

Caring Practices

PART II

Family-Focused Care

LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1. Identify the components of family-focused care.
2. Examine the need of families of acutely ill patients.
3. Discuss family-focused care from patient, family, and healthcare provider perspectives.
4. Integrate current knowledge of family-focused care into critical care nursing practice.
5. Analyze strategies to successfully implement family-focused care.
6. List optimal patient outcomes that may be achieved through evidence-based family-focused care.

Fay Wright

When an individual family member is hospitalized with a critical illness, change inevitably occurs within the family system. As the family adapts to a member's illness and approaches care decisions, the nurse's role is to facilitate the changes in the family's role, function, and adaptation. Family-focused care takes patient care to the next level. This approach considers patient needs to be a priority, but it maintains familial bonds and helps the family continue to support the patient as part of the family system.

DEFINITION OF FAMILY-FOCUSED CARE

Family-focused care is a method of care delivery that recognizes and respects the pivotal role of the family. It views the patient and family as a complete entity, while supporting families in their natural caregiving roles and ensuring family collaboration and choice in treatment decisions affecting patients. By its very nature, family-focused care opens up the care delivery system to include support and communication with families. Family-focused care involves developing and individualizing interventions such as visitation, communication, family involvement in caregiving activities, patient/family education, and counseling. The key elements of family-focused care present a philosophy of care that, when incorporated into practice, recognizes the uniqueness of each patient and family. By incorporating the elements of family-focused care into professional nursing practice, interventions can be developed that facilitate patient and family coping (see **Table 2-1**).

Family-focused care is imperative for quality patient care in today's healthcare environment. Patients and families are taking control of their health to ensure they receive the best care possible. Shortened length of hospital stays, families assuming direct caregiver roles, and increased involvement during the patient's hospitalization are all trends that require family-focused care. The publicity surrounding the Institute of Medicine's report on errors in patient care (2000), television shows that detail aspects of medical care, the nursing shortage, and the potential for medical errors likewise amplify the need for families to be actively involved in understanding the patient's care and advocating for the best practice.

TABLE 2-1 Key Elements of Family-Focused Care

Recognizing that the family is the constant in the patient's life while the service systems and personnel within those systems fluctuate
Being aware of family strengths and individuality and having respect for different methods of coping
Encouraging and facilitating family-to-family support and networking
Sharing complete and unbiased information about the patient's care with family members on a continuing basis in a supportive manner
Designing accessible healthcare delivery systems that are flexible, culturally competent and responsive to family needs

Source: Shelton & Stepanek, 1994.

The American Hospital Association's *Patient Care Partnership* document (2005) mandates a decision-making partnership between the healthcare system and the patient, thus facilitating patients' efforts to determine their own future. This partnership also highlights the responsibilities of the healthcare system to fully communicate treatment options and the plan of care.

In a discussion with critical care nurses about the changes in their practice, the primary concern identified was the growing lack of trust between nurses, patients, and families (Dracup & Bryan-Brown, 2002). This concern has grown to the point that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has developed standards to address the growing liability related to medical errors.

In JCAHO's 2005 publication *Healthcare at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*, one of the recommendations for preventing liability in case of medical errors is to promote open communication between practitioners, patients, and families. Open communication is a hallmark of family-focused care. Family-focused care increases the communication between patients, families, and healthcare professionals, building trust between all parties. When open communication exists, there is less confusion and frustration for all participants involved in patient care.

Imagine that your parent is having coronary artery bypass surgery (CABG). The surgeon has told you that the surgery is complete and that your parent will be admitted to the intensive care unit (ICU). You are directed to the ICU waiting room, where a nurse provides you with more information about how your

parent is doing and when you can visit. When you arrive at the waiting room, you call into the ICU on the phone outside the door—but no one answers. You call again. When you get a response, you are told to wait and informed that someone will get in touch with you soon, but no specific time frame is given. You do not know if your parent is in the ICU, what your parent's condition is, or when you will be able to visit. How do you feel?

If you are like most family members, you will become increasingly anxious and afraid. The uncertainty of not knowing what is happening or when you can see your parent becomes overwhelming, and you continue to call the ICU and seek information. With your constant calling, the ICU staff become frustrated that they cannot complete their work because of the interruptions from the "difficult family." This creates a situation where both the family and the staff are frustrated, anxious about communication and distrustful of each other.

