



Family experience survey in the surgical intensive care unit



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ABSTRACT

The experience of critical care is stressful for both patients and their families. This is especially true when patients are not able to make their own care decisions. This article details the creation of a Family Experience Survey in a surgical intensive care unit (SICU) to capture and improve overall experience. Kolcaba's "Enhanced Comfort Theory" provided the theoretical basis for question formation, specifically in regards to the four aspects of comfort: "physical," "psycho-spiritual," "sociocultural" and "environmental." Survey results were analyzed in real-time to identify and implement interventions needed for issues raised. Overall, there was a high level of satisfaction reported especially with quality of care provided to patients, communication and availability of nurses and doctors, explanations from staff, inclusion in decision making, the needs of patients being met, quality of care provided to patients and cleanliness of the unit. It was noted that 'N/A' was indicated for cultural needs and spiritual needs, a chaplain now rounds on all patients daily to ensure these services are more consistently offered. In addition, protocols for doctor communication with families, palliative care consults, daily bleach cleaning of high touch areas in patient rooms and nurse-led progressive mobility have been implemented. Enhanced comfort theory enabled the opportunity to identify and provide a more 'broad' approach to care for patients and families.

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In the intensive care unit (ICU), patients are critically-ill, often requiring mechanical ventilation and sedation which puts the decision-making burden on family members. This can be further complicated when the patient's wishes and goals of care are unclear. The communication between healthcare providers and patients and their family members is vital in ensuring that there is a clear view of treatment, diagnosis and prognosis especially in tenuous and quickly changing circumstances. Research to identify interventions to improve the patient and family experiences of the ICU includes communication training for healthcare providers, family involvement in decision-making and expanding resources to help prevent these negative long-term outcomes (Davidson, Hopkins, Louis, & Iwashyna, 2013; Davidson, Jones, & Bienvenu, 2012). The purpose of this study was to create a survey to capture the family experience in the surgical intensive care unit (SICU) based on Kolcaba's "Enhanced Comfort Theory." An overview of initial results and interventions are discussed.

The emergence of the concept of 'shared decision-making' between patients and physicians in which patients are empowered as active participants in their healthcare has resulted in a paradigm shift in the approach and delivery of care from a strictly medical approach to more patient-centered care (Charles, Gafni, & Whelan, 1997). Education on physician-patient communication has become an integral part of medical education and training. Surveying and reporting patient satisfaction with all aspects of care has come to the forefront. The Hospital

Consumers Assessment of Healthcare Providers and Systems (HCAHPS) initiative created a survey to standardize measurement and comparison of satisfaction with hospitals across the nation. It can be customized to the hospital's specific needs, and the results are made publicly available to consumers to ensure that hospitals are held accountable and continue to improve care (<http://www.hcahpsonline.org>). There are difficulties associated with accurately measuring patient satisfaction in every medical specialty, especially in critical care environments.

1. Family experience in the ICU

Hospitalization in the ICU often occurs because of an acute and life-threatening condition after a major health crisis or surgery. The admission is usually unexpected, and the condition of the patient is tenuous (Daly, Kleinpell, Lawinger, & Casey, 1994; Freichels, 1991). Whether critical illness is the result of a sudden major medical issue or chronic illness over years or decades, the entire family unit is impacted. Family members of the patient perceive the admission in the ICU as a stressful event which enhances feelings of vulnerability, intense emotions, fear and anxiety (Titler, Cohen, & Craft, 1991). The usual coping mechanisms of family members are often not sufficient to manage this complex situation, and they present with crisis behavior. Family members find themselves in a condition of physical and psychological exhaustion and disorientation (Forrester, Murphy, Price, & Monaghan, 1990), experiencing feelings of helplessness and desperation (Forrester et al., 1990; Schlump-Urquhart, 1990). These feelings of anxiety and insecurity are in part due to the inherent nature of the unit with the advanced

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medical and technological equipment, the constant monitoring of the patient, and the alarm signals (Keirse, 1980). Family members do not have control over the situation, and they are dependent on the efforts of nurses and physician. As the patient's condition is usually critical, it is imperative to meet the needs of the patient's family (Daly et al., 1994; Kleinpell & Powers, 1992).

Research and interventions to improve satisfaction include family involvement in rounds (Jacobowski, Girard, Mulder, & Ely, 2010), brochures and visiting hours (Henneman, McKenzie, & Dewa, 1992; Lautrette, Darmon, Megarbane, et al., 2007), advanced care directives (Silvester & Detering, 2011) and early integration of palliative care services (Curtis & Vincent, 2010). Further, the importance of communication is recognized in training focused on multi-disciplinary communication strategies for team members (Shaw, Davidson, Smilde, Sondoozi, & Agan, 2014). The difficulty of measuring family satisfaction with critical care has led to the development and testing of different surveys to accurately capture this experience. The Critical Care Family Satisfaction Survey (CCFSS) was developed and tested in different ICU and trauma units in the Lehigh Valley Hospital. Questions based on “Assurance,” “Information,” “Proximity,” “Support,” and “Comfort,” were found to be valid in measuring satisfaction with higher scores associated with completeness of information received (Wasser, Pasquale, Matchett, Bryan, & Pasquale, 2001). Another survey developed and tested in ICUs in six different hospitals in Canada based satisfaction on direct care, communication, environment and information needs. Overall satisfaction was high although communication with physicians was indicated as an area for improvement (Heyland, Rocker, Dodek, et al., 2002; Heyland & Tranmer, 2001). The Family Satisfaction Survey (FS-ICU 24) is a lengthier survey that was developed and administered in 23 ICUs across Canada aimed to determine the relationship between organizational culture and family satisfaction in critical care. This survey showed high levels of satisfaction and identified similar areas for improvement as the other two surveys (Henrich, Dodek, Heyland, et al., 2011). While all of these surveys provided important background for this study, they did not take into account the integration of palliative care, social work and cultural and spiritual needs of patients and families. A survey was created using Kolcaba's Comfort Theory (CT) framework in order to capture and identify areas of strength and weakness in delivery of a more ‘broad’ approach to care for patients and families in the SICU.

