainties associated with emergency department routines precipitate a need for information (McKnight, 1979).

The more acute the client's condition, the greater the need for families' to receive information. In other words, the relative accompanying the client suffering from an asthmatic attack is more likely to need information than a relative accompanying the client with a sore throat (McKnight, 1979).

A third factor influencing the need for information was the environment in which the family must wait. The study revealed that a waiting room which meets the basic needs of the population (i.e., accessible wash rooms, vending machines and telephones) tended to reduce their anxiety levels and need for information.

McKnight (1979) commented that within the family waiting area the intermittent presence of a nurse who provided client information seemed reassuring to the families. Furthermore, it was recognized that the interrelationship of all these factors (i.e., past experience, nature of the client condition and the environment) will assist the coping ability of relatives and friends. Thus, obtaining information and reassurance by a nurse, making observations at the side of the client and a comfortable environment to wait in are strategies which will decrease relatives' anxiety and increase their adaptative abilities to the crisis situation.

A similar investigation to determine the needs of families of emergency department clients was carried out by Rovelli (1980). She interviewed twenty families of seriously-ill emergency clients during the crisis period. Families were asked to rank in order of importance a list of thirty intrapersonal, interpersonal and environmental needs previously defined by families of critically-ill clients (Molter, 1979), along with the perceptions of family needs recognized by emergency department nurses and client-family representatives. Results indicated that the family's most important needs during the emergency visit were: 1) to be assured of the emergency staffs' professional concern; 2) to be confident in the staff's competence in contributing to the well-being of the critically-ill or injured client; 3) to be kept informed of the client's condition and progress; 4) to have questions answered honestly and in terms that were understandable; and 5) to have an opportunity to see the client.

A study by Cruz (1981) determined the need and perceptions of thirty family members of emergency department clients as revealed by their information seeking behavior. Her analysis indicated that a relationship existed between the need for information and the actual and perceived time the relatives spent waiting in the emergency department. Thus, as the actual and/or perceived time increased, the need for information increased. Results also demonstrated a direct relationship between the family members age and their need for information. Hence, as the family

subject's age increases, so does their need for information. Contrary to McKnight's (1979) analysis, there was no relationship between the severity of the client's health problem and the need for information. Furthermore, there was no recognized relationship between the family member's feelings or gender and the need for information. Additionally, the study revealed that 100% of the subjects' desired to be kept informed of the client's condition. Ninety-three percent desired to be active participants in client care, 23% desired to stay by the client at all times, 43% at all times except during the exam, and 33% to see and speak with the client every hour but otherwise remain in the waiting room (Cruz, 1981).

These psychosocial and environmental needs, identified by the families of emergency department clients, indicate some approaches that staff can implement toward supporting family adaptation to a crisis. Eggland (1975) summarizes such approaches for emergency nurses to utilize when assisting families of emergency department clients. This author suggests that the presence of a calm, efficient emergency department nurse will reduce familial anxiety and convey a feeling of security. Periodic reporting by this nurse concerning the client's progress provides the facts necessary to prevent constant questioning and sometimes the flight of imagination. After the doctor has examined and planned treatment for the client, the nurse can arrange a time for the doctor to talk privately with the family in a nearby room. When appropriate,

a time for the family to see the client may be designated. During long waiting periods, physical comfort of the family can be promoted by telling them where they can get a cup of coffee or make a telephone call. Prior to the client's discharge, the nurse may suggest community referrals for the family and/or client.

Based on her six phases of a family's recovery from a catastrophic event (i.e., high anxiety, denial, anger, remorse, grief, and reconciliation), Epperson (1977) suggested specific interventions health professionals can use to assist the family. During the initial period of high anxiety which is characterized by great physical agitation (i.e., high-pitched voice, wringing of hands) and other body reactions such as nausea, vomiting and diarrhea, staff must spend time providing brief, accurate information about the client and the reassurance that everything possible is being done. The family should also be encouraged to ventilate their feelings (Epperson, 1977).

The denial phase acts as a psychological preparation for any further bad news the family may receive about the client. Sometimes it provides an element of hope for the family to hold onto or it may indicate a sign of regression to childhood "magical thinking" (i.e., in spite of what happened, everything will be all right!). It is important for the staff to maintain a balance in this situation between the need for denial and the need to deal with reality. A statement such as, "Mr. Smith, John was such a healthy boy, it must be difficult for you to believe

that he might now be paralyzed," acts as a reminder of what is, without removing the denial defense. Appropriate reiterating of similar statements to the family conveys understanding and acceptance of their struggle with reality. Often, the denial phase lasts until the family is able to speak to the client (Epperson, 1977).

Anger expressed by families under sudden, severe stress seems to be amoeboid, taking many different shapes and directions. During this phase, anger can be directed inward or toward another family member in an apparent attempt to place the blame for what has happened. It can also be directed toward the physician and nursing staff, or the emergency medical technicians. Often, it is a diffuse kind of anger that lashes out at society or at life in general for allowing to exist circumstances such as high speed limits and lenient drunk-driving laws that may have contributed to the tragedy. During this phase, the health care provider interacting with the family should encourage ventilation of angry feelings and assist them to focus on the real cause of their anger. Epperson states that eventually the family realizes that they are really angry at the client for disrupting the family routine and causing great stress and disorganization within the family system. In dealing with families, Epperson has noted that unless the anger family members feel toward the client is verbalized and dealt with, expression later of passive-agressive behavior can cause further destruction to the family system. Also,

these family members need to be given reassurance that they are not "bad" persons for feeling angry (Epperson, 1977).

The grief phase usually follows the period of remorse. The family, at one time or another, experiences an intense period of sadness, a grieving time when their sense of loss, even temporary loss, becomes almost overwhelming. At this time, tears and deep sobbing are frequent. Some family members withdraw into privacy. Tears shed during this phase are different from those that offer a cathartic release of tension in the anxiety phase. This stage is the beginning of a grieving process, the duration and intensity of which depend on such factors as the medical condition of the patient, length of hospitalization, the family solidarity, and the degree of remorse experienced by the family. Most often, the health care provider just sits quietly with the family members, offering silent support. Many times physical closeness, holding a trembling hand, or embracing limp shoulders, conveys and empathy for and an understanding of what the family members are experiencing. These empathetic gestures are often all that are needed to begin the flow of copious tears that give some release to the deep emotional feelings of loss (Epperson, 1977).

Reconciliation usually occurs last and is a culmination point for the health care provider's intervention. At this time the high state of anxiety is diminished, the reality of the situation is clear or is becoming clearer to the family, anger and remorse have usually been expressed, and the grieving process has

begun. This is a phase of putting things in place, of being reconciled to the fact that something terrible has happened that deeply affects, and will continue to affect, the total family unit. Included in this period of reconciliation is a realistic sense of hope that, whatever hardship this tragedy may impose, the family can and will survive. This is the time when mobilization of the family system's resources begins, if it has not already, to enable the family to adapt to the current situation and cope with whatever is to come. During this phase, family solidarity seems to emerge and develop through concerted effort on the part of the family to plan for the future. During this phase, the social worker helps the family to start thinking about and begin to develop a feasible plan of action (Epperson, 1977).

An awareness of these relevant methods of intervention will provide emergency department nurses specific modalities for the care of relatives of severely-injured emergency clients. Furthermore, this holistic approach to emergency care promotes a healthy transactive process for families and their life situation.

C. Models of Family Intervention

Current literature discussing emergency patients emphasizes the need to give special consideration to families of these acutely ill patients (Yoder & Jones, 1982). In view of the identified psychosocial needs among emergency client's families, health professionals have designed programs in which nurses,

social workers and/or chaplains have extended their roles to offer support, communication and referrals for families in the emergency waiting area (Epperson, 1977; Fives, 1977; Groner, 1978; Hoover, 1979).

Groner (1978) describes a program of social work delivery in the emergency department. The application of crisis intervention theory is practiced by the assigned emergency department social worker. The utilization of this professional offers clinical evaluation, community referral and advocacy for client and/or families with a variety of problem categories (i.e., traumatic injury, death in the family, minor medical problems but severe anxiety and/or social problems, and need for assistance to utilize community resources). Successful social work interventions have been noted along with a reduction in the stress and pressure of the emergency setting.

Fives (1977), a head nurse in an emergency department, states that "chaplains are great when it comes to supporting the families of your critically-ill clients" (p. 58). This author remarks that there are many situations when emergency department nurses cannot take time to comfort or help families. Therefore, this emergency team requested clergymen to support and provide communication to these families. Every evening a clergyman (from a group of 25 including various denominations) volunteers to provide consolation, amenities, communication and other acts that ease the stresses experienced by anxious relatives. This family intervention program implemented by clergymen has proved to

be invaluable for the families and greatly appreciated by the emergency department nurses.

In an attempt to meet the psychosocial and physical needs of critically-ill client's relatives, a Nevada medical center designed a support and communication protocol that includes chaplains, physicians, social workers and critical-care nurses. This holistic and humanistic approach to critical care is initiated by the physician or emergency department nurse when relatives of severely-injured clients are assessed in the initial stages of the family crisis in the emergency department. This family care takes place even if the client is never admitted and dies in surgery or in the emergency department. If the client is admitted to intensive care, the psychosocial support begins in the emergency department and continues in the intensive care unit as long as necessary. Social workers and chaplains spend time with relatives in the waiting room. They bring relatives in to visit the clients, keep nurses and families interacting, help relatives understand medical equipment and procedures being used and the doctor's explanations of conditions, treatments, and prognosis.

In the intensive care unit, social workers and chaplains are in the unit during visiting hours. They focus on crisis situations that may develop, answer questions and at times provide physical comfort measures for the family. Intensive care nurses circulate among clients and relatives. They provide emotional care for relatives and once settled they implement

client and family teaching. They organize their client care schedules to leave the half-hour visiting periods for this holistic care.

Since the development of this program, the health professionals have expressed pride in knowing that their care has benefited clients and relatives. Furthermore, this support and communication system helped to transform one of the most potentially troublesome areas of the hospital into one of its strongest family and professional relation assets (Hoover, 1979).

D. Summary

This review of literature described the impact that sudden serious-illness or injury may have on the family system. Additionally, it identified familial needs at the time of a crisis and reported approaches that have been recognized by professionals as being useful in meeting these needs. Furthermore, a section describing the existing multi-discipline protocols that have been initiated to develop effective treatment in assisting these families has been documented.

It is clear from the preceding literature that a need exists for nurses to expand their psychosocial skills to assist relatives to adapt to the serious illness or injury of their family member. With this expanded role, nurses will implement holistic care in the emergency department when clients and families are suffering during the onset of their crisis. A limited number of studies

have addressed the need satisfaction of families of emergency department clients. Therefore, the purpose of this research was to determine the degree of relative satisfaction and to identify the individual (i.e., professional or other) who assisted the family member.

E. Theoretical Rationale

The theoretical framework applied to this study is the crisis model as developed by Lindeman and Caplan (1963). Crisis intervention is a brief treatment modality having the current crisis as its focus. Its goal is to reestablish the equilibrium that is disrupted by the crisis situation (Parad & Caplan, 1960).

"Crisis" in its simplest terms is defined by Caplan (1960) as "an upset in a steady state" (p. 34). This definition rests on the systems theory concept that an individual, a family, or any social system strives to maintain a state of equilibrium through a constant series of adaptive maneuevers and characteristic problem solving activities that allow for basic need fulfillment to take place. Whether a situation or event becomes a "crisis" depends greatly on how the family interprets the event in light of its own cultural and historical experiences. A crisis for one family may not be one for another.

Throughout a living system's life span, many situations or events occur which can lead to sudden breakdowns in the system's functioning. One event that can disrupt the usual homeostatic

state of a family system is the sudden, serious illness or injury of one of its members.

It is postulated that in a state of crisis the system's usual problem solving mechanisms are insufficient and do not rapidly lead the system back to a state of equilibrium. Often, a family must find new ways to deal with the situation which, up to the current crisis state, have been outside the realm of the family system's experience. Generally, these families require external intervention from professionals to maintain a healthy family system.

CHAPTER III

METHODOLOGY

A descriptive, non-experimental design was implemented to measure the degree of need satisfaction of family members who accompanied seriously-ill relatives to the emergency department. A structured interview schedule was used to collect the data. The interview guide consisted of a list of thirty-one statements with a six-point scale of broadly classified interpersonal, intrapersonal, and environmental needs. The subjects were requested to express the degree of need satisfaction only for those needs which were applicable to them during the time that they waited while their relative (i.e., the client) was being cared for in the emergency department. In addition, subjects were asked to identify the individual category(ies) (i.e., nurse, physician, secretary, self, or other relative, etc.) responsible for meeting each need. Anecdotal comments reflective of the emergency visit were also recorded.

A. Sample Selection

The accessible population for this study was comprised of the families of emergency victims who were summoned to the hospital and who waited in the emergency department. Non-random, systematic sampling was used to select as a subject one member of the client's family. This method consisted of selecting every second family whose relative's name appeared on the emergency

admission's list and whose admitting diagnosis met the criteria for classification as either a severe or major condition. Subjects were selected at random periods throughout the day, evening, and night hours.

