



Consistency of communication among intensive care unit staff as perceived by family members of patients surviving to discharge ☆☆☆

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ABSTRACT

Purpose: We hypothesize that intensive care unit (ICU) families frequently perceive that they have received inconsistent information from staff about their relatives and that these inconsistencies influence abilities to make medical decisions, as well as satisfaction.

Materials and Methods: We performed a prospective cohort study in the neurosciences and medical ICU at a university hospital. One hundred twenty-four family members of adult patients surviving to ICU discharge completed a questionnaire regarding perceptions of inconsistent information.

Results: Of 193 eligible patients, 64.2% had family complete the survey. Thirty-one respondents (25.0%; 95% confidence interval, 7.7) reported at least 1 instance of inconsistent information during their family member's admission, with no difference between the neurosciences ICU (21.5%; 9.3) and the medical ICU (31.1%; 14.1; $P = .28$). Of those who did receive inconsistent information, 38.7% (95% confidence interval, 18.2) reported multiple episodes and 74.2% (16.3) indicated that episodes occurred within the first 48 hours of admission. These episodes had an adverse effect, with 19.4% (14.7) indicating that they affected satisfaction and 9.7% (11.0) indicating that they made decision making difficult.

Conclusions: Episodes involving inconsistent information from staff as perceived by families may be quite prevalent and may influence decision-making abilities and satisfaction.

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1. Introduction

Following a 2001 recommendation by the Institute of Medicine that health care systems become patient centered [1], a taskforce of the American College of Critical Care Medicine and Society for Critical Care Medicine released practice guidelines for family support in intensive care units (ICUs) [2]. These guidelines recommended that all members

of an ICU team be informed of treatment goals for any particular patient, so that the messages given to the family are consistent [2].

Although studies have focused on ICU conflicts from the physician and nursing perspective [3–6], the literature regarding families' perceptions of the consistency of information that they receive is sparse. The Family Satisfaction-ICU survey instrument, a widely validated tool for assessing ICU family satisfaction, does contain an item that assesses the consistency of information provided by staff on a 5-point Likert scale [7–10]. However, the US critical care literature has yet to examine in depth the prevalence of discrete episodes of inconsistent information being given to families and, importantly, whether these events affect patient and family care.

This article reports data from a single-center cohort study using a novel questionnaire that was distributed to family members of patients surviving to discharge from the neurosciences ICU (neuro-ICU) and medical ICU (MICU) of an academic teaching hospital. The questionnaire was designed to assess how often families detected inconsistencies in the information that they received from various care providers. Furthermore, for those family members who did

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report that they received inconsistent information, we asked whether the inconsistencies affected their ability to make decisions about patient care and their general satisfaction.

2. Materials and methods

This study was conducted for 38 days and was approved by the hospital's human studies committee. The study was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

We collected data concomitantly from 2 separate ICUs, in part to have results from both a “comanaged” neuro-ICU (ie, where surgeons maintain admitting privileges) and a completely “closed” unit (ie, where members of the MICU staff serve as the attending of record for all patients admitted) [11]. At the time of the study, both units were comprised of 18 patient beds. The structure of morning rounds in both ICUs is multidisciplinary, with nurses, physicians, pharmacists, and respiratory therapists discussing patients together. On a typical day, the neuro-ICU physician team comprises of an attending neurointensivist, 3 neurocritical care fellows, and 2 residents. The neurosurgery team rounds separately during the morning, with communication between the surgical and intensive care team occurring generally during and after neuro-ICU rounds. The standard daily MICU physician team comprises 2 attending intensivists (with each patient assigned only to 1 attending), 2 critical care fellows, 2 third-year residents, 4 second-year residents, and 6 first-year interns.

All family members of patients admitted to the participating units during the study period were potential participants, regardless of sex, race, or the medical conditions of their loved ones. A research coordinator identified subjects by consulting with the charge nurses of the 2 ICUs on weekdays. Families of patients with planned discharges within 24 hours of this charge nurse consultation were eligible. Only 1 family member per patient was allowed to participate. When possible, a patient's health care proxy was selected among various family members for inclusion. When the patient's health care proxy was not available, any available family member was recruited. Minors, non-English speakers, and subjects whose loved ones either passed away during ICU admission or whose goals of care had been changed to intensive comfort measures (ICMs) only were excluded.

