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Registered Nurses as Family Care Specialists in the Intensive Care Unit

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Registered Nurses as Family Care Specialists in the Intensive Care Unit

Delores Privette Nelson, RN, BSN
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PRIME POINTS

- Emergent needs of families of critically ill patients can overwhelm hospital staff and distract from care of the patients.
- To meet the needs of patients' families, staff developed a family-centered care program in which critical care nurses act as family care specialists.
- Family care specialists provide a familiar face for patients' families and ease the workload of health care staff.
- Identification of end-of-life issues by family care specialists inspired creation of a palliative care consultation service.

Escalating needs of the families of critical care patients can overwhelm intensive care unit (ICU) staffing resources, contribute to occupational stress^{1,2} and turnover for nurses at the bedside, and markedly affect patients' response to illness.^{3,4} As overburdened staff nurses try to meet the needs of both patients and patients' families, a disparity may develop between desired and achievable nursing goals.¹ For example, the distraction of trying to meet a family's needs may slow critical patient care.

In 2000, requests by patients' families for information not only about the patients but also for the

families' personal needs (eg, lodging) overwhelmed staff nurses in the adult ICUs at St John Medical Center, a tertiary hospital in Tulsa, Oklahoma. At the same time, telephone calls with requests for information on patients beset the managers of the ICUs. The pervasive mood of the adult critical care unit was chaotic and stressed, signifying a need for change. A need for improvement was further supported by the results of a family satisfaction survey, which indicated a number of areas in which the satisfaction of patients' families was less than optimal. In response to this need, staff in the ICUs developed a new family-centered care program with 2 full-time positions for critical care nurses as family care specialists (FCSs). This change not only improved family care but also moved the culture⁵ of the ICUs from hectic to healing. Getting from the problem to the solution was, however, far from simple. In this article, we describe 5 basic steps the hospital took to develop a new family-centered program and explore the efficacy of the associated FCS positions.

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CE Continuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Understand the role of the family care specialist (FCS) in the intensive care unit (ICU)
2. Describe the duties of the FCS in the ICU
3. Recognize the benefits of a FCS in the ICU

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Development of the Program

Step 1: Identifying the Need

The results of a family satisfaction survey provided the first alert to a need for improvement in the adult ICUs. This initial indicator was also the first step in the development of a new program. The need for change was further supported by complaints of staff nurses in the adult ICUs of an increased workload burden. At least part of this heavier burden on staff was attributable to greater demands placed on them by family members of ICU patients.

Step 2: Information Gathering

The second step was information gathering related to strategies that would best serve the families of the adult ICU patients. Literature searches and perusal of medical journals by the interdisciplinary ICU management team, which consisted of the adult ICU medical director, nurse managers, a registered nurse (RN) data analyst, and other clinical staff as needed, were guided by the following question: What are best practices for meeting the needs of patients and the patients' families and for satisfying global safety needs as well as the hospital's needs? Information on hospital liaison positions in existence at that time was reviewed in addition to available data on family-centered care.

The top 10 needs from the Critical Care Family Needs Inventory (CCFNI)⁶

seemed to best address the diverse needs of the adult ICUs in the hospital. Items on a revised CCFNI are evaluated by using an ordinal scaling method that indicates which items are most important to patients' families (Table 1).

The 45-item needs statement in the original CCFNI was later divided into 5 domains of need⁷: support, comfort, information, proximity, and assurance.

Step 3: Acquisition of Funding

The third step was acquisition of funding through administrative approval. This approval was facilitated through presentations by the adult ICU medical director, who discussed the results of the family satisfaction survey, staff complaints, evidence gathered on family-centered care, and a proposed initiative for family-centered care.^{2,7} The initiative appealed to the hospital administrators because of their commitment to excellence, and 2 new full-time positions were approved for FCS nurses, 1 position for the 20-bed medical ICU

Table 1 Top 10 needs of the families of critically ill patients^a

1. Feel there was hope
2. Feel hospital personnel care about the patient
3. Have a waiting room near the patient
4. Be called at home about changes in the patient's condition
5. Know the prognosis
6. Have questions answered honestly
7. Know specific facts about the patient's prognosis
8. Receive information about the patient once a day
9. Have explanations given in understandable terms
10. Be allowed to see the patient frequently

^a Based on data in Molter.⁶

(MICU)/intensive cardiac care unit (ICCU) and 1 position for the 15-bed surgical ICU (SICU).