The five specific criteria for selection into this study were that the clients: 1) had severe or major conditions (as previously defined by Rutherford et al., 1980); and 2) were ultimately admitted to the hospital once stabilized in the emergency department. Additionally the interviewee (i.e., the client's family member): 3) was English speaking; 4) was able to read and write; and 5) consented to participate.

B. Setting of the Study

The setting for this study was the emergency department of a regional trauma center located in the midwest. Potential subjects were first contacted in the emergency department, but interviews were conducted on the hospital unit in a private area that was both comfortable and quiet. Data was collected during the months of August and September, 1982. Written permission to conduct the study was procured from the Institutional Review Board, as well as from several administrators residing over research and emergency care services in the medical center (Appendix E). Written informed consent to participate in the study was obtained from each subject (Appendix D).

C. Collection of Data

Following the client's emergency care and subsequent admission to the medical center, the selected family member was contacted by the researcher in the client's room. The purpose and nature of the study was explained and if the family member chose to participate in the study an appointment was made for the interview. This meeting was scheduled within twenty-four hours of the emergency visit. At the designated hour, the researcher met the relative in the client's room and accompanied him/her to a private area for the interview. After the prospective subject signed an informed consent (Appendix D), each need statement was read to the subject who was then asked to respond strongly agree, agree, uncertain, disagree, strongly disagree, or not applicable. If a need statement was identified by the subject as being applicable, he/she was then asked to identify the individual (i.e., nurse, physician, secretary, relative, etc.) who assisted him in meeting that need. Additional verbal responses reflective of the emergency visit were also recorded by the researcher. Confidentiality was maintained by omitting the family name from the tools. Furthermore, the family member was free to withdraw from the study during the entire time of the investigation.

D. Instrument

The instrument designed to measure the degree of need satisfaction of families of seriously-ill emergency department clients consisted of a two-part, forty-three item interview guide developed by

the researcher. The tool evolved from needs previously defined by relatives of seriously-ill clients (Molter, 1979; Rovelli, 1980), and perceptions of these needs described by emergency department nurses and patient-family representatives.

Part I consisted of thirty-two declarative statements which describe a specific need a family member may have encountered during the time they spent waiting in the emergency department. The needs were broadly classified as either intrapersonal (i.e., being able to have a family member or close friend accompany me when seeing the client), interpersonal (i.e., being able to see the client and given information regarding the condition of the client), and environmental (i.e., being able to sit in a waiting area near the client and to have use of a public telephone near the waiting room). A Likert-type 6-point scale measured the degree of satisfaction for each need as the relative responded to either SA (strongly agree), A (agree), U (uncertain), D (disagree), SD (strongly disagree), or NA (not applicable). In addition, each need statement was followed by a classification of individuals. When the need was applicable, the respondent was asked to state which classification(s) most clearly identified those who assisted them to meet that particular need. The classification of individuals consisted of nurse, physician, secretary, social worker, other relative, friend, other visitor, and a section to record any other individual which was not listed. Part II consisted of open-ended questions

regarding demographic data (i.e., age, sex, education, occupation, etc.) of the family member and circumstantial information (i.e., nature of the crisis; time waiting, etc.). Since this was the first time the instrument was being used, a pilot study was conducted and test-retest instrument reliability (i.e., stability) was assessed. Eight of the 15 subjects responded to the tool within twenty-four hours of the emergency visit and then after forty-eight hours. The test-retest scores are shown (Figure 2) and the linear equation which defines the line is $y = 1.22\ x - 19.6$. A significant ($p < .05$) correlation was shown using the Spearman Rank Order Test ($r_s = 0.87$).

E. Data Analysis

1. Chi-Square Analysis

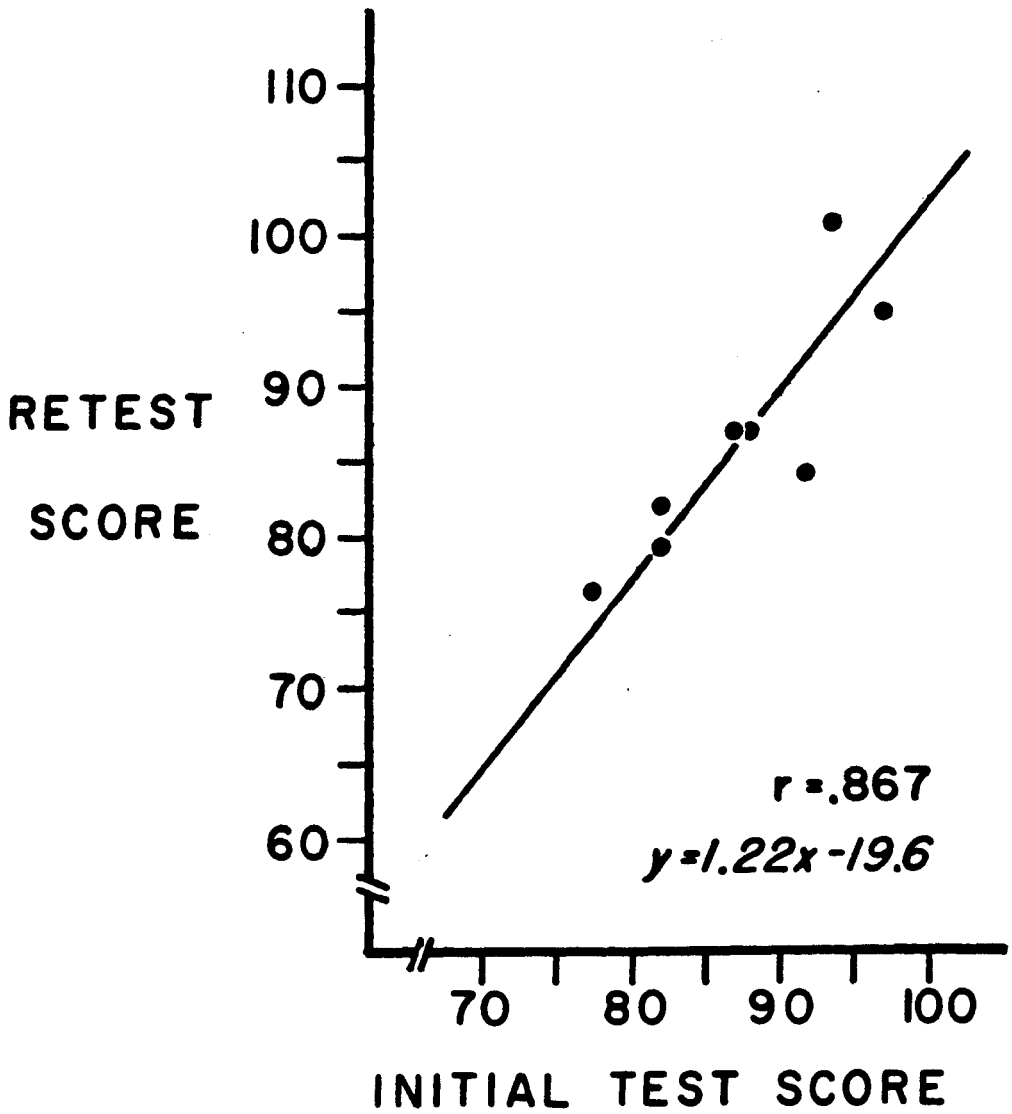
The extent of agreement (i.e., SA, A)/disagreement (i.e., SD, D) was computed for each individual need statement by Chi-square analysis. Chi-square was also used to determine the total agreement/disagreement to all thirty-one need statements. In addition, the determination of those needs which did not apply to the sample was obtained using the Chi-square. The probability for significance was set at $p < .05$.

2. Percent of Need Satisfaction

The response to each need statement was scored in the following manner: SA = 4, A = 3, D = 2, SD - 1. The uncertain category was not used, since it was only chosen three times in this study. The percent satisfaction score was computed according to

Figure 2

Figure 2 illustrates the reliability (i.e., test-retest) of the tool. Each point describes the relationship between the initial test score and the retest score for a single subject. The line was determined by linear regression for eight subjects (N=8). The equation of the line fitting the form $y = mx + b$ was: $y = 1.22x - 19.6$. The correlation coefficient, r, was .867. This was found to be a significant positive correlation ($p < .01$).


110
100
90
80
70
60
RETEST
SCORE
r = .867
y = 1.22x - 19.6
70
80
90
100
INITIAL TEST SCORE

Carey and Posavoc, 1973. Each subject's actual score was determined and divided by his maximum possible score. The maximum possible score was computed by assigning "4" to those needs which applied to that individual (i.e., excluding all the not applicable needs).

$$\text{Percent Satisfaction} = \frac{\text{Subject's Actual Score}}{\text{Maximum Possible Score}}$$

The overall percent satisifaction (i.e., for all thirty-one items) was determined as well as for only those items that applied to the sample population (i.e., excluding those items based on the Chi-square analysis that were significantly not applicable). Statistical differences between percent scores were obtained using either the independent Student's t-test when two groups were compared or analysis of variance for comparing more than two groups. $p < .05$ was accepted as significant.

3. Individual's Meeting Family Needs

A percent was calculated indicating the individual categories of those who had assisted the relative in meeting their needs. The percent of the individual category(ies) was computed by obtaining a sum of each category divided by the total of all the individual category(ies), minus the not applicable items. This value indicates the individuals' role categories identified as most responsive to the relative's needs.

4. Demographic Data

The demographic data (i.e., age, education, relationship to the client, nature of the crisis, familiarity with the emergency department, and hours waited) were analyzed using descriptive statistics.

CHAPTER IV

RESULTS

A. Overview of the Design

The aim of this descriptive study was to determine the degree to which the needs were met of families waiting for emergency department clients as well as to identify the individuals who participated in trying to meet these needs. The findings are presented foremost by illustrating the relatives' overall satisfaction scores. These scores are then classified for an analysis of extraneous variables which may have influenced the relatives' responses (i.e., time of day summoned to the emergency department, waiting time, and the relatives' relationship to the client). In addition, relatives' anecdotal comments are summarized (Appendices B and C).

B. Section I: Demographic Data

Fifty-one family members volunteered to participate in this study, the majority being female (73%). The mean age of the group was 44 years $\pm$ 2.05. Table 1 illustrates the family relationships of the subjects to the emergency victims. Since the majority of the subjects were female, it was not surprising that approximately 72% of the subjects were identified as wives, mothers, sisters, or daughters of the client, while husbands, fathers, brothers, or sons made up the remaining 28% of the

Table 1

Relationship and Age of Family Members to Emergency Department Clients

Relationship to Client	N	Percent of Subjects[a]	Age[b] (mean ± S.E.M.)
Wife	14	27	54 ± 3
Mother	12	24	32 ± 3
Husband	10	20	55 ± 5
Daughter	9	18	36 ± 4
Son	2	4	38[c]
Father	1	2	37
Brother	1	2	43
Niece-in-Law	1	2	27
Sister	1	2	62

[a]Total number of subjects is 41; female = 73%, male = 27%.

[b]Mean age ± S.E.M. of total population = 44 ± 2.

[c]When N < 5, standard errors were not calculated.

sample. These specified relationships, however, do not depict the sole "significant other" who accompanied the client to the emergency room but rather the role of the individual with the client who volunteered to participate in this study.

The educational background of the subjects revealed that 6% had less than a high school education, 47% were high school graduates and the remaining 47% had some education beyond the high school diploma. The subjects' occupations were diverse. Since a high percentage of subjects were female, 22% defined their role as homemaker and 16% as clerical workers. Other professional and technical roles included are further delineated in Appendix A.

The time of day that clients were brought to the emergency department and the period of time spent waiting by the client's families is illustrated in Table II. Thirty-seven percent of the subjects that visited the emergency department during the day (7 AM - 3 PM) waited 5.5 hours, while those (47%) waiting in the emergency department during the evening (3 PM - 11:30 PM) spent 4.8 hours waiting.

Only 14% of the subjects that participated in this study waited during the night (11 PM - 7 AM) and the average wait during this time period was 4.4 hours. The amount of time that the subjects waited for their relatives during the day, evening, or night shifts did not differ significantly ($p > .05$). Thus, despite differences in the number of clients seen during these three

Table 2

Time of Day and Hours Waited by Families

of Emergency Department Clients

Time of Day	N	Percent of Subjects	Hours Waited[a]
7 AM - 3 PM	19	37	5.5 ± 0.7 N.S.[b]
3 PM - 11 PM	25	49	4.8 ± 0.4 N.S.
11 PM - 7 AM	7	14	4.4 ± 0.7 N.S.

[a]Values represent the mean ± S.E.M.

[b]N.S. indicates not significant in comparing hours waited for each time period.

time periods, all subjects waited approximately the same amount of time. The nature of the clients' conditions, as well as availability of hospital beds may have influenced the number of hours they waited in the emergency department. For example, the client with a major condition may be detained longer in the emergency department due to diagnostic studies and treatment than the client with a severe condition which requires immediate attention and intervention to prevent permanent damage to the individual. The consideration of the availability of hospital beds as a factor which influences the time spent by the client in the emergency department is based on the relatives anecdotal comments regarding waiting (Appendix B).