How different this situation would be if upon arrival to the ICU family waiting room, the initial call is answered and a nurse comes out, makes introductions, and gives you an overview of what will happen to your parent upon arrival to the ICU and how the monitoring will occur, and states that within 45 minutes you will be allowed to visit with your parent. Forty-five minutes later the nurse brings you in to visit. While at the bedside, the nurse explains the tubes and machines and encourages you to touch and talk with your parent. The nurse explains how you and your family can support your parent. In this scenario, trust would develop. While you would still feel concern for your parent's well-being, you would have a sense of being informed and part of the care—an active participant in the healing process for your parent. When nurses are empathetic and open to interacting with patients and families, they connect and communicate in such a way as to promote trust and form positive relationships.

DEFINITION OF FAMILY

To practice family-focused care, one must first identify the family. The family is the basic unit of care. The family is who the patient identifies as important and significant and who influences the care and well-being of the patient. The traditional definition of a two-parent, nuclear family, while still present, is not the only way to define families. According to the U.S. Census Bureau (2000), one-third of U.S. families include members who are not biologically or legally related. Single-parent families are increasing, and 35% of all U.S. children live with step-parents or grandparents at some point in their lives. The number of same-sex partners who are starting families is also increasing. In our society, there are an increasing number of elderly who live alone. Redefining the way we describe the family is essential to providing family-focused care for critically ill patients.

THE EFFECT OF CRITICAL ILLNESS ON THE FAMILY

Critical illness of a family member creates a crisis and a sense of disequilibrium within the family system. Established roles and functions are disrupted (Hepworth, Hendrickson, & Lopez, 1994). The crisis of critical illness disrupts the family's usual methods of adapting to stress. Basic emotional and physical needs may not be met and new needs may develop (Hepworth et al.).

Molter (1979) published a seminal research report that identified the needs of critically ill patients' families. Using the Critical Care Family Needs Inventory (CCFNI), she interviewed the families of critically ill patients to determine their needs related to the critical illness of a family member in the ICU. The top ten needs are listed in **Table 2-2**.

The CCFNI has been used in many research studies, and its results have been replicated and validated (Wasser et al., 2001). The identified needs can be generalized to the critical care family population. The CCFNI needs can be grouped into five common themes (**Table 2-3**), which most ICU family members experience. These themes help families support the critically ill patient, help nurses develop interventions to facilitate family understanding of the patient's illness, and assist families coping with the crisis.

Families will individually express needs based on their resources, coping methods, values, and attitudes about critical illness and health care. Evaluation and incorporation of families' individual responses into the plan of care are essential to implement family-focused care. The family's needs provide a base from which to get started. When the family understands

TABLE 2-2 Critical Care Family Needs

To have questions answered honestly
To know specific facts regarding what is wrong with the patient and his or her progress
To know the prognosis/outcome/chance of recovery
To be called at home about changes
To receive information once a day
To receive information and understandable explanations
To believe the hospital personnel care about the patient
To have hope
To know exactly what/why things are being done to the patient
To have reassurance that the best possible care is being given to the patient

Source: Molter, 1979.

TABLE 2-3 Critical Care Family Need Themes

To receive assurance
To remain near the patient
To receive information
To be comfortable
To have support available

Source: Leske, 2002.

the patient's illness and treatment options, they are able to participate in decision making and provide emotional support to the patient. Involved families have time to process the impact of the illness on the family system. They are also able to observe care that is provided and to determine if and when it is time to withhold care.

IMPLEMENTING FAMILY-FOCUSED CARE

Early assessment and communication between the nurse and the family will identify the level of intervention necessary to support the family. Needs serve as building blocks for meeting the goal of helping the patient and family maximize their health and coping during the patient's critical illness. The complexity of each situation is distinct and requires an individualized plan of care. The earlier the healthcare team develops an effective relationship with clear communication, the more coordinated and effective care will be (Tracy & Ceronisky, 2001).

Recognize That the Family Is the Constant in the Patient's Life

Before, during, and after the critical illness, the family is a part of the patient's life. Families are not mere visitors, but rather an integral part of the patient's world and support system. The nurse is the visitor in the family system and has a transient relationship in helping the family seek balance and maintain its bonds.