Step 4: Deciding Who Would Fill the Role

The fourth step was deciding which discipline should fill the new role of FCS. Historically, staff at the hospital viewed patients' families as the province of chaplains, social workers, and other nonclinical staff; clinical staff provided care at the bedside for patients. However, the interdisciplinary ICU management team wanted critical care RNs to fill the FCS position⁸ because clinical knowledge and skills would equip the nurses to

- Communicate with a patient's family about all aspects of the patient's clinical problems, disease processes, treatments, and the ICU environment
- Act as liaison between patients' families and other departments in the hospital and community
- Have proximity to and a special rapport with patients and the patients' families

Although the ICU management team sought an evidence-based approach for this program, no previous

Authors

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Table 2 Family support protocol for the intensive care unit (ICU)

Saint John Medical Center Core Value: Human Dignity:

We respect the unique personhood of every individual with whom we come in contact in the provision of our services.

Goals:

- ❖ Foster family member(s) feeling comfortable, welcome and cared for in the ICU setting.
- ❖ Familiarize the ICU staff with family member(s) and family member(s) with the ICU setting.
- ❖ Assure family member(s) and patient safety and well-being while present in the ICU.
- ❖ Enhance family member(s) feelings of being involved in their loved one's care.
- ❖ Familiarize family member(s) with the available support services of pastoral care and social services.

Values Assessment

- Arrange for a family member(s) introductory conference within 24-48 hours of the ICU admission. (For patients with an anticipated length of stay greater than 48 hours.)
- At the conference, make all appropriate introductions and determine the relationship of the patient to each family member present. (List family member(s) and relationship to patient).

-
- Determine if the family member(s) has had previous experience with a loved one being hospitalized in an ICU setting.
 - Ask about the family member(s)' condition (How are *you* doing? Are *you* getting adequate sleep? Do *you* have a place to stay at night?). (Especially important with out of town family members.)
 - Determine from the family member(s) if the patient has a designated legal representative (durable power-of-attorney for healthcare, healthcare proxy, or legal guardian) to act as the family contact person. If not, determine which family member will assume the role of contact person.

Name and phone number of legal representative or contact person:

-
- Give the family an ICU information brochure.
 - Instruct the family member(s) on the importance of observing posted infection control signs and on safety issues, such as refraining from touching equipment.
 - Inform the family that, when they are visiting, they may be asked to leave the unit in certain situations (during report, emergencies or when certain procedures are performed.)
 - Explain to the family our wish to act in the patient's best interest and ask them if they can give "clear and convincing evidence" of the patient's wishes regarding the end-of-life issue of resuscitation. (This should be documented in the integrated progress note.)
 - Encourage family member(s) on positive interactions with the patient, (holding the patient's hand, talking to him/her, even when it may seem that the patient cannot hear.)
 - Explain the purpose of the care conference.
 - Explain the availability of advance directive counseling and include patient's family member(s) as an integral part of the process if the patient elects to execute a directive. (Provide the family with a copy of the Advanced Directive.)
 - If requested, provide the family member(s) with counseling on end-of-life issues.
 - Provide the family with information about the location and availability of the chapels. (See ICCU brochure.)
 - Provide the family with information about the names/pager numbers and availability of the chaplain and social worker assigned to the ICU. (Fill out ICCU brochure section.)

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documentation was found regarding RNs in this role. Placing an RN in this role was a proactive step made to meet the needs of patients' families described in published reports.

Step 5: Developing a Foundation and Function

After funding was obtained, the ICU management team selected Molter's research and the CCFNI⁶

as a foundation for the new family-centered care program. The team developed a family support protocol for the ICU (Table 2) that incorporated the top family needs from the CCFNI. This protocol remains an unchanged cornerstone for our current family-centered care program more than 5 years later.