The admitting diagnosis of the emergency department clients were classified into the following six categories: neurologic, cardiac, gastrointestinal, respiratory, trauma, and gynecology. The percentages of clients in each category is depicted in Figure 3 while the specific admitting diagnosis is listed in Table 3. Examination of these categories reveals a low incidence of trauma victims. Despite the fact that the choosen setting is a trauma center, limited trauma was evident during the summer and fall months of data collection. The majority of victims admitted were given either a neurologic (33%) or cardiac (25%) diagnostic label.

Neurologic	33%	**********
Cardiac	25%	********
Gastrointestinal	16%	*****
Respiratory	12%	****
Trauma	8%	***
Gynecology	4%	*

Figure 3. Health Alteration Precipitating Emergency Visit during the summer and fall months of 1982.

Table 3

Admitting Diagnosis of Emergency Department Clients

Neurology/Neurosurgery	Cardiac	Gastrointestinal
-Fever/Seizure	-Ventricular Tachycardia	-Duodenal Ulcer Bleed
-Seizure	-Chest Pain/ R/O Pericarditis	-G.I. Bleed
-Pain/Numbness Both Legs	-Pulmonary Edema	-Abdominal Pain
-Motor Vehicle Accident/ Concussion	-Post Bypass/Chest Pain, Fever	-Abdominal Pain/ Obstruction
-Numbness/Weakness L Foot	-Congestive Heart Failure	-Abdominal Pain/ Vomiting
-R/O meningitis[a]	-Fall from Ladder/Syncope Cardiac Etiology/Fracture R Foot	-Hx of CA/Abdominal Pain
-Hx Cancer of Brain/Vomiting[b]	-Post Bypass/Angina R/O Myocardial Infarction	-Postcolostomy/Abdominal Pain/Syncope
-Herniated disc	-Post Bypass/Chest Pain/ R/O Myocardial Infarction	
-Cerebral Vascular Accident	-Pacemaker Malfunction	
-Hx of Multiple Sclerosis/ Septic Shock/Post Code		
-Hx of Bypass/Cerebral Vascular Accident		
-Possible Recurrent Brain Tumor		
-Hx of Cerebral Aneurysm/ R/O meningitis		

Table 3 (continued)

Admitting Diagnosis of Emergency Department Clients

Respitratory	Trauma	Gynecology
-Pharyngitis/Shortness of Breath	-Fractured Ankle	-Post-Partum Hemorrhage
-Pneumonia	-Fractured Radial Head	-Pelvic Inflammatory Disease
-Cystic Fibrosis/ Acute Respiratory Distress	-Avulsion/Laceration Great Toe	
-Asthma	-Blow Out Fracture L Orbit	
-Allergy/Respiratory Distress		
-Anaphylactic Shock		

[a]R/O = rule out.

[b]Hx = history of.

C. Section 2: Data Analysis

1. Overall Need Satisfaction

The need satisfaction scores ranged from 64% to 98% with the overall mean ± S.E.M. percent satisfaction being 79 ± 1.3 (Figure 4). These scores indicate that the majority of the subjects' needs were satisfied during the time they spent waiting in the emergency department. To determine if the agreement of need satisfaction was significant, the overall extent of agreement versus disagreement of need satisfaction was analyzed using Chi-square which revealed a significant ($p < .001$) agreement of need satisfaction ($x^2 = 258$; $df = 1$).

2. Most and Least Satisfied Needs

Need statements which received the highest and lowest satisfaction scores are presented in Table 4 and Table 5. Among the needs most satisifed, being able to see the client was ranked the highest, all 51 subjects unanimously agreed that this need was met ($x^2 = 11.0$; $p < .001$). This need was identified as met most often by the nurse (50%). However, 23% of the subjects used their own initiative to see the client, while the physician assisted 21% of the subjects in meeting this need. The remaining highly satisfied needs included: 1) being told about any plans to transport the client to another area of the hospital, as these arrangements were being made; 2) being able to talk to the doctor treating the client; 3) being given explanations in words that

Figure 4.

Frequency distribution of satisfaction scores excluding the not applicable items of the need satisfaction tool. Chi-square analysis refers to family members responses of agreement versus disagreement.

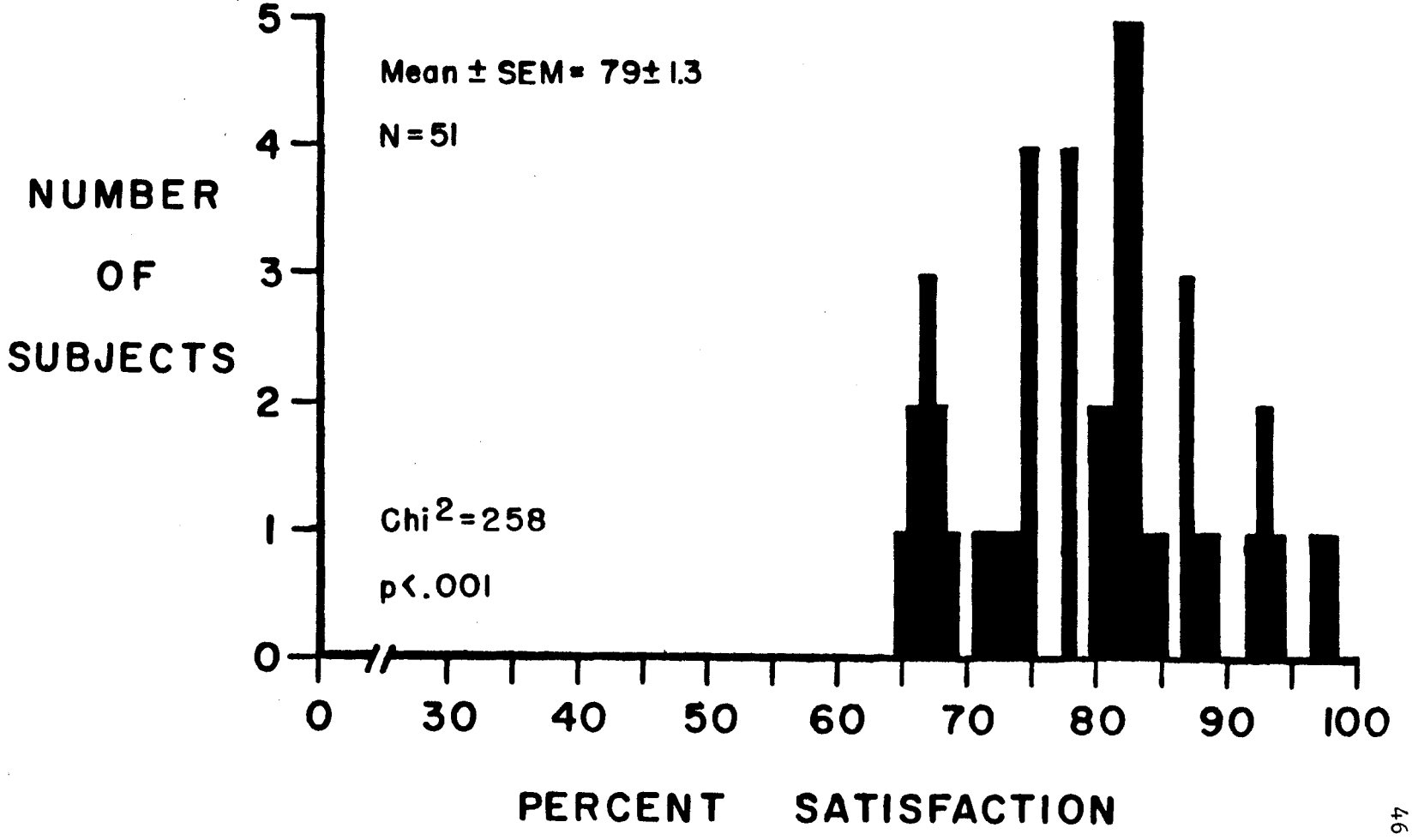

Mean ± SEM = 79 ± 1.3
N = 51
Chi² = 258
p < .001
NUMBER OF SUBJECTS
0
1
2
3
4
5
0
30
40
50
60
70
80
90
100
PERCENT SATISFACTION

Table 4

Chi-Square, Frequency Response and Individuals Assisting

Relatives Most Satisfied Needs

Need	Agreement Frequency/ Total Response Frequency	x^2	Need Met By/ Percent
Able to see client.	51/51	11.0 ($p < .001$)	Physician: 21 Nurse: 50 Secretary: 4 Myself: 23 Client: 2
Told about any plans being made to transport the client to another area of the hospital, while these arrangements were being made.	49/50	46.1 ($p < .001$)	Physician: 63 Nurse: 35 Secretary: 2
Able to talk to the doctor treating the client.	48/51	26.3 ($p < .001$)	Physician: 98 Nurse: 2
Given explanations in words I could understand.	47/49	6.4 ($p < .02$)	Physician: 75 Nurse: 23 Client: 2

Table 4 (continued)

Chi-Square, Frequency Response and Individuals Assisting

Relatives Most Satisfied Needs

Need	Agreement Frequency/ Total Response Frequency	x^2	Need Met By/ Percent
Felt the hospital staff were concerned about the client.	46/51	35.3 ($p < .001$)	Physician: 47 Nurse: 45 Secretary: 3 Whole Staff: 4 Male Attendant: 2
Able to have use of a public telephone near the waiting room.	46/47	43.0 ($p < .001$)	Physician: 2 Nurse: 2 Secretary: 2 Other Relative: 4 Myself: 89

Table 5

Chi-Square, Frequency Response and Individuals Assisting

Relatives Least Satisified Needs

Need	Disagreement Frequency/ Total Response Frequency	x^2	Need Met By/ Percent
Given direction as to what to say and do when seeing the client for the first time after the crisis.	29/31	25.3 ($p < .001$)	Physician: 0 Nurse: 50 Client: 50
Given information regarding the condition of the client prior to seeing him/her for the first time after the crisis.	17/31	0.29 ($p > .05$)	Physician: 56 Nurse: 28 Client: 5 Myself: 5 EMT: 5
Informed of the prognosis degree of recovery	15/29	0.03 ($p > .05$)	Physician: 81 Nurse: 19
Able to talk about negative or "bad" feelings I had such as guilt or anger.	10/18	0.53 ($p > .05$)	Physician: 63 Nurse: 25 Myself: 12

Table 5 (continued)

Chi-Square, Frequency Response and Individuals Assisting

Relatives Least Satisfied Needs

Need	Disagreement Frequency/ Total Response Frequency	x^2	Need Met By/ Percent
Told about social worker to help with family problems.	9/11	4.4 ($p < .05$)	Physician: 0 Nurse: 50 Myself: 50
Felt I needed to be alone and I was provided with a place to be alone while in the hospital waiting area.	6/7	5.3 ($p < .05$)	Nurse: 100

were understandable; 4) feeling that the hospital staff were concerned about the client; and 5) being able to have use of a public telephone near the waiting room.

The least satisifed needs refer to lack of information regarding the client and intrapersonal needs of the relative (Table 5). The needs with highest disagreement frequencies included: 1) being given direction as to what to say and do when seeing the client for the first time after the crisis; 2) being given direction regarding the condition of the client prior to seeing him/her for the first time after the crisis; 3) being informed of the prognosis; 4) being able to talk about negative or "bad" feelings the relative may have had such as guilt or anger; 5) being told about a social worker to help with family problems; and 6) if needed, being provided with a place to be alone while in the hospital waiting area.

3. Not Applicable Needs

The determination of those needs which did not apply to the sample were obtained using Chi-square. With the probability for significance set at $p < .05$, eleven of the thirty-two needs were deemed not applicable to the population studied. These needs are illustrated in Table 6. The majority of these needs represent items of an intrapersonal nature, the remaining are information seeking. When these needs were excluded, the mean overall satisfaction score (79%) and the frequency distribution of scores

Table 6

Chi-Square Analysis of Need Statements Which Did Not Apply

Need	Frequency Not Applicable	x^2	p
I did not know the events which brought the client to the emergency room, but once there I was given this information.	49	44.0	<.001
I was able to talk about negative or "bad" feelings I had such as guilt or anger.	32	4.0	<.05
I was allowed and/or encouraged to cry.	39	14.3	<.001
I felt my expressions of anger were accepted by the staff.	38	13.3	<.001
I was able to talk with the staff about the possibility of the client's death.	45	30.0	<.001
I was able to have a clergyman visit with me.	47	36.2	<.001

Table 6 (continued)

Chi-Square Analysis of Need Statements Which Did Not Apply

Need	Frequency Not Applicable	x^2	p
I was told about a social worker to help with immediate family problems.	40	16.5	<.001
I was able to have friends nearby for support.	41	18.8	<.001
I felt I needed to be alone and I was provided with a place to be by myself while in the hospital waiting area.	44	26.8	<.001
I was given explanations of the environment before going to the Intensive Care Unit.	42	21.3	<.001
I was told about a counselor to help with family problems.	46	33.0	<.001

(Figure 4) demonstrated a slight increase from that obtained when they were included (Figure 5).

4. Need Satisfaction and Extraneous Variables

The relatives overall percent satisifaction scores with respect to the time of day spent waiting in the emergency department is depicted in Figure 6. Satisfaction scores for the day, evening, and night are 80%, 77%, and 82%, respectively. These scores do not differ significantly ($F = 3.76$; $p > .05$) from each other, thus the time of day that the relative waited in the emergency department did not have any effect on their need satisfaction.