Development and validation of the survey itself proceeded in an iterative fashion. After an initial extensive literature review, the lead authors of this article formulated an initial questionnaire with the purpose of assessing families' key perceptions of the consistency of clinical information they had received. The questionnaire then underwent multiple revisions by a multidisciplinary, collaborative panel of hospital experts that included 3 senior nurses and 3 senior physicians from the neuro-ICU, the MICU, and the hospital's Critical Care Center. The purpose of these revisions was to achieve (1) panel consensus regarding qualitative content validity, (2) clarity at a seventh grade reading level, (3) comprehensiveness, and (4) minimal ambiguity and redundancy. Multiple examples of hypothetical situations involving the exchange of inconsistent information were provided within the survey as a guide. These various scenarios focused on family members receiving “mixed messages” from staff regarding the direction of patients' medical and surgical care plans, as well as prognosis. However, the questionnaire was designed so that respondents were ultimately allowed to interpret questions regarding “inconsistent information” as they best saw fit, so as not to assume up front what types of events affected family satisfaction (ie, regardless of whether these events may have been clinically significant or insignificant in the opinion of a care provider). The ease of comprehension of the questionnaire and its face validity were then tested initially on 25 neuro-ICU and MICU family members. Responses from these 25 family members were not included in the final analysis. The final 7-item survey is available as an appendix to this article (Appendix E1).

Attached to the questionnaire was a coversheet with the language of informed consent. A family member who returned the questionnaire was considered to have consented to participate in the study. In addition, a supplemental form for the collection of family demographic information was also provided. One question on the supplemental form asked respondents to indicate the number of formal family meetings that they participated in while their loved ones were admitted; for this particular question, the definition of “formal” was based on the judgment of the respondents.

After survey distribution, the research coordinator remained available, although not immediately present in the room, to answer questions. Surveys needed to be completed within 48 hours after patient discharge to be included in the study. Participants in the survey who expressed discomfort were withdrawn at their request. If needed, a social worker was provided to assist families with any emotional discomfort emerging from survey completion.

Data from completed surveys were transferred and stored in an electronic RedCap database, compliant with the US Health Insurance Portability and Accountability Act. All members of the research team were trained in protecting patient confidentiality.

The length of the study was predetermined by the availability of a full-time research assistant to ensure that as many families in both ICUs were enrolled as possible. Maximizing the capture rate of potential respondents was thus prioritized in our study design. Before data collection began, we calculated that obtaining at least 43 survey responses from each ICU—an estimate based on (1) our predetermined time frame with the research coordinator and (2) patterns in hospital ICU volume—would at least give the study 80% power to detect a 25% difference in the proportion of neuro-ICU and MICU family members reporting inconsistent information.

Patient and family characteristics were described using means with SDs and percentages. Responses to survey questions were described using percentages and 95% confidence intervals (CIs; calculated via standard methods for proportions). When appropriate, categorical variables were compared using the Fisher's exact test.

3. Results

Over the study period, 193 non-ICM patients were discharged (121 from the neuro-ICU, compared with 72 from the MICU). Of the 193 patients discharged, the research team was able to approach 166 of their families (106 from the neuro-ICU, 60 from the MICU). Subsequently, 124 surveys (79 from the neuro-ICU, 45 from the MICU) were returned to the team, representing a capture rate of 64.2% with regard to all possible family members available to participate.

The mean (SD) length of stay for patients was 4.1 (5.5) days (Table 1). Of note, 34.2% of neuro-ICU patients were scheduled neurosurgical admissions for routine monitoring after elective operations. The mean (SD) age for all family members who participated was 49.8 (14.0) years, respectively (Table 2). Most respondents were female (63.7%), white (81.5%), and either children (41.1%) or spouses (34.7%) of the admitted patients. Our respondents were mostly well educated, with 46.8% possessing a college degree and an additional 29% possessing a graduate degree. Of note, 57.3% of our survey participants indicated that they had prior experiences with family members admitted to an ICU.

Question 1 of the survey asked respondents to identify the member of the ICU team who was their main source of information during their loved one's admission. Most respondents identified the ICU nursing staff as this main source (75.8%; 95% CI, 7.6). Other main sources identified included attendings (16.9%; 6.7), residents (8.9%; 5.1), and fellows (4.8%; 3.8).

Questions 2, 3, and 4 of the survey addressed whether respondents had received inconsistent information from providers regarding their loved ones' clinical statuses, as well as the frequency and timing of these episodes if they occurred. Thirty-one respondents (25.0%; 7.7)

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