Recognition of these facts immediately suggests a number of nursing interventions. Ask patients who is important to them and who they want at the bedside. If the patient can not communicate, ask the family member who appears closest to the patient, who should be at the bedside.

Early relational work between the nurse and the family will facilitate communication throughout the patient's critical illness (Leske, 2002). Talking with families about the plan of care, daily changes, and the patient's progress is easier if a consistent caregiver has established trust and open communication. Johnson and colleagues (1998) reported that families experienced

enhanced satisfaction when the patient had the same nurse care for them for two consecutive days.

It is important to be consistent with the plan of care and communication. For example, if you have discussed that chest x-rays are performed daily but on one day the x-ray is deferred due to a system or a clinical issue, an explanation may be warranted. If family members expect a chest x-ray and it is not performed, they may assume something is wrong with the patient if the change is not communicated. Communicating honestly and simply about changes in the plan of care will decrease family anxiety.

Families Need to Be Near the Patient

In a family-focused care ICU, flexible visiting hours allow the family and staff to reach a mutual understanding about the length and timing of visits and the visitors permitted. Families are encouraged to be at the bedside, showing sensitivity for patient needs, activity level in the unit, and their own need for positive health. Talking with families before they enter the unit, thereby explaining unit routine and patient care needs, allows them to understand what is occurring at the bedside. Strict, rigid visiting policies with access being granted based on rule rather than assessment of patient needs, nursing care demands, and unit activities sets up a conflictual relationship between the patient, family, and staff. The ICU should establish practice guidelines for family visiting that incorporate patient and family needs for proximity, maintain family relationships, and allow the family to support the patient (Kirchhoff, Pugh, Calame, & Reynolds, 1993). Research demonstrates that flexible, inclusive, and open visiting that is responsive to patient, family, and care needs is beneficial to all parties (Titler, 1998). Flexible visitation involves assessing family, patient, and unit needs and preferences in order to develop guidelines and an individualized plan that frames the frequency, time, or length of visits. The visitation plan is routinely evaluated to determine if it is responsive to individual patient and family needs. The following clinical example illustrates the communication process that takes place when establishing a flexible visitation plan.

Alexander is admitted for an acute myocardial infarction. He is married with six children, all of whom live more than one hour away from the hospital. The nurse meets with Alexander's wife Katie at his bedside. Alexander is alert, yet groggy. During the nurse's initial interaction with Katie, she asks when Katie would like to visit. Katie informs the nurse that she needs to be with Alexander and has never slept away from him in their 35 years of marriage. The nurse explains the ICU environment, the noise of machines, and routine of care. The nurse also discusses the need for Katie to take care of herself so she can support Alexander.

Alexander holds Katie's hand and states that, while he doesn't want her to get tired, he would like her to stay with him as much as possible. Together, Alexander, Katie, and the nurse decide that Katie will stay at the bedside for as long as she would like, with the expectation that she will leave to eat and take a break every few hours. The nurse and Katie also discuss that when the children arrive, they will come into the room but no more than three people will be at the bedside at any given time because of space limitations. The nurse explains the need to call the unit secretary before walking into the unit as protocol for security. The nurse also discusses the need for Alexander to rest and states that the plan will be reevaluated based on how Alexander's care proceeds.

For the first 24 hours, Katie leaves only to go to the bathroom and eat a short meal. As the children arrive, Katie explains the visiting process. The children organize themselves and move in and out of the unit, visiting their father. The next night Katie leaves to go to a nearby hotel with her son. Katie felt comfortable with Alexander's progress and care but knew that she was tired. The nurse supported Katie's decision and assured her that she could call or return at any time.

This example illustrates the process of communication and assessment that occurs when a professional nurse develops a visiting plan as part of the patient's plan of care. The family participated in the planning process. As they developed comfort with the patient's status and care, they were able to reevaluate the plan and adapt it to continue to meet their needs.

Through conversations with the family, flexible visitation plans may be developed. These plans may limit the number of visitors at the bedside and may put some restrictions on when family may visit. It is common practice to limit visitation during shift report. The time limits often become a non-issue when family-focused care is implemented, as the family becomes integral to the patient's care.