The relatives' percent satisfaction score is illustrated comparing those waiting over five hours with those waiting less than five hours (Figure 7). A lower satisfaction score was expected with those relatives waiting for five hours or more, since an increase in waiting time generally provokes a greater need for relatives to receive information. Furthermore, the anecdotal comments reflective of waiting demonstrate an increase of needs with longer waiting time (Appendix B). However, in comparing the need satisfaction scores of those waiting more than (77%) and those waiting less than (80%) five hours, no significant ($p > .05$) difference was found.

The relatives relationship to the client and their mean percent satisfaction scores are presented in Figure 8. They include: daughters, 82%; mothers, 81%; wives, 78%, and husbands, 76%.

Figure 5.

Frequency distribution of satisfaction scores including all 31 items of the need satisfaction tool. Chi-square analysis refers to the family members responses of agreement versus disagreement.

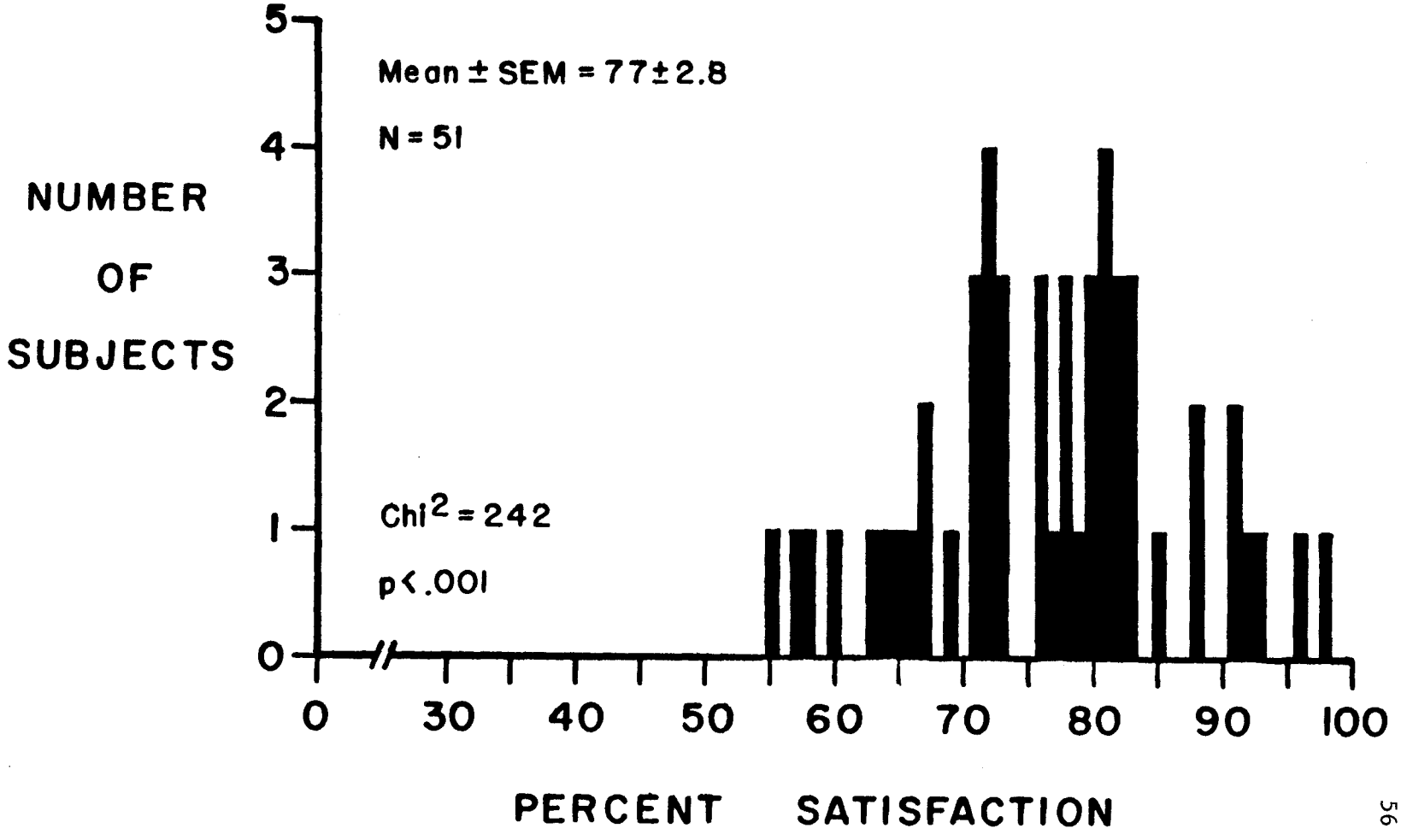

Mean ± SEM = 77 ± 2.8
N = 51
Chi² = 242
p < .001
NUMBER OF SUBJECTS
0
1
2
3
4
5
0
30
40
50
60
70
80
90
100
PERCENT SATISFACTION

Figure 6.

Mean satisfaction scores related to the time of day relatives spent waiting in the emergency department. Numbers inside the bar refer to the mean and standard error of the mean. The number in parenthesis refers to the numbers of subjects.

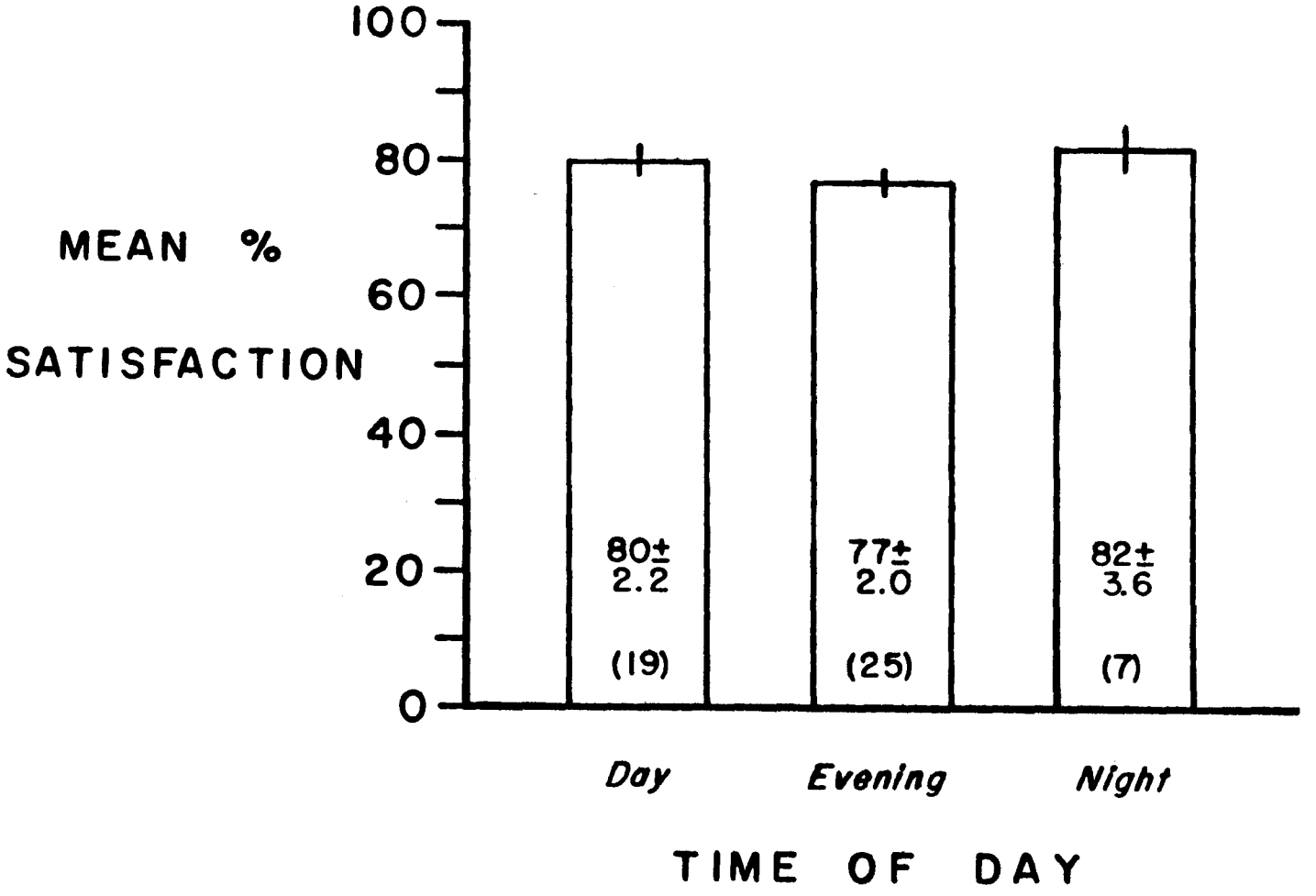
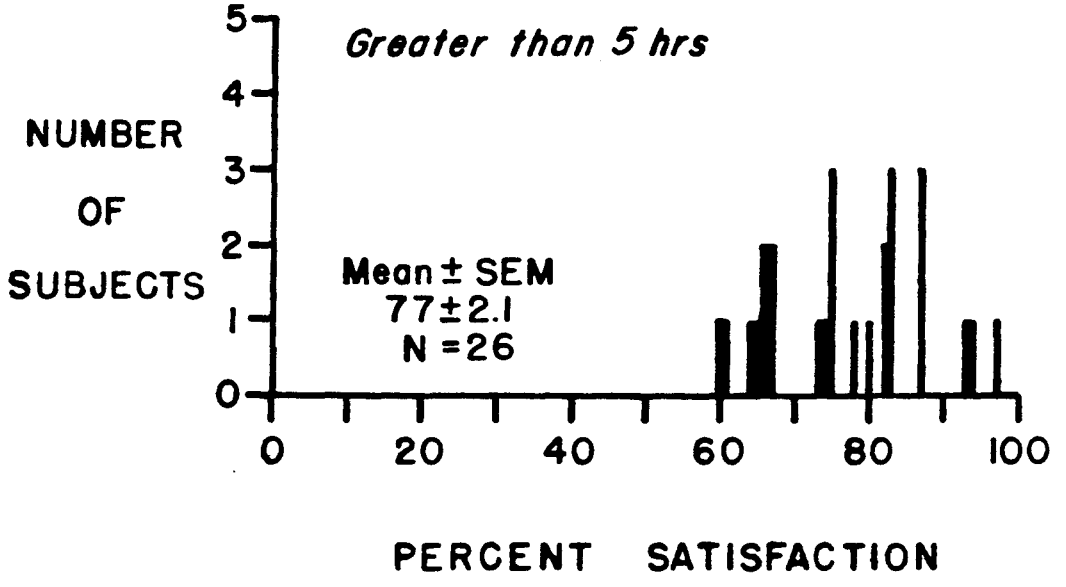

100
80
60
40
20
0
MEAN %
SATISFACTION
80±
2.2
(19)
77±
2.0
(25)
82±
3.6
(7)
Day
Evening
Night
TIME OF DAY

Figure 7.

Frequency distribution of satisfaction scores related to the relatives' time waiting in the emergency department.


Greater than 5 hrs
NUMBER OF SUBJECTS
Mean ± SEM
77 ± 2.1
N = 26
0
1
2
3
4
5
0
20
40
60
80
100
PERCENT SATISFACTION

