

Progressive Influences of Family in Intensive Care Nursing Interventions: A Review

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ABSTRACT

Introduction: This paper reviews the aspects of Family-Centered-Care (FCC) for patients in critical care nursing. FCC is an innovative and holistic approach consisting of planning, delivering, and evaluating the health care. It is mutually beneficial to the health and care of patients, their families, and especially the health care providers. Family members of the critically ill have a substantial role in the treatment trajectory of the patient, along with the nurses. FCC in critical care has opened a new dimension in improving the quality of care for the critically ill.

Methods: A systematic search of five electronic bibliographic databases (CINAHL, Medline, EMBASE, Google Scholar, and Cochrane Database of Systematic Reviews) was undertaken. The keywords used were "Nursing," "Intensive care," "critical care," and "Family Centred Care."

Findings: The review identifies the meaning of family involvement in the care of the critically ill patients and its positive outcomes on the health of the patient. FCC is developed under six categories: effects on patients, education and attitudes of nurses, effect on family and other factors (environmental, psychological and communication). Presence of a family member in the hospital ensures patients' safety and provide sense of security and confidence to patients under care. The research highlighted the needs of the family who have critically ill patients admitted in intensive care units. It was observed that there is a lack of appropriate literature and qualitative methods to assess the needs and interventions for the care of the family, as the time of health care providers is distributed in giving the required nursing care interventions to the patient and following the hospital care protocols.

Conclusion: The present literature review identified the importance of integrating FCC in the critical care units. This provides opportunities for improvement of care by involving and accommodating family members in the health team.

Keywords: Nursing, Intensive Care, Family Centred Care.

INTRODUCTION

Patient-focused care has always been a core aspect in nursing. A need has been recognized for imbining the participation of patients and their family in nursing. The family members of the patients are not actively involved in the patient's care especially in the critical care units. FCC is a model that motivates the

inclusion of family members in the planning and provision of care as well as in assisting the nurses. It should be noted that the family is usually defined as the parent(s), children, and significant others. Therefore they should be made a significant participant in the care plan of the patient through information and training. Studies discovered that FCC has

a tremendous influence on the patient and it helps in the immediate and long-term recovery of the patient.^{1,2}

The first major research conducted in this area was done by Molter (1979), who proposed that it is of great importance to include family in critical care. He also designed an exploratory, descriptive research design that involved a structured interview process, which took nursing care to an entirely different level with respect to family members of the critically ill. The "Critical Care Family Needs Inventory (CCFNI)" was developed in 1983 (by Molter and Leske) by randomly organising Molter's (1979) original list of needs. In this, the family needs were grouped into Leske's five dimensions, i.e., assurance, proximity, information, support, and comfort. The introduction of nursing systems, cybernetics and family therapy theories were also mentioned in the previous literature. A collaborative interdisciplinary approach is needed for the effective implementation of FCC. The quality of information provided to the members of the family about the patient influenced their level of satisfaction.^{3,4,5}

Traditionally, in critical care units, the nurses are found to be working in a triad relationship with the patient on the top end, doctors at one, and the patient's family at the other end, maintaining communication at all ends for effective delivery of the care and to expedite the patients' recovery. The involvement of family in pediatric intensive care and palliative care has been widely used as compared to adult patients requiring critical care. In the past various methodologies have been used to evaluate the results of FCC. A few of them provided valuable results indicating that involving patients' families in the critical care interventions along with the nurses benefits the patients' recovery and rehabilitation, coping strategies of family members with a reduction in anxiety levels. Calm and well-informed family members proved to be an important link to patient information and a valuable resource in the delivery of health care in intensive care

units. Family members are not considered as caring units in the nursing care interventions, and little knowledge is available on how to prepare a nursing care plan for the patients in intensive care units, in which the family is also a participant. To meet the expectations and needs of the family members in an ICU patient and their transfer to the general ward required modified FCC. It suggested an appropriate family needs assessment tool to measure and track these differences.⁶

METHODS

The online databases were scoured for the relevant literature. The five electronic databases searched were CINAHL, Medline, EMBASE, Google Scholar, and Cochrane Database of Systematic Reviews. The keywords used to refine the search were "Nursing," "Intensive Care," "critical care," and "Family Centred Care ." A total of 53 articles (abstract and full text) were found on these databases. However, after scrutiny, the researcher was able to extract only 23 full text and relevant articles for writing this review.