Some critical care nurses anecdotally report adverse patient responses to visiting, such as increased ventricular ectopy, intracranial pressure, and stress and anxiety. Clinical research does not support these reports, however. Routine nurse-patient interactions are as stressful as family interactions but have no harmful effects on patient blood pressure, ventricular ectopy, or intracranial pressure (Fuller & Foster, 1982; Hepworth et al., 1994). Initial adverse patient responses will diminish if the family is allowed to remain at the bedside and does not have limited access to the patient.

Schulte et al. (1993) studied the relationship between heart rate and ectopy in a cardiac care unit with restricted and flexible visitation. These researchers found no significant difference in the number of premature ventricular contractions or premature arterial contractions with flexible visitation when compared

with restricted visitation. The patients with flexible visitation experienced lower heart rates and appeared more relaxed than the patients whose families were restricted from visiting. (See the American Association of Critical Care Nurses' (AACN) protocol for practice for annotated bibliographies of these studies.)

When patients were asked about family visitation, patients reported that visiting is “a nonstressful experience because visitors offered moderate levels of reassurance, comfort, and calming” (Gonzalez, Carroll, Elliott, Fitzgerald, & Vallent, 2004). Family visitors explained clinical care information to patients and provided information to assist the nurse in understanding the patients.

If a patient requests to see a child family member or a child wishes to see the patient, that request should be honored. Developmentally appropriate education about the patient's illness and the ICU environment prepares the child to visit. Emotional support before, during, and after the visit enables the patient and child to maintain a bond and may help the child deal with the critical illness of an adult family member (Nicholson et al., 1993).

If the family is defined as whoever is significant to the patient, then the patient's beloved pet must be included in a family-focused care ICU. Pet visitation, when properly planned and monitored, can address the loneliness, isolation, and lack of emotional support that some critically ill patients face (Giulano, Bloniasz, & Bell, 1999).

Be Aware of Family Strengths and Have Respect for Different Methods of Coping

Every family has different strengths and supports. Yet research has shown that initially family members respond similarly to the crisis of critical illness regardless of their age, gender, or relationship to the patient, and the severity of the illness (Leske, 1992; Leske & Jiricka, 1998). Before the onset of a critical illness, the family is inevitably coping with the daily stresses of work, school, and finances. When a life-threatening change occurs, the family must respond. The amount of stress and the success of the family's coping prior to the critical illness affect how they will manage the new stress created by critical illness (Leske, 2003). Families with more extensive resources and coping skills will more effectively adapt to the crisis of the critical illness. If their strengths do not compensate for the new demands faced, the family will become unbalanced and their adaptation will decrease. Research has shown that problem-solving communication is a significant family strength influencing family adaptation (Leske, 2003). Nursing interventions that help mobilize family strengths and meet identified family needs promote the adaptation of families of critically ill patients.

Families Need Information

Family members will ask questions, take notes, and bring research from the Internet to discuss with the healthcare team. It is important to not assume that the family member is trying to document mistakes but rather is keeping track of what transpires and what is said. The critical care nurse should assess the knowledge that the family has and needs. The family should be encouraged to take notes and write down their questions, and their need to understand should be clearly acknowledged. Have the family identify a family spokesperson who will make sure all members remain informed. Notebooks help the family organize and gather information in a setting with a large amount of new and ever-changing information. Repeated questions are not really directed to understanding how the ventilator works or what the electrocardiogram (ECG) pattern is but rather represent a plea to understand the patient's condition and to develop some sense of control. Honest, thoughtful answers will help this inquisitive person as well as disseminate information throughout the family.

Occasionally, a family member may also be a healthcare professional. Assessment of the family member's level of knowledge and expertise should be made and can serve as a foundation for further information. One should not assume the presence of knowledge or understanding of the patient's condition.

Families Need Assurance

Family members may ask a lot of questions, want to chat about providers' lives outside the ICU, and get to know the nurse and the unit. Family members are looking for answers and assurance that the patient is receiving the best possible care. With greater understanding, their ability to support the patient grows.