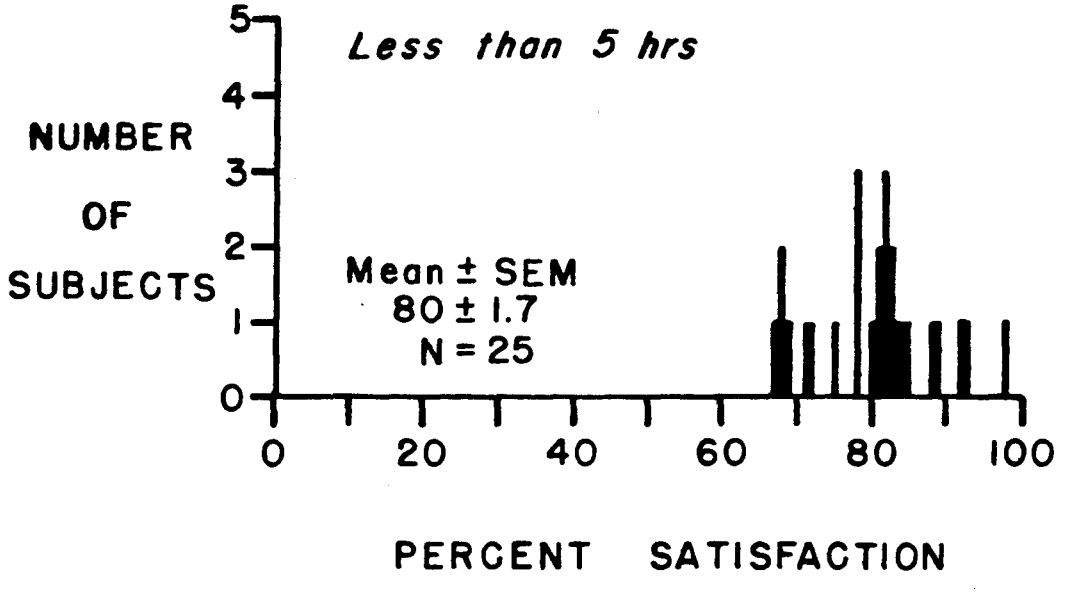
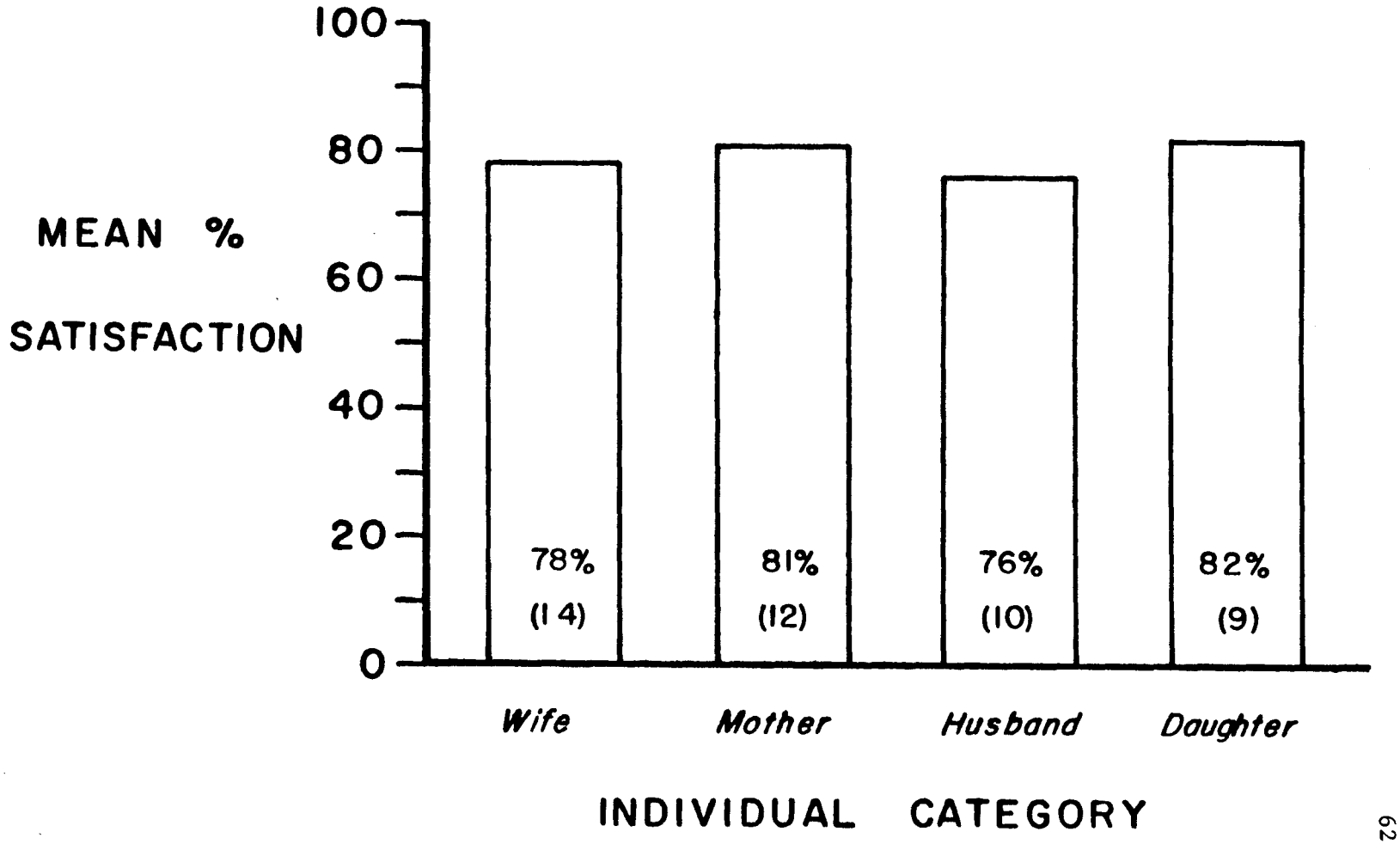

Less than 5 hrs
NUMBER OF SUBJECTS
Mean ± SEM
80 ± 1.7
N = 25
0
1
2
3
4
5
0
20
40
60
80
100
PERCENT SATISFACTION

Figure 8.

Bars represent the mean percent satisfaction related to the relative's relationship to the emergency department client. Numbers inside the bars represent the mean percent satisfaction. Numbers in parenthesis refer to the number of subjects.


MEAN %
SATISFACTION
100
80
60
40
20
0
78%
(14)
81%
(12)
76%
(10)
82%
(9)
Wife
Mother
Husband
Daughter
INDIVIDUAL CATEGORY

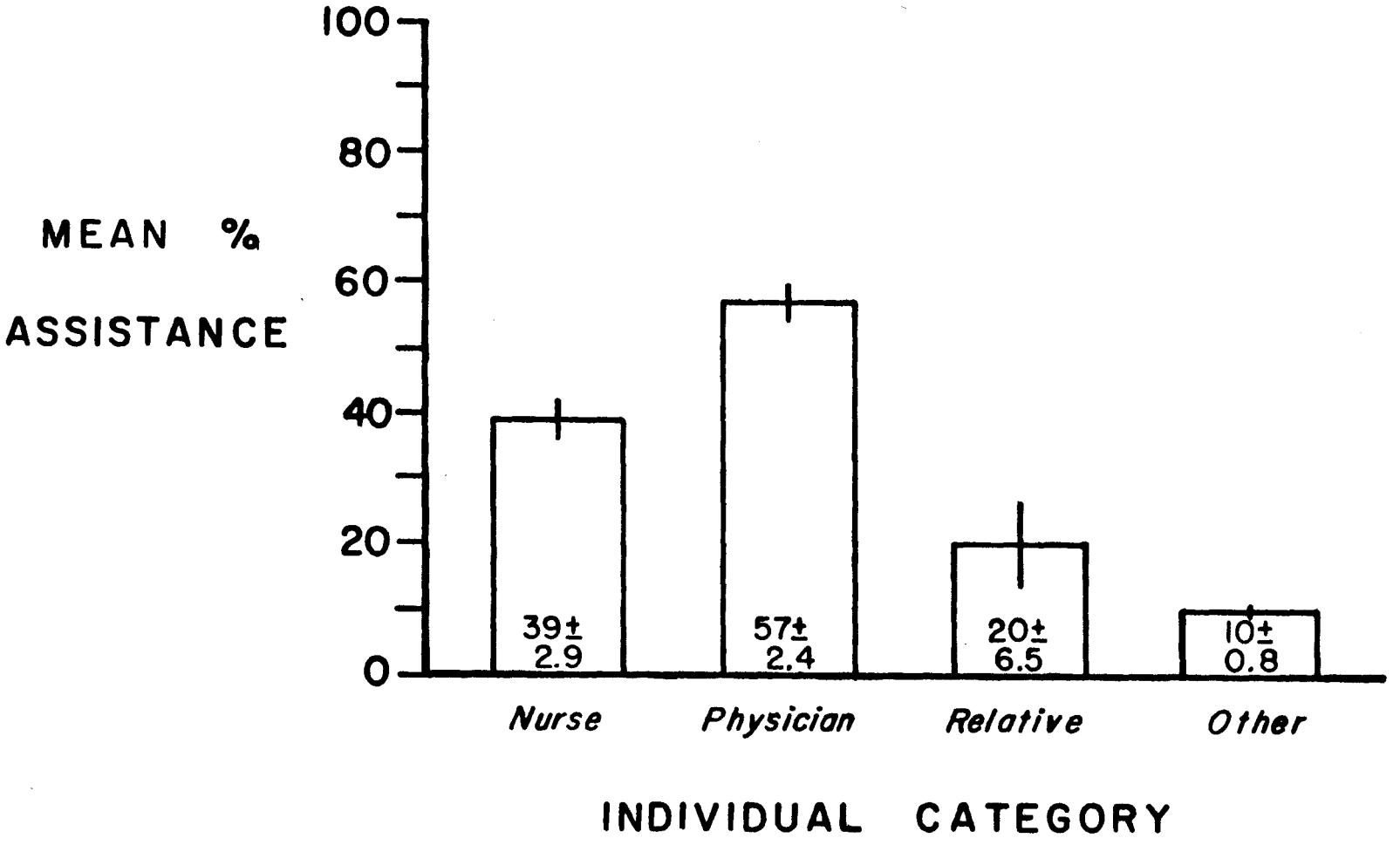
These scores do not differ significantly ($F = 0.34$; $p > .05$) from each other. Therefore, the family member's relationship to the client had no effect on their need satisfaction.

5. Individual Categories Assisting the Relatives

Another purpose of this study was to ascertain who were the primary resources for the relative in need of assistance. The role category of those individuals identified by the subjects as having helped them in meeting their needs has been summarized in Figure 9. The percentages total to more than 100% since the family members could record more than one individual who assisted them. As illustrated, the majority of the needs were met by the physician (i.e., 57%). The medical staff accounted for the greatest percentage of help in thirteen of the need statements. These needs primarily consisted of information as well as personal concerns. Specifically, the informative needs included information regarding: the condition of the client prior to seeing him or her, diagnostic studies and treatments underway, the prognosis, the client's response to treatment, and admission of the client. Additional information needs included that any explanations be given clearly and that a private setting be provided. The physician was also foremost in meeting personal needs of the relative. These needs included: reassurance that the best care was given, communication of the feelings that the hospital staff were professionally concerned about the client,

Figure 9.

Bars represent the mean percent assistance related to the individual role category. Numbers inside the bar are the mean $\pm$ standard error of the mean per category.


MEAN % ASSISTANCE
100
80
60
40
20
0
39± 2.9
57± 2.4
20± 6.5
10± 0.8
Nurse
Physician
Relative
Other
INDIVIDUAL CATEGORY

encouraging the relative to be hopeful and assisting the relative toward acceptance of the reality of the crisis.

The nurses met the relatives' needs 39% of the time. She demonstrated the most help in assisting the relative to see the client and permitting the family member to have a close friend or relative accompany them when seeing the client.

The relatives demonstrated their own initiative to locate the waiting area, the public telephone, and to purchase a refreshment.

There are a variety of responses given in the "other" category. These individuals include: friend, client, another family member, the entire family, an emergency medical technician, a secretary, a volunteer, and all the staff. These individuals demonstrated a very modest amount of intervention throughout all the need statements.

6. Anecdotal Comments

The relatives were unable to "identify needs other than those previously mentioned" (i.e., need statement thirty-two). Despite their inability to define any other needs, they were eager to provide comments regarding their stay in the emergency department. These anecdotal notes have been classified according to their central issue (Appendix B). These classifications were prioritized accordingly: waiting, information/interpersonal, concern, environmental, procedural, miscellaneous, and intrapersonal.

As described, waiting seems to be a major issue for the relative in the emergency room. On closer examination, these comments infer a dual relationship. Waiting for the family member increases their need for information and basic needs (comfort and food) for the client.

Information seems to be a necessary ingredient for those waiting in the emergency department. Relatives expressed the desire to be informed periodically on the patient's progress and procedures being performed.

Concern was described as necessary for the client and the relative. Concern for the patient was impacted as periodic assessment and comfort measures. Demonstrating a respectful approach in interacting with relatives and providing information was described as concern for the relative.

Procedural comments were reflective of the information sought by the staff and possession of significant items. The demand for demographic data with each visit to the emergency department and the emergency staff's retention of the client's identification card which is necessary for medical care were cited as a stressor for the relative.

Environmental comments addressed were related to the lack of privacy in the emergency area and the assaulting exposure to the devastating problem of others present in the emergency department.

Miscellaneous notes comprised some realistic reflections of relatives such as: "the needs depend on the nature of the crisis", and "with many people in the emergency department, you can't expect total attention."

The last category reflects a few intrapersonal needs of the relatives. These comments infer that the accompanying relative may be suffering too. This health alteration may have precipitated from the crisis or be a chronic disorder of the relative.

In addition to these reflections of the relatives, anecdotal comments specific to each need statement have been documented (Appendix C). These comments are multidimential as they describe the personal experiences and feelings of the relatives in relation to the individual need statements. In general, the relatives' comments reflected their perceptions of the emergency department experience including the staff's interaction with them and the client.

CHAPTER V

DISCUSSION

A. Overview of the Design

In light of the findings of previous studies (Cruz, 1981; McKnight, 1979) which have documented the needs and perceptions of families of emergency department clients, the purpose of the present study was to determine the degree of need satisfaction of family members who were waiting for clients in the emergency department. Based on an assessment of 31 needs and a sample of 51 subjects, the major finding of this investigation is that the needs of families of emergency department clients were generally satisfied. Those needs which were most satisfied seemed to represent "essential" or "basic" requirements for those who accompanied and waited for their family members in the emergency department. Such needs included seeing the client, being informed of transport plans, talking to the doctor, being given clear and understandable explanations, feeling the staff were concerned, and having use of a telephone. On the other hand, the least satisfied needs represented supplementary desires aimed at the personal needs of the relatives as well as additional needs regarding information about the client. For example, these needs included being given direction as to what to say or do as well as information regarding the client's condition prior to seeing him for the first time after the

crisis, talking about "bad feelings", being told about the assistance of social service, and being provided with a place to be alone. Thus, the staff was most successful in meeting the basic needs of families but was not as successful with familial intervention beyond these needs. Although it is beyond the scope of this study to determine why needs were or were not met, it is possible that such "supplementary" needs may be neglected due to lack of time or most likely lack of awareness of such needs on the part of the staff. It should be noted that satisifaction of these needs may only require a few minutes of time from the staff. In view of these results, it would be of interest for future studies to determine the staffs' perception of the needs of families of emergency department clients.