FINDINGS

In recent times the effectiveness of nursing care has shown positive trends when specific identified human needs were considered earlier those needs depended only on patients' medical diagnosis. The research has shed light on the needs related to biological rhythm, identity, self-esteem, control and interdependence, information and communication, territoriality, spiritual health (BISCITS), hope, meaning, and purpose.⁷

In a case, study FCC was divided into three concepts: Respect, Collaboration, and support. In this research consisting of 75 control & 99 family interventions were studied. The FCC helped improve the patients' family perceptions of respect, support, and collaboration, Patients' safety and security, and family integrity and closeness. In a study, nurses rated hindrances and help in end-of-life care, most of them were related to family members; for e.g., acceptance of patient's

death, asking for more technical treatment, and showing anger.^{8 9 10}

FCC was developed on the basis of 6 categories: effects on patients, nurses' qualification and attitudes, factors affecting the environment, psychological assessment, communication, and family effects.¹¹

The ineffectiveness of comprehending the diagnosis, prognosis, or treatment by the family members increased their anxiety. However, caregiving aspects such as feeding, bathing, etc., increased the satisfaction of the family members as well as the nurses. In some cases, both nurses and family members believed that the participants might add to the suffering of the family in the acute phase of the illness, which might negatively affect the quality of care as their lack of knowledge can put the patient in the difficult situation such as accidental extubation while caring, catheter removal and failure to comply with measures to prevent hospital acquired infection while performing basic care. It was suggested that the family members might be more helpful in the rehabilitation phase.¹²

In critical care units where death and discussion about end-of-life care are very common, it becomes very difficult for the critical care team, including physicians and nurses, to communicate with family members. Therefore a "family conference" was suggested between the critical care team and the family members as a part of FCC for quality improvement of patient care. There might be one or several family conferences and communication workshops between the nurses and the family that can improve the FCC philosophy. these conferences achieve a common understanding of the disease and the treatment issues and ensure that the family knows how to reach the health care team for questions or queries.¹³

A descriptive survey design was developed which highlighted issues of individual choice to get involved in health care. This study described the positive and negative attitudes of the health care providers and family members. The ethical criteria of

the study stated not to include the participant on compassionate grounds, he/she has to be a family member of the patient. The relatives were involved after 48 hours of the patient's admission to the ICU. The relative sample consisted of majorly wife/husband (45%), The next daughter/son (30%), (20%) mother, and the rest (5%) were blood relatives.¹⁴

The development of the questionnaire consisted of various aspects of care such as family care, patient and professional care, and the ICU environment. Its results revealed that the families were less satisfied with the information provided but were satisfied with the timing and the amount of information.¹⁵

A face-to-face and telephone survey has been mentioned specifically in the case of dialysis patients and their designated surrogates. The dialysis is required in chronic critical conditions, which is long-term and benefits the patient through FCC. This paper presented differences in preferences for the care planning as the surrogates often lack the information needed to make such decisions and why they lacked information. This study was based on end-of-life (EOL) decisions.¹⁶

Shared decision-making is an important aspect of FCC, and its implication is immense in terms of the decision support tool. Many times when the patients are not in the condition to make decisions regarding health care during their critical illness, they often depend upon their family members, especially those family members with higher education. It was reported that patients in terminal stages of life were more passive with respect to treatment decision preference than those in initial stages. Therefore, family members play an important role in the decision-making process in such cases. The health care team facilitates the decision-making for the treatment of an individual by including family members through FCC.¹⁷

Many pieces of research revealed that nurses apparently believe family visits can negatively affect the patient physiologically and is of limited benefit to the patients' psychology. However, the studies showed

that families are not just mere visitors in the critical care unit. This paper suggested that visiting rules should not be applied to family members and even pets, and hospitals should plan spaces to accommodate the family members.¹⁸

