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ORIGINAL ARTICLE

# A survey of the attitudes and perceptions of multidisciplinary team members towards family presence at bedside rounds in the intensive care unit

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**KEYWORDS**
Family presence;
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**Summary**
*Objective:* To describe the attitudes and perceptions of intensive care unit (ICU) staff [critical care physicians and fellows (MDs), registered nurses (RNs), allied health discipline (HD) and managers] towards family presence at bedside rounds.
*Research methodology:* We developed, tested and administered a questionnaire to the multidisciplinary staff.
*Setting:* 24-Bed medical surgical ICU.
*Results:* 160/221 (72.4%) individuals responded, including 12 MDs, 95 RNs, 48 HD personnel, 4 managers and 1 unspecified. While most MDs strongly agreed and HD and management groups somewhat agreed, most RNs strongly disagreed with providing family members the option to attend rounds. Over 50% of respondents either strongly or somewhat agreed that the presence of family members prolongs rounds, reduces the medical education provided to the team and constrains delivery of negative medical information. Compared to MDs, RNs expressed greater reservation to family presence at rounds. Among RNs, more experienced RNs, expressed greater reservation with family presence during rounds.

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*Conclusion:* We found significant differences among the attitudes of health care providers towards family presence at bedside rounds with RNs, especially more experienced RNs, expressing the greatest reservation. Qualitative research is required to explore perceived and actual barriers to family member presence at rounds.


**Implications for Clinical Practice**

- We explored multidisciplinary bedside rounds as a venue for information sharing with families when time constraints and availability of key health care providers, especially physicians, can limit the frequency of family meetings.
- While desirable, the practice of family presence during bedside rounds is often met with ambivalence by ICU health care providers. The specific reasons for this ambivalence have not been well delineated.
- This research is novel in exploring the attitudes and perceptions of staff towards family presence at bedside rounds in a multidisciplinary adult ICU.
- RNs reported the most discomfort in having family members present at bedside rounds. Further research is required to understand the barriers to implementing best practice guidelines into the clinical realm to enable family visitation and involvement in care.
- Our findings suggest that there may be knowledge gaps pertaining to the potential benefits of involving families in the information sharing and gathering processes that typically occur during multidisciplinary bedside rounds. In addition, they suggest the need to develop a policy regarding family presence at bedside rounds to address the ambivalences expressed by diverse health care practitioners and limit practice variation.

## Introduction

Critically ill patients are often unable to communicate with intensive care unit (ICU) clinicians or participate in treatment decisions. Substitute decision makers (SDMs), typically family members, are often approached to make decisions on behalf of critically ill patients. Family members have a strong desire to obtain vital medical information to enable them to better understand their loved one's health problems and facilitate surrogate decision-making (Kleiberg et al., 2006). With the advent of electronic technology, family members have ready access to medical information (Kaplan et al., 2004). Consequently, family members are more informed about health care issues, their healthcare rights and have greater expectations to participate in health care decisions (Davidson et al., 2007).

Medical information is generally imparted to SDMs and family members of critically ill patients in formal family meetings and at bedside updates. Time constraints and limited availability of key health care providers, especially attending physicians, constrains the frequency with which information exchanges can occur. At present, family members of critically ill patients in our ICU have not been invited to be present at multidisciplinary bedside rounds. Few Canadian ICUs have formal policies regarding family presence at bedside rounds. Notwithstanding, a study of hospitalised paediatric patients supports that when given the option to attend, 85% of parents participate in bedside rounds (Muething et al., 2007). Others have noted that participation in bedside rounds affords individuals the opportunity to obtain valuable information (Lewis, 1988) and that communication practices can impact patient outcomes (Wanzer et al., 2004). A quality improvement initiative permitting parents to be present at bedside rounds in a paediatric ICU found that this practice was perceived to be beneficial by physicians, nurses and parents (Kleiberg et al., 2006).

There is a paucity of literature addressing the attitudes and perceptions of health care providers towards having family members present at bedside rounds in the adult ICU setting. The American College of Critical Care Medicine Task Force considers family presence at bedside rounds to be the least studied practice issues in developing 'patient-centred ICU models of care' (Davidson et al., 2007). The task force acknowledges the desire of patients and families to play a larger role in decision-making and underscores the benefits of family participation in rounds (Davidson et al., 2007). While desirable, the practice of family presence during bedside rounds is often met with ambivalence by ICU health care providers. Reasons for this ambivalence have not been explored previously. We sought to evaluate the attitudes and perceptions of ICU physicians (MDs), registered nurses (RNs), management and allied health disciplines (HD) personnel towards family presence at bedside rounds.

## Methods

### Sampling frame

We conducted a cross-sectional, self-administered survey to determine the attitudes and perceptions of MDs, RNs, HDs and ICU managers towards family presence at bedside rounds in a 24-bed Medical Surgical Intensive Care Unit (MSICU) at a teaching hospital in a large metropolitan centre. We generated lists of potential respondents including 11 MDs who regularly attend in the MSICU, 3 ICU fellows, 122 RNs, 76 HDs and 8 managers. The HD group included bioethicists, chaplains, dietitians, pharmacists, physiotherapists, respiratory therapists (RTs) and social workers. The