B. Not Applicable Needs

The majority of the needs which did not apply to the sample in this study represented items of an intrapersonal nature (Table 6). These "not applicable" responses supported the reports of previous researchers. Specifically, Molter (1979) reported that families of intensive care clients considered their intrapersonal needs as lower in priority than their need for information regarding the client. Furthermore, Cruz (1981) reported no significant difference between the feelings of families of emergency department clients and their need for information. Thus, the majority of families in this study recorded nearly all of the intrapersonal needs as "not applicable". This author is of the

opinion that intrapersonal needs are significant to those family members suffering from a sudden illness or injury inflicted on their relative. The reason why the majority of intrapersonal needs were not applicable to the population studied may be related to the severity of the condition bringing the client to the emergency department. Although the chosen setting is a regional trauma center, no major trauma victims (Table 3) arrived at the emergency department within the time frame of data collection (i.e., two months). This limitation of trauma may explain some of the "not applicable" responses among the relatives' intrapersonal needs.

Another reason for the non-applicable items may be attributed to the confidential nature of the intrapersonal needs. Support for this reasoning is quantitatively demonstrated in the test-retest of the subjects in the pilot study. Thirty-nine percent of the responses in the intrapersonal group were originally scored not applicable but on retest recorded as disagree, agree and/or strongly agree. Consequently, the researcher's second meeting with the relative may have imparted a sense of trust in the family member and thus, establishing a therapeutic relationship conducive to relating intrapersonal needs and their satisfaction or dissatisfaction. Furthermore, family members' anecdotal comments (Appendix C) are reflective of their response to the intrapersonal need statements. Some relatives describe these needs as "private" or "inappropriate" to be demonstrated either verbally or non-verbally by them in the

setting of the emergency department. In addition, their responses implied that they felt their needs were of low priority compared to the needs of the client. In effect, they did not want to utilize the staff's time that could be directed to the care of their loved one. Finally, it is possible they felt that the admission of such needs is not "socially acceptable" and expression of such needs may result in their being rejected by the health team.

C. Relationship of Need Satisfaction to Other Variables

The study interviewed family members who waited in the emergency department at three different time periods; day, evening, and night (Table 2). At these respective times there is a difference in the number of professional nurses present in the emergency department. During the day, evening, and night shifts, there are five, six, and four registered nurses on duty, respectively. It is possible that this difference in staffing may influence the staff's contact with the family. However, the data revealed that there was no significant difference in the relative's satisfaction scores related to the time of day they were in the emergency department (Figure 6). Therefore, despite differences in staffing patterns, the relatives' needs were satisfied. It is possible that the relatives may have had decreased expectations of the health team at times of limited professional staffing and/or increased client population (Appendix B).

A comparison of the satisfaction scores for those who waited less than five hours with those who waited more than five hours revealed no significant difference (Figure 7). Cruz (1981) reported a significant ($p < .05$) relationship between relative waiting time and their need for information. Despite similar satisfaction scores, numerous anecdotal comments regarding waiting and information supports Cruz's findings (Appendix C). For example, "three hours seemed like an eternity waiting for information", "I waited two hours before any information", and "I sat two hours alone, not knowing what they were doing to my husband or how he was doing."

The need satisfaction of family members was examined with respect to the family member's relationship to the client. Since the majority of subjects interviewed were female, the majority of familial relationships were either wives, mothers and daughters; only ten subjects were "husbands" to the clients. Olson (1970) states that familial roles function according to the expectations of the family. This author hypothesized that there may be some difference in need satisfaction with respect to familial roles, yet the data revealed no difference with respect to this variable.

D. Individual Categories Assisting the Relatives

The physician was most frequently cited as assisting the relative (Figure 9). He intervened most often in areas that can be

considered appropriate to his role (i.e., providing information regarding the client's condition and treatment rendered). Furthermore, the physician also extended reassurance and encouragment to the family members. Thus, the physician did not limit his intervention to the client. Rather, based on the results, the physician identified the illness or injury as affecting the entire family system and did assist the family members to cope with the crisis.

A reason as to why the physician was cited most often as assisting the relative may be related to the vast number of medical personnel present in the selected emergency department. Since the setting is a teaching center, there were numerous medical students, residents, fellows, and attending physicians available. Thus, it is possible that this setting was biased in favor of the physician.

The emergency department nursing staff demonstrated limited assistance (39%) to the family members (Figure 9). It is possible that the nurse may have regarded these needs as the responsibility of the physician. Furthermore, these results may in part provide support for Yoder and Jones' (1982) study which found that emergency department nurses were that their intervention rightfully belongs to the ill or injured client. No data was obtained regarding the academic preparation of the emergency department nurses in this setting. Therefore, one cannot speculate as to if academic preparation was an important variable in these results.

Despite the overall limited familial intervention by the emergency department nurse, she was cited most often as the

individual who assisted the relatives in seeing the client. In addition, the nurse also permitted the family members to have significant others accompany them when seeing the client for the first time. These specific areas of familial intervention may be viewed by the nurse as appropriate to her role in the emergency department. Thus, this nursing activity was directed at maintaining the personal integrity of the client (i.e., insuring the client's relationship with significant others) (Levine, 1967).

Certain needs were met by the relatives own initiative. These include such environmental needs as locating the waiting area, the public phone, and refreshments. Yet some may still require assistance with certain environmental needs due to high levels of anxiety. In particular, one relative anxiously asked where the phone was located while standing right next to it. It was interesting to note the strategies the relatives engineered to overcome the barriers in the emergency department. For example, a few of the relatives with past experience in the emergency department learned of alternate unlocked entrances into the emergency department. Others requested assistance of non-professional staff for access to the client. Thus, the more experienced family member in the emergency department will implement strategies to satisfy his needs.

E. Limitations

One of the major limitations of this investigation is that the majority of intrapersonal need statements did not apply to

the sample studied. This is most likely due to the following two reasons. First of all, this study did not include families of emergency department clients with life-threatening conditions. The intrapersonal need statements are most likely very applicable to this group; however, for ethical reasons, this group was not studied. Secondly, although the chosen setting is a regional trauma center, no major trauma victims arrived at the emergency department within the time frame of data collection (i.e., two months). Again, the intrapersonal need statements are probably appropriate to families waiting for a relative who has suffered a traumatic injury.

Finally, another limitation may be related to the fact that the investigator, being a nurse, possibly created some bias in the relative's response. That is, it is possible some subjects may have been reluctant to answer honestly about matters related to the investigator's professional peers.

F. Significance

This investigator has provided information regarding the quality of family intervention in the emergency department. The results describe the contact and intervention families receive during this crisis period, and who among the emergency department team presently provides family assistance. The results substantiate the need for some emergency department nurses to look beyond the physicial treatment of the client and to assist the family in

coping with the crisis of the injury of illness (i.e., holistic care).

The nursing staff, by providing care to these families, harvest rewards of professional achievement, and acknowledgment of holistic nursing care. Craven (1972) states that if a nurse expands her concept of the client from that of an individual on a stretcher to one of a participating member of a family, then she will expand her role to assist relatives to cope with the client's illness while simultaneously maintaining family function.

The quality of the adjustment of the family members will be a contributing factor to the client's psychological well-being. The client's emotional stability is often disrupted during the crisis and throughout their hectic stay in the emergency department. Levine's principles (1967), which provide structure and understanding of nursing activities, addresses the conservation of the client's personal integrity. This nursing principle guides nursing intervention toward the maintenance of the client's relationship with significant others (i.e., family members). In addition, relatives who accompany the client to a trauma center exhibit high anxiety levels, that are often passed along to the client and impair their ability to cope. Since high levels of anxiety are likely to be dibilitating, and since close relatives are the chief social support for the client, it follows that any reduction of their high anxiety will be helpful to the well-being of the client (Bunn and Clark, 1979).

This investigation has offered insight regarding the relative intervention at the time of a crisis. Furthermore, the procurement of this information conveys to emergency practitioners an orientation for familial intervention as defined by the source--the family. Thus, effective treatment for such families may be initiated at the onset of the crisis in the emergency setting.

G. Recommendations

In light of the findings reported in this study, recommendations for future investigation would include: 1) Replication of this study in a trauma center including families of major trauma victims; 2) Replication of this study in a non-teaching hospital; 3) A study investigating the relationship between the nurses' perceptions of the needs of families of emergency department clients and the nurses' academic preparation; and 4) A study comparing the physicians' and nurses' perceptions of the needs of families of emergency department clients.

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APPENDIX A

Table 7

Distribution of Family Members' Education and Occupation

Education Level	Percent (N=51)	Occupation	Percent (N=51)
Less than High School	6	Homemaker	22
High School	47	Clerical	16
Greater than High School	47	Retired	8
		Indust. Production	8
		Administrative	6
		Business Owner	6
		Computer	6
		Health	6
		Construction	4
		Food Service	4
		Performing Arts	4
		Design	2
		Education	2
		Mechanic/Repair	2
		Service	2
		Miscellaneous	2
		Temp. Unemployed	2

APPENDIX B

OVERALL ANECDOTAL COMMENTS

Classifications

I.	Waiting (11)	**********
II.	Information/Interpersonal (10)	**********
III.	Procedural (3)	***
IV.	Concern (4)	****
V.	Miscellaneous (3)	***
VI.	Environmental (4)	****
VII.	Intrapersonal (2)	**

I. Waiting

- "How come it takes so long?"
- "Waited too long for the room."
- "Waited eight hours. My son (the client) was hungry. I had to get him a candy bar. No lunch or dinner. The nurse in Emergency didn't bother to get the child any food."
- "Three hours seemed like an eternity waiting for information. I know it takes time for testing."
- "Someone should supervise the X-rays to expedite matters. It would help the patient and family. I went into the nurses to get things going. They were very nice to me!"
- "Long wait for family and patient (he was waiting without anything to eat). Suggestion - Use regular beds if you have to be there for a long time."

- "While waiting the staff should come back and say something to the family. I waited 2 hours before any information."
- "They didn't have a bed in the hospital. We waited eight hours. Long wait, but as long as my husband was taken care of, I was at ease."
- "Four and a half hours waiting for a hospital bed, when we were told it would take 10 minutes. It gets depressing waiting and listening to the other patients moaning and groaning. The nurse was very helpful. She kept trying to get a bed and keeping me informed."
- "My mother was in pain and waited 40 minutes for X-ray. I went to the desk to ask what was the hold-up. They said X-ray was busy. Being in the emergency room befo-e, I knew where X-ray is located. I walked over there and the techs were standing around talking about a picnic. I was angry over this."
- "The waiting just increases the family's problems. It makes you wonder what is going on with the patient. We waited 5 hours. We were tired, anxious, and couldn't sit and watch the television in the waiting area."

II. Information/Interpersonal

- "I would have liked to have had my husband and son near me - also, to have had the MD explain more especially cause of illness."

- "Be informed periodically. They need more help, especially weekends."
- "After arriving in the Emergency Department, I sat 2 hours alone, not knowing what they were doing to my husband or how he was doing. Due to the time of day, there was limited contact with me. After 2 hours, the nurse told me I could see my husband and then directed me to admitting. This was the only time I was able to see the nurse. Most important is that my husband was taken care of, which they did."
- "Nurse should take a more active role. MD had accent and I would have liked nurse's assistance in understanding him. Also, I would have felt comfortable with the nurse's assistance."
- "Keep family informed, updated on patient progress and procedures . . . 'We're working on it. We're waiting for lab.' While waiting, another patient asked me to get bed pan and take it away. She said, 'See, they forgot about me! What's going on?' They need more help."
- "They need to confirm things. Need more help."
- "I wanted to stay with my mother. I wanted to listen to all they were telling her and doing for her."
- "We needed information and weren't told anything."

III. Procedural

- "The patient has been to this emergency room before. Why do I have to complete a form answering the same questions, age, address, etc.? Shouldn't it be on the computer?"

- "I was terribly concerned about getting my red card back at the end of the visit."
- "I was happy with the preparation of care for my son when we arrived in the emergency room. It was the help and communication of ambulance people while traveling to the hospital."

IV. Concern

- "I feel what is most important is to have concern for the patient, continue to check her periodically. I was pleased the nurse checked my wife every 15 minutes."
- "They were concerned and talked to you like you have a brain."
- "Nurses should be compassionate. They were cold, seemed not to care. I questioned my son's restraints and they were upset. They seemed not to be concerned with my son's age and injury. The nurses tole me to go out of the ER. I was asking, 'Why?' My son wanted me to be with him. The nurse said 'Try to get rid of her.'"
- "I wished they would have given my brother something for pain. I was upset and felt sorry for my brother since he was in such pain. I asked the staff to give him something for pain, even an ice pack. They said he couldn't have anything."