According to a study, The family members provide some form of guarantee to ensuring protection of patients' rights and observe treatment; it was also possible for them to notice mistakes and prevent them. Patients felt less abandoned and had an indirect connection with the rest of the world outside hospital through their relatives. This way, they felt that they were still a part of the social community. The family presence gave the patients a sense of security and protection during ICU stay which renders them feeling powerless, insecure, and exposed. It also gave the feeling of belongingness.⁹

The research has identified the positive and negative attitudes of ICU nurses and the relatives of critically ill patients towards their relative involvement in patient care, and the benefits perceived by participation in care is mentioned and shift towards family-centered care have been examined by the previous research.¹⁹

A scoping review identified the components of involving family in the patient care in intensive care units being family's presence, their own needs, communication and information, decision making and contribution to care.²⁰

Despite FCC's positives, there are many barriers to promoting the same in the hospital environment, especially in critical care units. These barriers are identified as constraints on space, time, and ability to meet the physical needs of the patient. Additional barriers include lack of knowledge and lack of organizational support for FCC.²¹

This study elaborates on the guiding and supervising role of the nurse in supporting families in ICUs, and the contribution of family members toward patients' care and recovery, while in ICU. The families' contribution can

be at different stages of recovery, like getting to know about the patient through family, family participation in care, and the nurses' role in supporting families of patients admitted in ICU.²²

DISCUSSION

Earlier, the nurses assessed patients' needs based on physiological functions, and their emphasis was on the identification of physical needs; however, nonphysical needs were considered as just important. In the family care model, the elements of were: family is constant, professional collaboration, family strength, complete information, emotional and financial support, and the design of the health care delivery system.²³⁻²⁶

The previous studies suggested for the nurse to assess the needs of the family along with the patient requiring critical care. It was suggested that the family could attend rounds to provide information about the patient's response to treatment, information related to prognosis, and patient care planning issues.^{27,28}

The three most common care activities provided by the family members were massage, passive limb exercises, full wash and eye care.

The nurse's role in FCC had various barriers. The nurses thought that on collaborating with the family members, their nursing tasks would take longer time, increase their workload (as the relative would need teaching), and will make awkward enquiries related to the condition of the patient. The relatives felt their anxiety elevated and required constant reassurance about what was happening and why, this was a major barrier experienced towards associating the family members in the care of the patient.^{27,29}

The various barriers to nursing family communication were categorized into four parts such as system barriers, nurse and physician barriers, patient and family barriers. System barriers included heavy patient load or not enough nursing staff in the unit, or family members unable to attend the patient's care.

The nurse barriers include lack of support from nurse colleagues and outside the scope of nursing practice. The physician barriers included conflict within the health care team, lack of communication between physicians and nursing staff, and physicians discouraging nurse communication with family on certain topics. The patient /family barriers include: family does not visit or call, family is angry, the family has unrealistic expectations of medical treatment, or language difficulties.^{30,31}

It could be considered obvious that physical care requires a special, intimate relationship. Agitated patients and family members occupy a lot of nursing time.³²

To optimize patient care in ICU by involving family, the nurse needs to be more focused and hence construct well-designed nursing care plans which allow the family members to be around and participate in the care along with the nurse. Extensive qualitative studies need to be conducted to develop such integrated care plans involving the family of the patient in nursing care.

CONCLUSIONS

Although existing research supports the participation of family members in the physical care of critically ill patients, a low level of evidence was found of its actual implications in the critical care nursing and its benefits to both the nurses and the relatives of the patient. Further research that explores the more active role of family in the chronic illness care (i.e. at the rehabilitation phase) than in the acute care. In addition, information on medical history of the family members is an important aspect to be taken into account before introducing the family member into FCC as an already sick person cannot take care of the critically ill. FCC also promotes closeness and family integrity. Patients' needs in terms of BISCITS must be included in critical care and the nurses must be prepared and educated. In terminal cases at least two family members are suggested to be present for supporting the patient as well as one another to maintain the continuum of

care. An evaluation tool should be made to reinforce and evaluate the interventions of FCC by nurses.

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