Even though this protocol has not changed, methods used by the FCS

nurses to meet the diverse family needs of the ICUs have expanded to include a multiplicity of family-focused interventions (Table 3) Over time, application of the protocol evolved to meet the needs of the populations of the individual units. The more advanced age and multiple disease processes of the typical MICU and ICCU patients necessitated a greater focus on end-of-life issues for those units. The FCS in

Table 3 Duties of family care specialists

- Provide individual nurturing and emotional support for family members of patients who are facing end-of-life issues
- Enhance family members' feelings of involvement in their loved one's care by instructing them in care that can be done by family members
- Assist the critical care staff development specialist in assessing learning needs and in planning and implementing education programs for critical care staff and students
- Familiarize patients' family members with the available support services of pastoral care, social services, and other ancillary services as indicated
- Contribute to the weekly interdisciplinary management team to provide ongoing assessment, implementation, and evaluation of practices in the intensive care unit
- Collaborate with the interdisciplinary team and medical students on rounds
- Assist in developing educational programs for patients' family members and for students
- Continually evaluate the effectiveness of the family care program and making recommendations for improvement
- Provide patients' families or significant others with relevant health care and safety education
- Ensure that documentation in each patient's care record accurately reflects coordination of family care

the MICU/ICCU, who received training from the End-of-Life Nursing Education Consortium,⁹ became increasingly involved in situations of patients' families during the time leading up to and even beyond the

ral to drug treatment or other counseling services, a situation that further affects the patients' families. In all instances, the FCS provides a vital link to adjunct services, such as social work, clergy, and self-care resources.

to, programs about safety in the ICU for patients' families, presentations on end-of-life issues for staff, and orientation to family care for new hospital residents. The FCS position is also a "hands on" role, so the FCS nurses occasionally supplement ICU staffing or staffing of the hospital's rapid response team. Retaining an active role in the unit milieu helps maintain nursing skills and promotes a collaborative relationship with the staff nurses. The current FCS nurses provide leadership and education for individual ICU staff in the development of family care skills to help the staff after hours and on weekends when an FCS is not available.

Benefits of Having an FCS *Benefits to Staff Nurses*

Although our ICU staff nurses did not initially anticipate any benefits from having an FCS other than the obvious advantages to patients'

This innovative RN position exemplifies our belief that nursing care should be a force for medical excellence and compassionate care for patients' families as well as for patients.

patients' death. The SICU patients tended to be younger than those in the MICU/ICCU and had problems related to trauma and life-altering injuries. Therefore, the SICU FCS may be called upon to provide crisis intervention for patients' families affected by trauma ranging from motor vehicle injuries to assault-related wounds. In addition, trauma patients in the SICU may need refer-

Expansion of the FCS Role

The ability to remain responsive to the needs of patients' families and to ICU staff has been a pivotal ingredient in the long-term success of this family-centered care program. Functions of the expanded FCS role currently include planning, developing, and presenting educational programs for unit staff and patients' families, including, but not limited

families, the nurses were pleasantly surprised to find their workload lightened. Currently, each FCS is an appreciated staff member and enjoys the staff nurses' enthusiastic support. Input was solicited from the hospital's bedside ICU nurses about the efficacy of the FCS position. In a survey, MICU, ICCU, and SICU nurses were asked, "On a scale of 0 to 10, how likely would you be to