V. Miscellaneous

- "They did a good job! Impressed that they let me stay while doing treatments."

- "Many people need care in the ER, you can't expect total attention."
- "The needs depend on the nature of the crisis."

VI. Environmental

- "Our daughter died a short time ago from an overdose. The waiting was bad but it was horrible to have to look and listen at a young woman next to my husband (client) who took an overdose and alcohol."
- "While waiting in the ER, you are exposed to a lot of other problems going on in the department. One example was a drunk screaming. The nurses tried to keep the area quiet and comfortable as can be by closing the doors. Despite their efforts, it still gets to you."
- "Could have offered me some coffee."
- "I couldn't find a bathroom."

VII. Intrapersonal

- "I know my husband needed the help but I was suffering too. I felt in shock and all alone. I kept trying to hold back the tears. I felt like I needed some help too, but I knew the staff was busy."
- "I'm just worn out! I've had three strokes. I can't help my wife as I would like to. I don't have any anger. I just want to do what I can to help my wife."

APPENDIX C

FAMILY MEMBERS ANECDOTAL COMMENTS SPECIFIC

TO THE INDIVIDUAL NEED STATEMENT

- I DID NOT KNOW THE EVENTS WHICH BROUGHT THE CLIENT TO THE EMERGENCY ROOM BUT ONCE THERE WAS WAS GIVEN THIS INFORMATION.

"After being called to the emergency room and seeing him, the nurse stated to me that he had a serious disease but I didn't know what she meant by that."

"I was called by my son (who received a call from the neighbor of the patient). The hospital has my home and work number. They should have called me and given me some information."

"I was informed that she was in the emergency room. I arrived and Mom was not seen yet. I was here 1½ hours before seeing a neurologist. I walked in and spoke to the nurse."

"I received all the tender loving care in the ambulance, then it dropped off in the emergency room. The staff were very busy and I went up to the secretary. I was told by the secretary to go in and talk to the nurse. The nurse told me to wait outside and someone would come to talk with me."

- I WAS ABLE TO SEE THE CLIENT.

"Long time waiting, over 2½ hours prior to seeing him for the first time. I asked, the nurse said one family member could go in."

"I asked the nurse if I could stay with my husband. I stood for several hours. No one asked me if I could have a chair. One nurse later on asked me how I was feeling since I was standing so long."

"Not right away. They had me wait 45 minutes in the waiting room."

"I just asked the secretary to buzz the door open and I walked in to see my father. I grew up in Cook County's emergency room."

- I WAS GIVEN INFORMATION REGARDING THE CONDITION OF THE CLIENT PRIOR TO SEEING HIM/HER FOR THE FIRST TIME AFTER THE CRISIS.

"The reception here was not very good. I didn't understand what the neurologist was telling me. I tried to interrupt him when I didn't understand."

- I WAS GIVEN DIRECTIONS AS TO WHAT TO SAY AND DO WHEN SEEING THE CLIENT FOR THE FIRST TIME AFTER THE CRISIS.

"Mother was concerned how I would respond to the sight of the tube so the nurse prepared me."

"(The nurse said) 'Only stay for a little while.'"

- I WAS GIVEN INFORMATION ABOUT DIAGNOSTIC TESTS DONE FOR THE CLIENT.

"The physician asked me to leave the room. He examined my husband and came out to the waiting room to give me information three hours after being in the emergency room."

- I WAS GIVEN INFORMATION ABOUT TREATMENTS DONE FOR THE CLIENT.

No comments.

- I WAS ASSURED THAT THE BEST CARE WAS BEING GIVEN TO THE CLIENT.

"They were worried about my husband. I was happy with the care."

"I felt very confident. The physician talked to me and explained everything. The nurse gave me confidence that he was getting good care."

"I was kept informed and assured by the physician."

"Many physicians came in to see my father (the patient). They had everything under control. They knew what was happening."

"We didn't talk to the physician. No one talked to me."

"I couldn't really say. I don't know what transpired while I was in the waiting room. I waited from 5 to 10 PM for a room. They had to make up their minds what they would do for her."

"They were pleasant and informative."

"I took it on faith and the physician partially assisted."

"No one said it but I sensed it! Very attentive staff, physician put us at ease. Told us what was going on and examined her. In contact with PMD until he took over."

"The PMD made us feel confident. The hospital staff didn't communicate much with us."

"Time should have been shorter. Nobody knew what anybody (MD) was doing. No coordination. One MD didn't know what the other was doing. The nurse knew what was going on. Testing and eight hours is hard on a five year old. 60% of time was waiting."

"Nurses were compassionate, kept their cool and smiles despite all that was going on."

- I WAS GIVEN EXPLANATIONS IN WORDS I COULD UNDERSTAND.

"I didn't ask too many questions. I was upset."

"I had to ask; they really didn't want to tell me. The physician gave the most imformation."

"If I didn't understand, I asked."

"They didn't explain much. Said they are fine and seen by different physicians.

- I WAS ABLE TO TALK TO THE DOCTOR TREATING THE CLIENT.

No comments.

- I WAS INFORMED OF THE PROGNOSIS.

"They assured me it was not life-threatening."

- I WAS ABLE TO TALK TO THE NURSE CARING FOR THE CLIENT.

"I talked to several nurses. They were very understanding."

"The nurse took his temperature and then I didn't see her anymore, the MD took over."

"The nurse assisted the MD but she didn't talk with me."

The nurse stopped several times to see how my mother was doing."

"The nurse was very helpful. She reassured me about spinal test."

"The nurse apologized for waiting so long. Another nurse wanted to call someone to see if they could be with me. They were very nice to me."

"We didn't need the nurse. We had three MDs taking care of him. The nurse who took the temperature didn't even come back to take the thermometer out."

"The nurse was very helpful and polite."

"Intermittently I would approach the nurse. There were so many, they didn't offer any information."

"We were there at the changing of the shift and they were wonderful."

- I WAS ENCOURAGED TO BE HOPEFUL.

"I was not encouraged to be sorrowful. They were looking for answers. They didn't want to commit themselves."

"Later, one MD did tell me the injuries could have been much worse."

"I had my own feelings. I was left to my own inner resources. No one helped with that."

"I didn't have any doubt."

"You feel better when you have someone with you."

- I FELT THE HOSPITAL STAFF WERE CONCERNED ABOUT THE CLIENT.

"Nurses were cold, just another emergency room case. The physician made us feel concerned."

"Demonstrating concern is where the nurses need to come in and emphasize this in this case. The nurse on days was good. After 3 PM no one seemed to bother with him.

"The staff were busy but my Dad was being observed and monitored. They weren't with him all the time but that may not have been needed."

"The staff were working with efficiency but impersonal due to the hectic environment. They can't take time with only one person and their feelings."

"It's a touchy question. They were too business-like and I was upset. Maybe I was looking for someone to hold her hand (the client) but only it doesn't work that way. When I summoned them, they came. And, one nurse apologized that they didn't have a chair. I had to stand the entire time and I have my own medical problems."

- I WAS GIVEN INFORMATION AS TO HOW THE CLIENT WAS RESPONDING TO THE TREATMENT.

No comments.

- I WAS GIVEN INFORMATION CONCERNING THE CLIENT'S CONDITION IN A PRIVATE SETTING.

"Things like that don't bother me."

- I WAS ABLE TO TALK ABOUT NEGATIVE OR "BAD" FEELINGS I HAD SUCH AS GUILT OR ANGER.

"I had some negative feelings. They told me six years ago that my husband's brain tumor would not come back."

"I'm a very private person."

"Guilt--We were cleaning a desk in the basement. It was too hot. Too much work for him. I kept these feelings to myself."

"Anger--at my son for being in a fight and being injured. The physician helped me deal with it."

"I was angry at the resident. He wouldn't answer any questions. I was told if I didn't like it, I could go out. No help from the staff. My husband helped."

"Guilt--'gut feeling'. Being a nurse, I was wondering if I was negligent in looking out for my father."

"Anger--MD sent him home too early (in-patient, one month). Just at home in the past 24 hours and now in the emergency room."

"I did have irritation. It subsided! I couldn't be sure right now what caused it, but I think it was about getting my red card back."

"I was just worried."

"I felt safe because of the MD. He was competent and informative."

"It hurt me to see my husband suffer. He was in paid for a long time."

"I was confused at the time. Nothing like this has ever happened before."

"I was feeling curiosity. Unclear what was happening."

"I was disappointed that my mother was sick again. Fearful about possible surgery, I kept it to myself."

"I wondered why did it happen to her? My daughter, but I didn't talk to the staff about it."

"I was hesitant to leave my husband since the door was locked. When I wanted to come back in the secretary said 'What do you want to do in there?' I felt like I was being locked out!"

"Initially, I was afraid. I thought it could be serious. I didn't know who to blame."

"I had feelings of anger that were intensified by waiting. My father was sweating while lying on leather (shut-off stretcher). Three times they moved the patient in emergency room. They mixed up with intensive care unit and regular bed. The staff were very busy."

"We've been trying to get them to quit driving. I was angry at my parents."

"The nurse encouraged me to express anger."

- I WAS ALLOWED AND/OR ENCOURAGED TO CRY.

"I held it in and cried when I was alone."

"I was upset but I'm getting used to the emergency room and injuries. I've been here quite a bit with my son. The physician helped me."

"I was upset, but I didn't let the staff or my husband know."

"You are not encouraged to demonstrate any emotion. Don't make a scene. They would rather have you out in the hall."

"I was crying. My girlfriend helped me."

- I COULD NOT BELIEVE WHAT HAPPENED, BUT I WAS ENCOURAGED BY THE STAFF TO ACCEPT THE REALITY OF THE CRISIS.

"I didn't want this to happen, but I thought it might. You never know what will happen and the MDs are not God!"

"There is a difference between a professional and a layman. They are concerned but not in the sort of way I am concerned. With emergency room work you have to develop a hard shell to survive, so I have to understand."

"I was shocked but we watched my husband since he was sick. The nurse and MD were compassionate as to what was happening."

"The nurse and MD look at you and can tell how you feel. They encouraged me to accept the reality."

"No support, no information."

"I wasn't surprised but disappointed. The surgeon told me about the problem and what they could do for it."

"I didn't get any encouragement or discouragement. The staff did what they had to do. They were kind."

"I was wondering what it could be. They didn't know what the problem was, but they were supportive."

"I knew it would happen. My father did it before. I took his keys away. Another relative told me I was mean."

- I FELT MY EXPRESSIONS OF ANGER WERE ACCEPTED BY THE STAFF.

"I didn't let them know."

"The doctors later understood my concerns and explained."

"The MD sat with his coffee and then walked around the emergency room even though he knew we wanted to talk to him. The staff had too much work. I don't think this should be an excuse. They didn't come out to you. You feel like a nag. My sister was upset and while talking with the MD, she was talking when he was talking. He told her 'you could take your father to another hospital.'"

"Anger was expressed to my wife."

- I WAS ABLE TO HAVE A FAMILY MEMBER OF CLOSE FRIEND ACCOMPANY ME WHEN SEEING THE CLIENT.

"I realize you can't stay in the emergency room. Relatives around it would make things uncomfortable for the MD and nurse. Relatives should stay for 5-10 min. I knew my husband wasn't too bad so I would leave. There were other patients coming in. If it were my mother or granddaughter, I would stay."

"Only one parent could accompany the child in the emergency room. So my husband had to wait outside."

"One nurse called a family member to be with me. She called my daughter."

"Our child 15 months old stayed with us. The nurses were great. They brought a crib for the baby to stay in."

"The daughters wanted to be with their father. Since he could not talk well (CA of the throat), they were concerned about his communication with the staff. The nurse told us we had to leave."

- I WAS ABLE TO TALK WITH THE STAFF ABOUT THE POSSIBILITY OF THE CLIENT'S DEATH.

No comments.

- I WAS ABLE TO HAVE A CLERGYMAN VISIT WITH ME.

"Not necessary at that moment."

"I never gave it a thought in the emergency room. Maybe I have some bitterness."

"I would have liked very much to have seen a clergyman."

"Not at this time. I wanted to see my mother relieved of pain first. Then other needs can be taken care of: spiritual, social service, etc."

- I WAS TOLD ABOUT A SOCIAL WORKER TO HELP WITH IMMEDIATE FAMILY PROBLEMS.

"I try to work my problems out myself."

"I asked to talk with a social worker later on. I didn't want to be accused of hitting my son but we need the assistance of social service. I have no insurance for him. At present, I am looking for a job."

"We were, but in the emergency room I was mostly concerned about my father's condition and would be concerned about a social worker later on."

"Could have used one. Left home quickly and had no cash with me. Parking attendant took a check. Also, I needed money for lunch."

"Long term could have interviewed with financial matters."

"Later could have used one, but no one asked."

- I WAS ABLE TO HAVE FRIENDS NEARBY FOR SUPPORT.

"Would have liked it but I was alone."

- I WAS ABLE TO SIT IN A WAITING AREA NEAR THE CLIENT.