One study found that having family members with high levels of optimism was strongly correlated with greater satisfaction with needs being met and feelings of affiliation with both physicians and nurses (Auerbach et al., 2005). To build on this family strength, nurses may communicate positive changes and encourage family members to participate in the patient's care.

Families Need to Be Comfortable

It is important to accept a family member's expression of feelings and to develop comfort with crying and emotionality. Assessment of the effect of crying on the patient should be made. If the patient becomes upset when the family member cries, the family should be moved away from the bedside. If it doesn't affect the patient, expression of emotion can be allowed to continue in the patient's view.

Some families are more effective than others in supporting their ill family member at the bedside. Some family members' coping behaviors may lead a novice nurse to label them as dysfunctional, needy, or difficult. Chesla and Stannard (1997) discuss the effect of labeling family behaviors. Once labels were assigned and communicated from shift to shift, the family began to take on more negative behaviors. When family behaviors were discussed in a descriptive manner, the increase in "negative behaviors" was not identified and a decrease in dysfunction was noted. However, the goal with family-focused care is not to fix any dysfunctional family dynamics. Nurses can acknowledge any perceived dysfunction and communicate with the family to focus on the common goal of patient recovery. Family members arguing at the bedside may affect the stress levels of the patient and of the ICU as a whole. The arguing family requires refocusing back on the patient, moving any heated discussions away from the bedside and developing plans of visitation and communication that keep the heated discussions away from patient care areas. Building relationships with the family early during the critical illness and clearly communicating behavioral expectations decrease and prevent behaviors that interfere with the patient's health and well-being.

Share Complete and Unbiased Information about Patient's Care with Family Members on a Continuing Basis in a Supportive Manner

The clarity of the information discussed with families as well as the attitude of the healthcare provider are important in determining the family's ability to understand the information (Jurkovich, Pierce, Pananen, & Rivara, 2000). Communication must be meaningful to the family. Understandable language that is not filled with medical jargon is essential. Think about getting a report on the first day of your first clinical rotation. How much did you understand? Did you understand what an IV, CVP, ABG, or pulse ox was? Listen to the way you communicate with families. Use simple terms to explain patient care procedures (see **Table 2-4**).

A structured plan of calling the patient's family daily (Medland & Ferrans, 1998), giving informational booklets (Henneman, McKenzie, & Dewa, 1992) about the ICU, holding orientation meetings (Chavez & Faber, 1987), and providing educational videotapes has been found to help meet the information needs of critically ill patients' families.

During initial interactions as well as in daily communication, the nurse should share specific information with the family (**Table 2-5**). This important information includes vital signs, level of consciousness, status through the night, changes in condition, and plans for the day. It is important to determine

TABLE 2-4 Communication Principles for Family Understanding

- Use analogies.
- Draw pictures.
- Use words, not letters.
- Rephrase.
- Reframe.
- Repeat.

what additional information is important to the family. Determine how the family thinks the patient is doing when providing these updates.

Information families receive so that they can make care decisions is often inadequate or lacking. Effective communication with the staff is the best antidote for uncertainty among the patient's family members (Kirchhoff & Beckstrand, 2000). After more than two decades of research evaluating the needs and satisfaction of families of ICU patients, it is clear that improved communication, enhanced support systems, and a friendlier environment decrease frustration and promote feelings of satisfaction. From the research, several themes and principles have become apparent, which formed the basis of the Critical Care Family Assistance Program (CCFAP) (Lederer, Goode, & Dowling, 2005). Started by the Chest Foundation, a philanthropic arm of the American College of Chest Physicians, in collaboration with the Eli Lilly and Company Foundation, the CCFAP study "supports the delivery of a family assistance program model that has the potential to significantly alter the critical care environment for ICU patients and their families" (Lederer, Goode, & Dowling, p. 65S). The study's dual purposes are "determining the efficacy of the model as a replicable model in a variety of hospital ICU environments and assessing the impact of the model on family satisfaction with the care and treatment of their loved ones in critical care units" (Lederer, Goode, & Dowling, p. 65S).