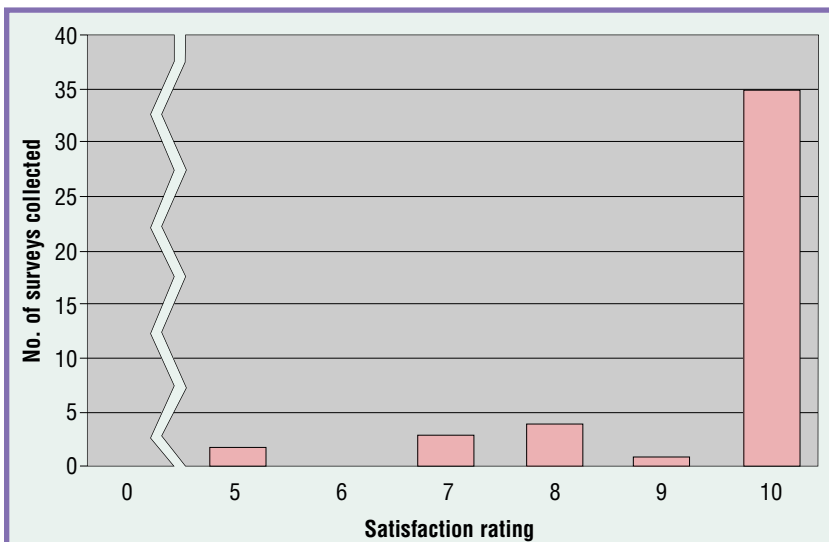


Figure 1 Results of survey to assess nurses' satisfaction with the family care specialists. Satisfaction was rated on a scale of 1 (least likely to recommend the program to another facility) to 10 (most likely to recommend the program to another facility).

Table 4 Examples of comments of staff nurses on the family care specialist

When a patient remains critical for several days, as a nurse I feel the need to focus on the patient only. The FCS [family care specialist] helps with all the extra family issues. The FCS also assists with informing families of prognoses that are not easy to handle.

I recently returned after working at a big East Coast hospital without a family care specialist. Patients' families had unrealistic expectations for their loved ones' survival. A family care specialist can present the family a balanced, nonbiased list of all the options.

I can think of many situations where the FCS has been helpful in continuity and assisting primary nurses in family issues: advance directives, living wills, meeting with families, and explaining the unit environment and the workings and culture of the unit.

Very necessary members of our staff. Provides invaluable service to the family, physicians, and staff.

A consistent face for the family. The FCS knows all details of the patient's whole stay.

With constant staff changes on the unit, the FCS . . . holds everything together.

Needs nursing background, must be a registered nurse!

Allows the primary nurse to focus on the patient.

A great service to our unit.

Helps the nurses and doctors communicate better with [patients'] families.

Thank God for the FCS!

recommend an FCS program to colleagues at another health care system?" The survey form also provided space for the respondents to indicate why they would or would not make a recommendation.

Of the 75 surveys handed out to nurses on both day and night shifts, 42 (56%) were completed. The combined responses from all units were overwhelmingly supportive, with no negative comments (Figure 1). The

only comment with a possibly negative note concerned having an FCS routinely take patients on short-staffed days. This comment was offset by the overwhelming consensus that the FCS nurses consistently helped ease the work load (Table 4). The most frequent favorable remarks stated that although a patient might have a different staff nurse from day to day, the unit's FCS provided a familiar face for the patient's family. This continuity of care throughout a patient's stay in the ICU was valued by the staff nurses. The staff nurses also valued the support provided by the FCS nurses for staff as well as for patients' families. Having an RN as the FCS was seen as essential by the staff nurses.

Benefits to the Hospital

Among the benefits to the hospital was receiving the 2006 Family-Centered Care Award¹⁰ of the Society of Critical Care Medicine. This award recognizes innovations that improve care provided to critically ill and injured patients and their families (or designates). Applicants for the award are evaluated for their link to direct patient care, for raising the standard of family-centered care, for the ability to demonstrate innovation, and for the ability to be a model for emulation. Applicants must provide evidence of comprehensive services and interdisciplinary efforts to improve care for patients' families in the ICU. Applicants must also foster support for families of critically ill patients that are meaningful to the families and must include patients' families in the provision of care to critically ill patients, including end-of-life care.