"I liked the waiting room off to the side. This way you didn't see other sick patients coming into the emergency room."

"I was told to wait outside the locked doors and after the response from the secretary 'What do you want to do in there?', I didn't want to go back out and be locked out."

- I WAS ABLE TO HAVE USE OF A PUBLIC TELEPHONE NEAR THE WAITING ROOM.

"I was nervous so I asked where the phone was. I was standing next to the phone, but I didn't see it. In the emergency department, you have to try and keep control."

"I couldn't get any change to make a phone call. They were telling me to go from one person to another."

"We had to find one on our own in the main lobby."

- I WAS ABLE TO GET A CUP OF COFFEE OR OTHER REFRESHMENT NEAR THE WAITING ROOM.

"I didn't ask. I didn't want to leave my wife for coffee. I've been living on coffee and eggs for three weeks."

"Mouth gets dry when you are tense. You need some refreshment."

"I asked the nurse. I was frightened it was late; no one was around, but I did find my way. You can't get back in the emergency room, so I had to ask the way and I walked around."

"I didn't want to leave him. I was anxious to see how he was and what was wrong."

"I didn't want coffee. They don't serve Bud."

- I FELT I NEEDED TO BE ALONE AND I WAS PROVIDED WITH A PLACE TO BE BY MYSELF WHILE IN THE HOSPITAL WAITING AREA.

"I would have preferred to be alone."

"For a while I would have liked to be alone."

"I'm better off with people around then to be all alone."

"I walked out of the emergency room and the nurse talked with me for a minute. It helped!"

"I was in such a state of shock. I just knew I had to keep going. Is there a chapel in this hospital?"

- I WAS TOLD ABOUT ANY PLAN BEING MADE TO TRANSPORT THE CLIENT TO ANOTHER AREA OF THE HOSPITAL WHILE THE ARRANGMENTS WERE BEING MADE.

"The staff kept saying they would admit him, but we had to wait a long time."

"I was told he was goind to be admitted but it was six hours before they had a bed."

"They had to move someone out to put my husband in the intensive care unit, so we had to wait in the emergency room. I felt he was in good hands in the emergency room while waiting."

- I WAS GIVEN EXPLANATIONS OF THE ENVIRONMENT BEFORE GOING TO THE INTESIVE CARE UNIT.

"The nurse took the panic off of that. I was told why and what they would do for her in the intensive care unit, not that she was coming up here to die."

"I wasn't told but I figured it out because of my husband's condition and my past experience. I sat on a stool for six hours while my husband was in the emergency room waiting to be admitted. I could have waited in the waiting area, but I preferred to stay with him. My buttock was killing me from sitting on the hard stool."

- I WAS TOLD ABOUT A COUNSELOR TO HELP WITH FAMILY PROBLEMS.

No comments.

APPENDIX D

INFORMED CONSENT

Participant's Name: _____ Date: _____

Project Title: Need Satisfaction of Families of Emergency Department Clients

The purpose of this study is to find out if the needs of families or friends of emergency clients are being met and which members of the hospital staff are meeting these needs. You will be asked to fill out a questionnaire that will take about 15-20 minutes of your time. The questionnaire lists 32 needs that you may have had during the emergency visit. You are to circle a response indicating whether you agree or disagree that this need was met. Responses are stated on a scale of strongly agreeing (the need was met) to strongly disagreeing (the need was not met). If the need did not apply to your experience, you will circle not applicable (NA). If you do not recall the response to a particular need, you will circle U for uncertain. If the need was met then you will be asked to circle a response indicating which member of the hospital staff met the need. In addition, you will be asked to answer a few questions about your background (age, sex education) and other emergency department experiences (nature of the crisis, time waiting).

Since your name is not required, no one will know, except yourself, how you have answered. All responses will be kept confidential. Responses will be destroyed upon completion of the project.

This study will provide information about how the hospital staff helps families in crisis. If you choose to participate there is no risk to you except the possible discomfort of thinking and talking again about a painful experience; however, sometimes people find it helpful to talk about such an event. This may be a benefit to you. The information obtained from this study about how the hospital staff helps families in crisis, may also be of benefit to those families facing similar crisis in the future.

Your participation will be of no financial cost to you. Your time and help in this study is greatly appreciated.

CONSENT

I have fully explained to _____ the nature and purpose of the above-described procedure and the risks that are involved in its performance. I have answered and will answer all questions to the best of my ability.

_____
(signature: principal investigator)

I have been fully informed of the above-described procedure with its possible benefits and risks. I give permission for my participation in this study. I know that Patricia Rovelli will be available to answer any questions I may have. If, at any time, I feel my questions have not been adequately answered, I may request to speak with a member of the Medical Center Institutional Review Board. I understand that I am free to withdraw this consent and discontinue participation in this project any time without prejudice to me. I have received a copy of this informed consent document.

I understand that behavioral research such as that in which I have agreed to participate, by its nature, involves risk of injury. In the event of psychological injury resulting from these research procedures, treatment will be provided at no cost, in accordance with the policy of Loyola University Medical Center. No additional free medical treatment or compensation will be provided except as required by Illinois law.

In the event I believe that I have suffered any psychological injury as a result of participation in the research program, I may contact Dr. S. Aladjem, Chairman, Institutional Review Board for the Protection of Human Subjects at the Medical Center, telephone (312) 531-3380.

I agree to allow the results of the questionnaire to be available to other authorized physicians and researchers for the purpose of evaluating the results of this study. I consent to the publication of any data which may result from these investigations for the purpose of advancing medical knowledge, providing my name or any other identifying information (initials, social security numbers, etc.) is not used in conjunction with such publication. All precautions to maintain confidentiality of the medical records will be taken.

_____
(signature)

_____
(signature: witness to signature)

APPENDIX E

LOYOLA UNIVERSITY MEDICAL CENTER

2160 South First Avenue, Maywood, Illinois 60153 312 531-3000

July 21, 1982

Patricia Rovelli, R.N.
School of Nursing
Loyola University Medical Center

Re: "Need Satisfaction of Families of Emergency Department Clients."
IRB# 7/82-3e.

Dear Ms. Rovelli:

At the July meeting of the Institutional Review Board, the Board voted to approve the above-captioned study via Expedited Review.

Your study now has full IRB approval and has been assigned the IRB number indicated above.

Sincerely,

Silvio Aladjem, M.D., Chairman
Institutional Review Board for the
Protection of Human Subjects - Medical Center

SA/s

cc: L. Janusek, R.N., Ph.D.
IRBPHS Members
IRBPHS file

CONSENT

RESEARCH TITLE: NEED SATISFACTION OF FAMILIES OF EMERGENCY DEPARTMENT CLIENTS

The above study is designed to assess the degree of need satisfaction of families of seriously-ill emergency department clients. As Director of this unit, I have been informed of the above study, its process and rationale.

I hereby give my permission for this graduate student to carry out the above project on this unit pending Internal Review Board approval.

Director: [signature] MD Date: 7/15/82

Assistant Director - Emergency Dept.

Witness: [signature]

(Also approved by Dr. ... & Dr. John A. ...)

INTER-OFFICE COMMUNICATION

LOYOLA UNIVERSITY MEDICAL CENTER

To WHOM IT MAY CONCERN **Date** July 29, 1982

From Carol DeBiase, RN, Ed.D.
Associate Director of Nursing/
Nursing Practice **Subject**

Ms. Patricia Rovelli has permission from the Department of Nursing to interview patient's family members regarding their treatment in the Emergency Room. Her research study has formal IRB approval and she has a written consent from the patient and family. If you have any questions regarding Ms. Rovelli's research project, do not hesitate to contact me.

CDB/ws

APPENDIX F

COVER SHEET

The purpose of this study is to: 1) identify the extent to which needs of families of emergency clients are being met in today's emergency settings, and 2) establish who among the health team are meeting these needs. This research supports the requirement for families to receive assistance at the time of a crisis. As a family member of an emergency client, your personal experience will contribute to this inquiry.

Participation entails 15-20 minutes to answer a interview guide listing needs that have been previously defined by families in crises. Please respond, by interpreting the degree you felt each particular need was met or not met during your time spent in the emergency department. Responses will be recorded on a scale of strongly agreeing to strongly disagreeing. Circle the one that best describes your personal experience. If the need is not applicable, please circle NA. If you do not recall the response to a particular need, circle U for uncertain. Along with measuring the degree of satisfaction of each need, I will ask you which person or persons on the health care team demonstrated the responsibility for meeting the specific need. If it was someone <u>other</u> than those mentioned, please identify in the space provided. If no one assisted you with that particular need, then leave the response uncircled. And, if there is a need that was not mentioned, please fill it in at the end of the list of needs in the appropriate space privided and state who met that particular need.

Confidentiality will be maintained. Your name will not be required on the interview guide. The results of this study will be confined to the scope of nursing and medical practice for the purpose of improving patient and family care. If you should wish to be informed of the results, please advise me of your interest, and I will share this data with you. Thank you for your participation in this study.

INTERVIEW GUIDE ON THE DEGREE OF NEED SATISFACTION

OF FAMILIES OF EMERGENCY DEPARTMENT CLIENTS

Subject # _____ Date and Time _____

Part I: In the statements below, the word client refers to the person receiving treatment in the emergency department. Using the following code, please circle the response that best matches your actual experience for each of the following statements.

CODE: SA = Strongly agree
A = Agree
U = Uncertain
D = Disagree
SD = Strongly disagree
NA = Not applicable

Remember, if the statement does not apply to you, please circle NA. For the responses beneath each need statement, circle the individual(s) who assisted you in meeting the need. Please identify any other person not listed. If no one assisted you, leave the reply uncircled.

SA A U D SD NA 1. I did not know the events which brought the client to the emergency room, but once there I was given this information.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 2. I was able to see the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 3. I was given information regarding the condition of the client prior to seeing him/her for the first time after the crisis.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 4. I was given direction as to what to say and do when seeing the client for the first time after the crisis.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 5. I was given information about diagnostic studies (tests) done for the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 6. I was given information about treatments done for the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 7. I was assured that the best care was being given to the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 8. I was given explanations in words I could understand.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 9. I was able to talk to the doctor treating the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 10. I was informed of the prognosis (the degree of recovery).

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 11. I was able to talk to the nurse caring for the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 12. I was encouraged to be hopeful.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 13. I felt the hospital staff were concerned about the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 14. I was given information as to how the client was responding to the treatment.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 15. I was given information concerning the client's condition in a private meeting.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 16. I was able to talk about negative or "bad" feelings I had such as guilt or anger.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 17. I was allowed and/or encouraged to cry.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 18. I could not believe what happened, but I was encouraged by the staff to accept the reality (truth) of the crisis.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 19. I felt my expressions of anger was accepted by the staff.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 20. I was able to have a family member or close friend accompany me when seeing the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 21. I was able to talk with the staff about the possibility of the client's death.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 22. I was able to have a clergyman visit with me.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 23. I was told about a social worker to help with immediate famliy problems.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 24. I was able to have friends nearby for support.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 25. I was able to sit in a waiting area near the client.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 26. I was able to have use of a public telephone near the waiting room.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 27. I was able to get a cup of coffee or other refreshment near the waiting room.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 28. I felt I needed to be alone and I was provided with a place to be by myself while in the hospital waiting area.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 29. I was told about any plans being made to transport the client to another area of the hospital, while these arrangements were being made.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 30. I was given explanations of the environment before going to the Intensive Care Unit.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 31. I was told about a counselor to help with family problems.

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

SA A U D SD NA 32. List any other need you had but was not mentioned?

_____

Was this need met? Yes _____ No _____

Need Met By: Nurse, Physician, Emergency Room Secretary, Patient Representative, Social Worker, Religious, Other Relative, Friend, Other Visitor, Other _____

Part II:

1. What is your relationship to the client?

Wife _____	Sister _____	Other _____
Husband ___	Brother _____	
Mother ____	Aunt _____	
Father ____	Uncle _____	

2. What is your age?

_____

3. What is your educational level?

Grammar School _____
High School _____
College _____
Graduate School ____

4. What is your occupation?

_____

5. Were you with the client as the crisis occurred?

   Yes _____ No _____

6. Were you called to the emergency department after the client arrived?

   Yes _____ No _____

   If Yes, by whom? _____

   And, what information were you given?

   _____

7. What is the nature of this emergency visit?

   _____

   And, what was the outcome? _____

8. Have you yourself ever been a patient in this emergency department?

   Yes _____ No _____

9. Is this your first visit as a relative to the emergency department?

   Yes _____ No _____

10. What time of day were you summoned to the emergency department?

    Morning _____ State approximate time.
    Afternoon ____
    Evening _____ _____

11. How many hours have you been in the emergency department?

    Less than 1 hour _____
    1 hour _____ 4 hours _____
    2 hours _____ 5 hours _____
    3 hours _____ More than 5 hours _____

APPROVAL SHEET

The thesis submitted by Patricia Marie Rovelli has been read and approved by the following committee:

Dr. Linda Janusek, Director
Assistant Professor, Nursing and Physiology, Loyola

Dr. Dorothy Lanuza
Associate Professor, Nursing, Loyola

Dr. Donna Rankin
Assistant Professor, Nursing, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

4-22-83
Date

Director's Signature