Family-Centered Care of the Critically Ill

Article

- *Davidson JE, et al. Guidelines for family-centered care in the neonatal, pediatric, and Adult ICU. Crit Care Med 2017; 45:103-128.*

Background

- Critical illness has significant impact upon family members
- Decision making often falls to family members, as most critically ill patients too sick to participate in decision making
- More than 50% of critical illness survivors have significant disability at DC – burden falls to the family
- 25% to 50% of family experience acute stress, post-traumatic stress, anxiety, and depression after critical illness of a loved one – "Post-Intensive Care Syndrome-Family"
- Family-centered care – recognizes central importance of family to patient's recovery

Guidelines

- Objective – provide clinicians with evidence-based strategies to optimize support of the family of critically ill patients in the ICU.
- Not simply an update of the initial 2007 guidelines; a new and more rigorous analysis; represent current state of science in family-centered care
- Interdisciplinary team of 29 members
- Used literature search *and* incorporation of patients and family members (qualitative literature search and direct consultation)
- Developed PICO questions and used GRADE tool to assess quality of evidence
- Included 236 articles
- 23 recommendations – overall based on moderate to very low level of evidence; all recommendations were "weak"
- Impractical to implement all recommendations in a single ICU

Select Recommendations

<u>Family Presence in the ICU</u>

- *Suggest family members of critically ill patients be offered open and flexible family presence at the bedside that meets their needs while providing support for staff and positive reinforcement to work in partnership with families. (2D)*
    - Most of literature is observational or descriptive in nature
    - No RCTs addressing effect on family-centered outcomes
    - Quality of evidence very low

- *Suggest that family members be offered the option of participating in interdisciplinary team rounds to improve satisfaction with communication and increase family engagement. (2C)*
    - Majority of literature is descriptive or observational
    - In general, families are satisfied or slightly more satisfied when they participate in rounds and tend to be in favor of participation compared with traditional rounds format
    - Only 1 low-quality RCT
    - Data suggest no immediate harm
- *Suggest family members of patients be offered the option of being present during resuscitation efforts with a staff member assigned to support the family. (2C)*
    - Several national organizations have made formal statements in support
    - Large body of descriptive and qualitative literature
    - Few RCTs or observational studies (several ED and prehospital studies)
    - Despite this, few institutions have adopted policies regarding presence of family during resuscitation in the ICU or ED
    - Primary concern from inexperience providers is family interference with procedures, psychological trauma and litigation
    - Role of staff support of family during resuscitation not addressed in literature

<u>Family Support</u>

- *Suggest that ICUs provide family with leaflets that give information about the ICU setting to reduce family member anxiety and stress. (2B)*
    - 2 studies the demonstrate written materials can improve family member psychological distress
    - Quality of evidence moderate
    - No demonstrated associated risk
    - Low cost intervention
- *Suggest that ICU diaries be implemented to reduce family member anxiety, depression, and post-traumatic stress. (2C)*
    - Diary written for the ICU patients during their time of critical illness
    - 2 RCTs –reduce the risk of post-traumatic stress at 3 & 12 months after pt DC
    - Quality of evidence low
    - Can be written by relatives, nurses, physicians, and others
- *Suggest that validated decision support tools for family members be implemented in the ICU setting. (2D)*
    - One published study – decision support aid used in academic medical center associated with lower clinician-family discordance about prognosis, better quality of communication, and better medical comprehension
- *Suggest that among surrogates of ICU patients who are deemed by clinician to have a poor prognosis, use communication approach, such as the VALUE mnemonic, during family conferences to facilitate communication*
    - VALUE mnemonic significantly reduced symptoms of PTSD, depression, and anxiety among family members at 90 days after patient death

- VALUE = Value family statements, acknowledge emotions, listen, understand the patient as a person, elicit questions

Communication with Family Members

- *Suggest that healthcare clinicians in the ICU use a structured approach to communication (VALUE) when engaging in communication with family members, specifically including active listening, expressions of empathy, and making supportive statements around non-abandonment and decision making. In addition, offer written bereavement brochure. (2C)*
  - One multicenter prospective RCT – family members of dying patients given brochure with proactive communication strategy for family conference resulted in fewer symptoms of PTSD, depression, and anxiety
- *Suggest that ICU clinicians receive family-centered communication training as one element of critical care training. No recommendation can be made to suggest the use of any specific communication training programs that have been evaluated based on existing evidence. (2D)*
  - Quality of evidence very low
  - Seems intuitive but only 2 studies examined family-reported outcomes
  - A low risk intervention; costs are unknown
  - Current best-practice are not well established

Specific Consultations and ICU Team Members

- *Suggest proactive palliative care consultation be provided to decrease ICU and hospital LOS among selected critically ill patients. (2C)*
- *Suggest social workers be included within an interdisciplinary team to participate in family meetings in order to improve family satisfaction. (2D)*
  - Quality of evidence very low
  - Single RCT and one observational study
  - Demonstrated nonsignificant improvement in overall satisfaction
- *Given the consistency of expression of family values for availability of spiritual care, accreditation standard requirements, and association with increased satisfaction, suggest that families be offered spiritual support from an advisor or chaplain. (2D)*
  - Evidence of very low quality; no studies with control group
  - Probable benefit with low risk of harm

Operational Issues

- *Suggest that protocols be implemented to ensure adequate and standardized use of sedation and analgesia during withdrawal of life support. (2C)*
  - Family outcomes have not specifically been examined in existing studies
- *Suggest that nurses be involved in decision making about goals of care and trained to provide support for family members of critically ill patients as part of an overall program to decrease ICU and hospital LOS and improve quality of communication in the ICU. (2D)*