CT has four assumptions: the need for comfort is basic, persons experience comfort holistically, self-comforting measures can be healthy or unhealthy and healthy enhanced comfort leads to greater productivity. Patients achieve “enhanced comfort” when comfort is met in four contexts: physical, psycho spiritual, sociocultural, environmental (Kolcaba, 1994). These types of comfort can be juxtaposed with the four contexts to make a taxonomic structure that helps to define comfort as a patient outcome. The taxonomic structure can be used as a map to help guide the care of the patient and family (Kolcaba, Tilton, & Drouin, 2006). Comfort interventions are often non-technical but may supplement technical interventions, such as creating a quiet area in the emergency department (environmental) so that a patient with acute MI can decrease anxiety which may in turn decrease tachycardia, cardiac output, chest pain and ultimately myocardial oxygen demand (Krinsky, Murillo, & Johnson, 2014). While CT has been studied in the context of pediatric patients (Kolcaba & DiMarco, 2005), psychiatric patients (Apostolo & Kolcaba, 2009), as well as cancer patients and their caregivers of patients (Lamino, Turrini, & Kolcaba, 2014), it has not been applied in the context of critical care. The acknowledged nature of critical care on the family unit has lasting psychological effects on patients and their families regardless of outcome (Davidson et al., 2012, 2013; Titler et al., 1991) calls for an approach to care in which comfort theory is integrated into the delivery of care for patients and families. Through the ICU course, families will experience discomfort, and comfort is not as much the absence of a negative stimulus but rather a more holistic approach to care in which the individual needs of patients and families are assessed and integrated into the approach to care (Kolcaba & DiMarco,

Table 1

SICU palliative care triggers.

Eligibility criteria
One of the following must be present:
1. Stay in SICU greater than 10 days
2. Any repeat admission to the SICU during this hospitalization
3. Post cardiac arrest
4. Metastatic cancer or locally advanced lung, pancreatic, or head and neck cancer
5. Presence of 2 or more life-threatening co-morbidities:
- Severe brain injury: Glasgow Coma Scale <9 (off sedation)
- Hypotension requiring use of a vasopressor agent for >12 hours
- End-stage renal disease: GFR < 30
- End-stage liver disease: MELD ≥ 30
- Severe sepsis
- Any active cancer, excluding non-melanoma skin cancer
- Pre-existing tracheostomy, excluding head and neck cancer

2005). This holistic or ‘broad’ approach might help to improve the experience of critical care. CT is used to help identify modifiable factors that can improve caregiver's comfort as well (Lamino et al., 2014). This operationalization of comfort lends a theoretical framework in which the experience of critical care can be captured and interventions developed to improve the experience for patients and families. In addition, CT allows for “proactive assessment” that calls for for positive indicators of day-to-day progress like hope, resiliency, or transcendence (Kolcaba et al., 2006).

2. Methods

The SICU is a 14 bed closed unit in a 1,171 bed tertiary hospital in New York City. This unit manages the post-operative care for patients from general surgery, liver and intestinal transplant and surgical oncology by an ICU team consisting of an attending intensivist, critical care fellows, surgery and anesthesiology residents, nurse practitioner, physician assistant, bedside nurses and a full-time social worker. There is an average of 60 admissions per month, and the average length of stay is 7 days. The SICU has an early palliative care consult initiative to rounds on patients every day and integrate these services into patient care when one of the ‘triggers’ is met (Table 1), not only for discussions about goals of care and hospice but also symptom management and other supportive services. Consults to spiritual life and other specialties are also made as needed. The Surgical Intensive Care Unit Family Experience Survey was developed through a multi-disciplinary quality improvement team, consisting of SICU nurses, physicians, social work and research, in consultation with palliative care, and the Hospital Office for Excellence in Patient Care and Spiritual Life. Due to the nature of the survey, this study was given exempt approval from the IRB waiving the need for informed consent. A two page survey with three sections was created (Fig. 1). Two demographic questions were asked about the respondent's relationship to the patient and patient's ICU length of stay to maintain anonymity. The following section consists of 12 Likert scale questions (very satisfied to very dissatisfied) that address perceptions of communication, care and resources. These questions drew on the four aspects of “enhanced comfort”—“physical,” “psycho-spiritual,” “sociocultural” and “environmental” in order to directly identify and enhance the critical care experience for families and patients. The “physical” components of comfort included: perceptions of the efforts to meet the needs of and overall quality of care given to the patient, “psychosocial” comfort included updates from and availability of doctors and nurses, explanations provided about patient's condition, efforts to include them in decisions of patient's treatment and services provided by social work, “sociocultural” comfort included spiritual, cultural and again social work, and “environment” comfort included cleanliness. The final section has two open-ended questions allowing respondents to comment on the ‘best’ and ‘worst’ aspects of care to elaborate on anything positive or negative that was or was not referenced above. Families of all patients who are transferred, discharged or expired in the

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