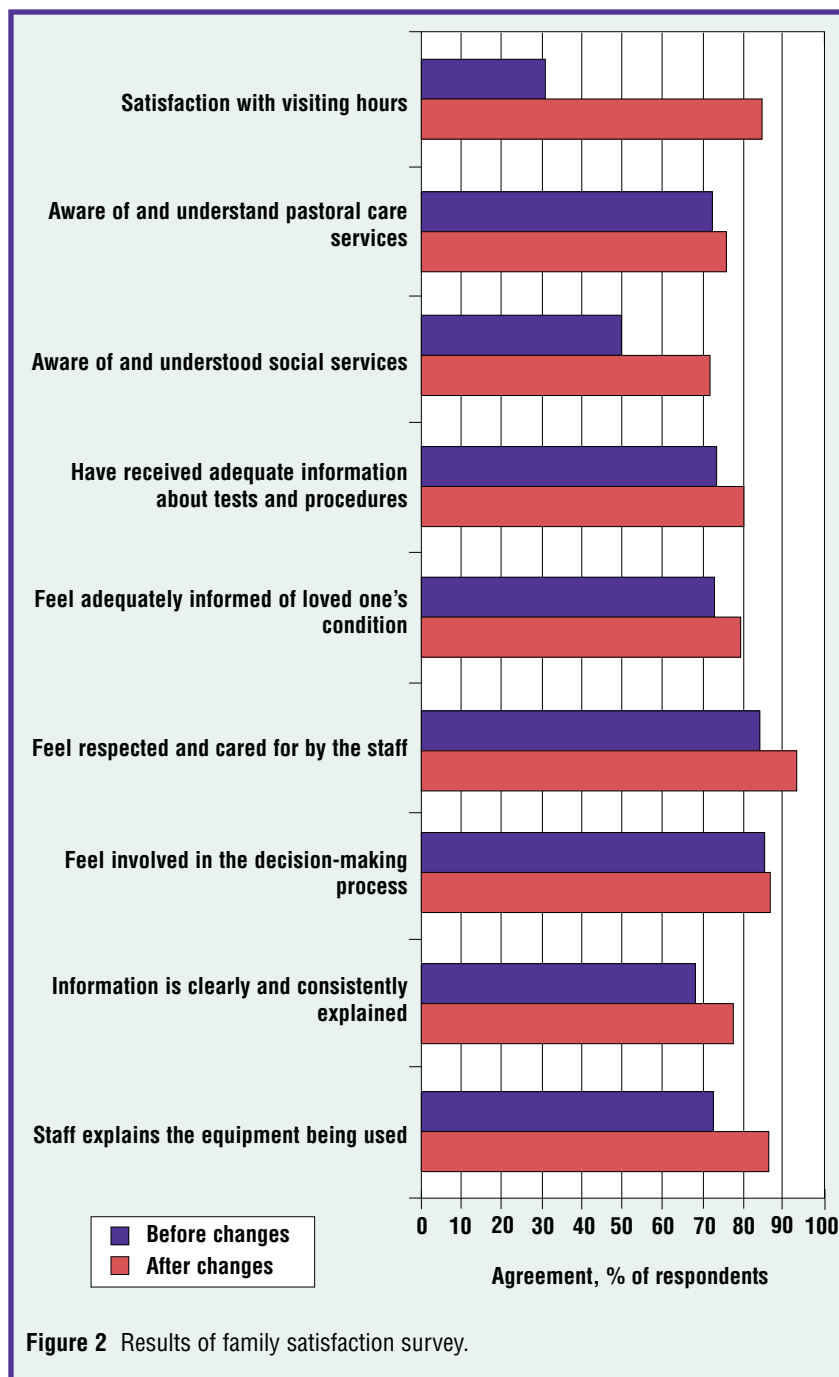


Figure 2 Results of family satisfaction survey.

the hospital. Initiated by an FCS, the PCCS branched into an entirely separate program in 2004. This rapid-response consulting service offers adult patients access to a multidisciplinary team of palliative care specialists and is available to all adult hospital inpatients regardless of the patients' location. The team is led by a physician specializing in palliative care and includes a full-time RN, a part-time RN, a social worker, and a chaplain, all extensively trained in palliative care. The PCCS provides services in conjunction with the attending physicians' curative efforts and, unlike hospice care, is not limited to patients who are terminally ill. With the focus on relieving physical, psychosocial, and spiritual suffering, the goal of the PCCS is to help patients maintain the best possible quality of life.