The CCFAP study is now in its third year. Preliminary data reveal an improvement in communication between the families and various members of the ICU team, increased ratings regarding family involvement in decision-making processes, and decreased stress levels for family members. It was concluded that the CCFAP has been successful in meeting the needs of families of ICU patients (information, flexible visiting policies, and assurance that the patient is receiving the best care). There was no significant difference in the families' perception of quality of care as provided by the ICU team members. In contrast,

TABLE 2-5 Example of a Family Assessment and Information Checklist**Initial Interaction**

1. Introduce yourself, including your credentials.
2. Ask what the family member's relationship to the patient is.
3. Explain the ICU family-focused policy: "Families are important to us and you are welcome!"
4. Discuss the patient's current status and the nursing care routines.
5. Explain the visiting guidelines (e.g., times determined by family needs, three at the bedside at a given time, calling before entering the unit from the waiting room phone). Children may visit after meeting with the nurse.
6. Identify the family members who will be visiting. Chart the names and times each will be visiting.
7. Discuss appointing a family spokesperson to coordinate communication with other family members.
8. Give the family the unit phone number. Discuss coordinating calls. Ask who will be calling and chart these names on a flow sheet.
9. Distribute the family information book. Point out important information.
10. Follow up with any questions or concerns.

Follow-up Visits

1. Introduce yourself and give your credentials. If you don't already know, find out who the visitors are and if they have visited before.
2. Discuss the patient's current status and the nursing care routines.
3. Determine whether they have any questions or concerns.
4. Ask if they would like to speak with a physician or other team member.
5. Assess interest in participating in care activities (e.g., mouth care, foot rub, ice chips).
6. Ask how they are doing. Are they eating? Sleeping?

Sources: Henneman, McKenzie, & Dewa, 1992; Wright, 2000.

the ratings for this variable were high prior to the implementation of the study (Dowling & Wang, 2005).

Several implications have been drawn from the available data. First, "healthcare organizations have a responsibility to foster an environment that protects the physical and emotional health of severely stressed family members who assemble in their facilities to participate in the treatment of a loved one." Second, "nothing is as effective in meeting and promoting satisfaction, not only with the families but also with the hospital staff, as improved and consistent communication. All members of the staff must be able to depend on every other team mem-

ber to be faithful to communication responsibilities" (Dowling, Vender, Guilianelli, & Wang, 2005, p. 92S).

Design Accessible Healthcare Delivery Systems That Are Flexible, Culturally Competent, and Responsive to Family Needs

Family-focused care requires that all members of the healthcare team support the philosophy of care. Teaching the principles of family-focused care to unit secretaries, security, volunteers, housekeepers, and aides can be enormously helpful and effective in providing family support. "For example, instead of being viewed as 'gatekeepers,' unit secretaries should function as liaisons between patients' families and nursing staff, assisting in relaying information and helping support family-centered decisions" (Henneman & Cardin, 2002, p. 15). In a family-focused care ICU, the patient and family members are considered integral members of the healthcare team, taking part in daily rounds as active participants (Uhlig, Brown, Nason, Camelio, & Kendall, 2002). Hospital volunteers, when trained by ICU nurses, can provide nonmedical information, comfort, and support to families of critically ill patients (Appleyard, Gavaghan, Gonzalez, Ananian, & Tyrell, 2000).

Support groups can strengthen the family's understanding of ICU care as well as provide an informal network of other families who are experiencing the crisis of critical illness (Halm, 1991).

Participation in patient care in the ICU has been associated with enhanced family satisfaction (Wasser et al., 2001). Assisting with care can maintain family bonding and promote togetherness. Patient comfort and healing are also enhanced (Azoulay et al., 2003). Nurses should explore the family's preferences for participating in patient care on an ongoing basis. The family may want to participate in a minor way (e.g., passing an alcohol wipe or other piece of equipment) or a major way (e.g., assisting with bathing, turning, range of motion, or mouth care).

It is important to be aware of the diversity of patients and their families. Culture affects the individual's view of time, space, family structure, illness, health, and death, all of which color the family's interaction with the healthcare team (Wright, Cohen, & Caroselli, 1997).

Families Need Support

Family needs can often be met with basic nursing interventions, such as giving information, providing reassurance, and offering a flexible visiting schedule. Other families may need more support from colleagues in social services or spiritual care.

With appropriate resources and preparation, families can be present during most procedures, including resuscitation.

