Announcing: New Guidelines for Family-Centered Care in the ICU

By: Judy E. Davidson, DNP, RN, FCCM, FAAN

In January 2017 I had the privilege and honor of serving as lead author of the new Society of Critical Care Medicine guidelines for Family-Centered Care. These practice guidelines were developed over the course of three years collaboratively with an international panel of 31 content experts from neonatal, pediatric and adult critical care using strict CMSS guidelines for evidence analysis. Mary Wickline, UC San Diego Biomedical Library, was the systematic review librarian on the project. Patricia Graham, RN, CNS recruited patients and families from the Patient/Family Advisory Council at UC San Diego Health as informants to the guidelines development throughout the process. We actively sought out approval from members of the LGBTQ community for the terminology used in new definitions for family and family-centered care to assure these definitions would meet the needs of this population.

Robert El-Kareh, MD, PhD, bioinformatics professor UC San Diego, supported the workgroup with the development of an electronic tool to prioritize action plans for translating the guidelines recommendations into practice. This is the first practice guideline developed through the Society to be released simultaneously with translation tools. A second work-tool was also developed to help clinicians locate tested and publicly available work-products to implement the recommendations into practice. Evidence-based practice is a combination of scientific evidence, clinician experience and patient/family values. In the past, however, guidelines focused on the scientific evidence, and sometimes formed consensus statements from clinician experience.

This is also the first practice guideline to use a structured approach to evaluating the clinician experience and values surrounding the concept of interest through a coordinated search of the qualitative and descriptive literature. Qualitative and descriptive literature informs us generally through interviews, observations and surveys. This is where family values and clinicians' clinical experiences are often expressed, recorded and analyzed. The guidelines writing task force dedicated six months to reading all of the qualitative and descriptive literature related to family-centered care in the ICU, sorting it for themes, and then using those key concepts to frame questions using PICO format. Once the PICO questions were written, the quantitative evidence from experimental literature was evaluated to determine best practices. Further, in areas where there was scant experimental evidence, the values and experiences extracted from the qualitative and descriptive literature were partnered with quantitative outcomes to further support moving a recommendation forward. For example there is very little evidence from true experiments that spiritual care in the intensive care unit (ICU) changes outcomes. However, families clearly and consistently express the need for spiritual care through interviews, observations and surveys. Therefore, a recommendation was made to

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offer spiritual care to families of ICU patients largely based on the qualitative literature. The same was true of family sleep. With open flexible family presence it can be assumed that some families will choose to be present at night. To do this, we need to offer them a sleep surface and consider family sleep. There were no studies demonstrating best methods of doing this, or even whether or not they would use a sleep surface if we provided it. However, there was ample evidence of the adverse outcomes from sleep disturbances in families of ICU patients. The evidence of harm due to sleep disturbance warranted a recommendation to consider family sleep even though we do not yet know the best way to approach the issue.

The 24 practice recommendations in the guidelines are clustered into five categories: Family presence, Family communication, Family support, Inter-professional Team and Operational/Environmental issues. Open flexible family presence is encouraged. Of note, as a Society, we are attempting to retire the term 'visitation' and shift to a philosophy of family presence and engagement. Family presence at rounds and resuscitation is encouraged. The use of family diaries is now officially endorsed as a way to optimize the mental health of patients and their families in the ICU. Because the outcomes of these interventions have been shown to decrease post-intensive care syndrome-family (PICS-F), decreasing anxiety, depression and symptoms of post-traumatic stress, providing family-centered care is more important than merely achieving patient satisfaction scores. Millions of Americans are admitted to the ICU yearly, and with them millions of family members are exposed to the crisis of critical illness. By adopting these tested best-practice approaches to family-centered care we can optimize the health of these families, and thereby strengthen the health of our community. Provision of family centered care, then is a matter of public health.

These guidelines are available through the UC San Diego library.

REFERENCES:

Davidson, J. E., Aslakson, R. A., Long, A. C., Puntillo, K. A., Kross, E. K., Hart, J.,... Curtis, J. R. (2017). Guidelines for family-centered care in the neonatal, pediatric and adult ICU. Critical Care Medicine, 45(1), 103-128.