Conclusion

Escalation of ICU family needs will most likely continue as the population ages. An estimated 80% of the population of the United States will experience an ICU during their lifetime, as a patient, a member of a patient's family, or a friend of a patient.¹¹ The stressors produced by the ICU experience can severely challenge not only patients and their families but also health care providers. The RNs in the role of FCS met a critical need at St John Medical Center, and our results suggest a method of coping with the escalation of family needs in other ICUs. This innovative RN position exemplifies our belief that nursing care should be a force for medical excellence and compassionate care for patients' families as well as for patients. **CCN**

Benefits to Patients

In addition to a higher level of satisfaction with care among family members of ICU patients (Figure 2), the complex end-of-life issues identified by the FCS nurses inspired creation of a separate palliative care consultation service (PCCS), which benefits adult patients throughout



To learn more about families in critical care, read "The Vortex: Families' Experiences With Death in the Intensive Care Unit" by Karin T. Kirchhoff et al in the *American Journal of Critical Care*, 2002;11:200-209. Available at www.ajconline.org.

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Financial Disclosures

None reported.

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CE Test Test ID C0932: Registered Nurses as Family Care Specialists in the Intensive Care Unit

Learning objectives: 1. Understand the role of the family care specialist (FCS) in the intensive care unit (ICU) 2. Describe the duties of the FCS in the ICU 3. Recognize the benefits of a FCS in the ICU

1. What provided the first alert to a need for improvement in the adult intensive care units (ICUs)?
 - a. Staff nurses' complaints of an increased workload burden
 - b. Results of a family satisfaction survey
 - c. Staff nurses' complaints of lack of continuity of care
 - d. Results of a risk management survey
2. What was the second step the hospital took to develop a new family-centered program?
 - a. Developing a foundation and function
 - b. Acquisition funding
 - c. Deciding who would fill the family care specialist (FCS) role
 - d. Gathering information
3. The interdisciplinary ICU management team wanted which health care professional to fill the FCS position?
 - a. Critical care registered nurses
 - b. Hospital liaisons
 - c. Chaplains
 - d. Social workers
4. Research by which investigator provided the foundation for the new family-centered care program?
 - a. Malcrida
 - b. Kirchoff
 - c. Molter
 - d. McDonagh
5. Compared with the typical medical ICU and intensive cardiac care unit patients, what best describes the surgical ICU patients at this hospital?
 - a. Greater need for crisis intervention
 - b. Multiple disease processes
 - c. Greater end-of-life issues
 - d. Advanced age
6. The most frequent favorable remarks about the efficacy of the FCS position in a survey of bedside ICU nurses concerned which of the following?
 - a. Continuity of care
 - b. Communication with patients' families
 - c. Knowledge of unit culture
 - d. Staff for the hospital's rapid response team
7. The hospital received the 2006 Family-Centered Care Award sponsored by what professional organization?
 - a. International Trauma Anesthesia and Critical Care Society
 - b. European Society of Intensive Care Medicine
 - c. Society of Critical Care Medicine
 - d. The American Trauma Society
8. Which of the following is correct about the separate palliative care consultation service inspired by the family-centered program?
 - a. It benefits only adult ICU patients.
 - b. It is limited to terminally ill patients.
 - c. Its goal is to help patients maintain the best quality of life.
 - d. It focuses only on spiritual suffering.
9. According to the Critical Care Family Needs Inventory, what is the most important need identified by families of critically ill patients?
 - a. Knowing the prognosis
 - b. Feeling there was hope
 - c. Having a waiting room near the patient
 - d. Having questions answered honestly
10. What core value was identified in the family support protocol for the ICU?
 - a. Patient education
 - b. Patient safety
 - c. Family comfort
 - d. Human dignity
11. What area of the family satisfaction survey improved the most following institution of a new family-centered care program?
 - a. Feeling respected and cared for by staff
 - b. Staff explanations of equipment
 - c. Feeling involved in the decision-making process
 - d. Satisfaction with visiting hours
12. What area of the family satisfaction survey demonstrated an approximate 20% improvement following institution of a new family-centered care program?
 - a. Clear and consistent explanation of information
 - b. Awareness and understanding of social services
 - c. Adequacy of information about tests and procedures
 - d. Awareness and understanding of pastoral care services

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

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Objective 3 was met	<input type="checkbox"/>	<input type="checkbox"/>
Content was relevant to my nursing practice	<input type="checkbox"/>	<input type="checkbox"/>
My expectations were met	<input type="checkbox"/>	<input type="checkbox"/>
This method of CE is effective for this content	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> easy <input type="checkbox"/> medium <input type="checkbox"/> difficult		
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