Family presence during care procedures, including resuscitation, enhances the family's ability to trust that all care measures have been implemented, understand that curative measures may no longer work, and realize that end-of-life decisions need to be made (Jones & Buttery, 1981).

Meyers et al. (2000) found that 100% of family members who stayed during resuscitation would do it again if the same situation occurred. They experienced many benefits related to their presence (Table 2-6). The family members understood the need for appropriate behavior during the resuscitation and felt that their presence helped them deal with the patient's status and that they provided comfort to the patient during the resuscitation.

Nurses have the power to control important end-of-life memories for the families of dying patients through communication and support of families throughout the critical illness, including end-of-life care (Lewandowski, 1994).

Nurses can help ensure attainment of optimal patient outcomes such as those listed in Box 2-1 through the use of evidence-based interventions.

SUMMARY

Critical illness is a journey for both the patient and the family. In a family-focused care unit, the family receives navigation information that enables them to proceed on the journey of critical illness with the patient, so all parties can move together through the critical illness. Family care skills are part of becoming an expert nurse (Benner, Tanner, & Chesla, 1996).

Life-saving interventions and family interactions become much more rewarding when the work focuses on a patient instead of the accomplishment of a procedure or task. Studies have shown that where work is meaningful, critical care nurses'

Box 2-1

Optimal Patient Outcomes

- Increased collaboration between RN and family members
- Increased communication between RN and family members
- Increased patient and family education
- Increased family trust
- Implementation of open/unrestricted family visitation
- Family participating in planning and providing care

job satisfaction increases and stress is reduced (Stechmiller & Yarandi, 1992).

One of the greatest professional satisfactions is talking with family members and teaching them about the techniques and care procedures that are being performed. Education facilitates the family's understanding of care the patient is receiving. Families who have interactions with nurses who practice family-focused care express how impressed they are with nurses' knowledge, compassion, and caring (Wright, 2000).

When the nurse develops a relationship with the family, the family develops trust with healthcare providers, which in turn decreases their stress and anxiety (Leske, 2002). Families also feel more comfortable leaving the bedside and getting rest and food when they have a trusting relationship with the ICU staff (Wright, 2000). Critical care nurses have the unique privilege of working with families during an exceptionally stressful hospitalization. Being open to the family allows the nurse to make a difference during one of the most challenging times in the life of a patient and family.

TABLE 2-6 Benefits to Family Members Who Are Present during Invasive Procedures and Resuscitation

- Relief from wondering about what was happening to the patient
- Visual and verbal knowledge of the patient's care and condition
- Provision of comfort and protection to a loved one who was in pain, vulnerable, or defenseless
- Patient/family connectedness and bonding maintained
- Opportunity for closure
- Spiritual experience

Source: Meyers et al., 2000.

CASE STUDY 1

Janet is an 83-year-old woman who was admitted to the ICU with a hemorrhagic stroke. Janet has been married to Bert for 66 years. They live independently in their own home. Janet's blood pressure is 160/100, her heart rate is 120 with 3 to 6 PVCs/minute, she is breathing with the assistance of a ventilator, and she requires sedation because she is trying to pull out her endotracheal tube and intravenous (IV) lines. Janet is agitated, confused, and restless despite the IV sedation. The visiting hours in the ICU are hourly for ten minutes. Bert sits in the family waiting room until he is able to visit.

When he is allowed in to visit, he goes to Janet's side, kisses her, and talks with her about their life together and his desire for her to return home. While he is there, Janet appears to relax; her heart rate is 110 with a decrease in PVCs, and her blood pressure decreases to 140/88 without any change in medications. Bert also appears more relaxed. When the nurse announces the end of visiting time, Bert begins to cry and asks the nurse to let him stay with his wife. He is told that it is not the policy and that Janet will get more rest if he leaves the room.

CRITICAL THINKING QUESTIONS

1. What caring practices could a nurse implement in a family-focused care environment that would address Bert's concerns?
2. Design an informational poster for staff about family-focused care.
3. Discuss the evidence-based literature that supports family visitation.
4. How will you implement your role as a facilitator of learning for this patient or staff?
5. How would you modify a plan of care for patients of diverse backgrounds who request to stay at the bedside in an ICU?
6. What patient care outcomes would you expect with family-focused care?

CASE STUDY 2

Evan is a seven-year-old boy whose mother is in the ICU. He is having difficulty sleeping and needs to visit his mother. Evan's father discusses his concern for his son as well as his belief that his wife would feel better if she saw Evan. In the discussion with Evan's father, the nurse explains that the unit has a family-focused care policy and that Evan may visit his mother after the nurse explains to him what equipment he will see and what his mother will look like with an endotracheal tube and IV lines in her arms. The nurse also explains how the unit will sound and smell.

After talking with the nurse, Evan went in, hugged his mother, and talked with her. His mother opened her eyes and looked at him. The nurse and his father answered questions and helped Evan sit on the bed so his mother could hold his hand. He cried because his mother could not speak to him but she smiled and he felt better. That night, Evan slept through the night for the first time since his mother was admitted to the ICU.

CRITICAL THINKING QUESTIONS

1. Describe the bedside environment and noises in the ICU in terms that a non-healthcare provider can understand.
2. Given that Evan wants to be with his mother, how would you approach this situation in a family-focused care unit?
3. Explain how the Synergy Model can help to ensure that the family has the appropriate nursing care to ensure optimal outcomes. Use the grid provided below to analyze the case. Determine whether the nurse displayed each characteristic and what actions would demonstrate competency in each characteristic.

SYNERGY MODEL	Nurse Characteristics	Qualities Displayed by the Nurse in the Case	Actions the Nurse Can Take to Demonstrate the Characteristic
	Clinical judgment		
	Advocacy/moral agency		
	Caring practices		
	Collaboration		
	Systems thinking		
	Response to diversity		
	Facilitator of learning		
	Clinical inquiry		

Online Resources

American Association of Critical Care Nurses (2001). *For Those Who Wait: A Guide to Critical Care for Patients, Families and Friends*. Aliso Viejo, CA: American Association of Critical Care Nurses. This information booklet for families reviews critical environment information and provides a helpful glossary of medical terms. <http://www.aacn.org>; go to AACN Ethics Website—Family-Centered Care.

Diagrams and definitions about the care in a critical care unit: <http://www.icu-usa.com>

CASE STUDY ARTICLES THAT ILLUSTRATE SUCCESSFUL FAMILY-FOCUSED CARE PRACTICE

Leske, J. S. (1998). *Creating a Healing Environment—Family Needs and Interventions in the Acute Care Environment [Protocols for Practice]*. Aliso Viejo, CA: American Association of Critical Care Nurses.

Titler, M., & Drahozal, R. (1998). *Creating a Healing Environment—Family Pet Visiting, Animal-Assisted Activities and Animal-Assisted Therapy in Critical Care [Protocols for Practice]*. Aliso Viejo, CA: American Association of Critical Care Nurses.

Society of Critical Care Medicine. (2002). *Patient and Family Resources: ICU Issues and Answers Brochures*. Chicago, IL: Society of Critical Care Medicine.

- “Common Problems of Critical Illness” addresses conditions that may bring a loved one into the ICU or that may develop while in the unit.
- “What Are My Choices Regarding Life Support?” deals with the decisions patients and families face regarding specific forms of life support.

- “Participating in Care: What Questions Should I Ask?” guides family members on how to interact most effectively with ICU team members.
- “Taking Care of Yourself While a Loved One Is in the ICU” stresses the importance of self-care while supporting a loved one in the ICU.
- “Why Do ICU Patients Look and Act That Way?” provides an illustrated guide to equipment and procedures that will affect the loved one’s appearance in the ICU.
- “Helpful Hospital Safety Tips” lists ways you can work with your healthcare team to make your journey fast, easy, and, above all, safe.
- “When Your Child Is Admitted to the Intensive Care Unit” is every family’s guide to understanding what is happening to their child in the pediatric intensive care unit.

- “Making Decisions When Your Child Is Very Sick” is a guide to help family and friends understand what difficult decisions need to be made when a child is in the ICU.

ONLINE ACTIVITIES

1. Provide websites with instructions for activities to enhance student learning, as appropriate.
2. Take a patient’s diagnosis from a clinical experience and explore the information and links at <http://www.icu-usa.com>.
3. From a family member’s perspective, discuss the information’s effectiveness.

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