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Psychosocial Care Models for Families of Critically Ill Children in Pediatric Emergency Department Settings: A Scoping Review

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ABSTRACT

Problem: Critical illness in children is a significant and stressful life event for families. Within pediatric emergency department (ED) settings it is acknowledged that these crises are challenging for both the families of these children, and for the clinical staff treating the child. Literature recommends routine care should include an offer to the family to be present with their critically ill child, however there is a lack of clarity regarding specific family care models or evidence-based interventions to guide clinical practice.
Eligibility criteria: Peer reviewed articles written in English, published between 2006 and 2016, proposing or testing psychosocial care models in pediatric (or mixed) emergency settings.
Sample: Nine articles met inclusion criteria.
Results: Search results showed limited evidence available in the literature at this time. Thematic analysis of article content and proposed model showed strong support for the benefit of family presence, including shifting the family role from passive to active, needing to be inclusive of the psychological impact of critical health events, importance of multidisciplinary education, and the need for additional exploratory and empirical research to evaluate and refine proposed care models.
Conclusions: Pediatric emergency health events are challenging for both families and staff, and care models provide staff with a consistent, evidence-informed approach to caring for families in challenging situations.
Implications: There is a need to find common ground from specific discipline guidelines into a multidisciplinary team approach for the care of families within emergency care.

Background

Context

Critical childhood illness is described as being one of the most stressful life events for parents and families of children undergoing life-saving critical care (Butler, Copnell, & Willetts, 2013; Dudley, Ackerman, Brown, & Snow, 2015). Advances in medical technology allow children to be cared for better and longer, though these life-saving interventions are increasingly invasive. Family lives are disrupted as parents focus on the challenge of caring for their child within a hospital environment (Abuqamar, Arabiat, & Holmes, 2016; Allen, 2014; Cypress, 2014). Families often transport their ill child to hospital themselves, and are actively involved in providing pre-hospital care within the community prior to arrival of emergency services personnel (Hsiao et al., 2016; Joyce, Libertin, & Bigham, 2015). Once arriving at an ED a large team of specialist staff will take over care, and the family are thrown into what is often described as an unfamiliar and overwhelming environment with limited certainty or assurance (Allen, 2014; Cypress, 2014; Gage, 2013; Hsiao et al., 2016).

Family Experience

Pediatric critical health events are well documented as being distressing and challenging for families, with both injury and illness groups experiencing and being at greater risk of a range of psychopathological and psychosocial risks (Landolt, Ystrom, Sennhauser, Gnehm, & Vollrath, 2012; Price, Kassam-Adams, Alderfer, Christofferson, & Kazak, 2016). Children and families who perceive a high risk of life threat, reoccurrence, or complications related to pediatric illness or injury are at greatest risk (Price et al., 2016). In ED settings, given a choice between being present or being in another room, the majority of families choose to be present and available to the family member while they are undergoing life-saving care (Hsiao et al., 2016; Jabre et al., 2014; Pasek & Licata, 2016).

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Historically the benefits for family presence have been debated in the literature (Moreland, 2005; Robinson, Mackenzie-Ross, Campbell Hewson, Egleston, & Prevost, 1998). There is now consensus regarding the emotional and psychological benefits for families to be present in resuscitation situations if they choose to do so (Compton & Fernandez, 2014; Jabre et al., 2014; Smith McAlvin & Carew-Lyons, 2014). This has primarily been driven by the shift towards family centred care models in patient care (Gooding, Pierce, & Flaherty, 2012).

Staff Experience

The experience of medical and nursing staff providing resuscitation care in pediatric settings is documented within the literature, with staff reporting this to be both professionally and personally challenging (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). Providing psychosocial support to families in these cases is acknowledged to be particularly challenging for staff involved (Alisic et al., 2016; Garcia-Izquierdo & Rios-Risquez, 2012). Clinical staff appreciate having concrete guidelines and information regarding how to support families in these stressful situations, with research recommendations consistently advocating for increased education of staff undertaking acute family support work (Alisic et al., 2016; Holbery, 2015). The recommendations are often broad, lacking in specific detail and with limited testing.

Aims – Planning for Care

Clinicians undertaking this work often receive limited warning time regarding the patient's arrival. This requires staff to be ready to engage with a family immediately, but limits time to prepare, leaving clinicians to assess and intervene with families simultaneously. The moment families' walk through the door is the key point to commence support work – the stress does not stop when they arrive at hospital, but can be the start (or an ongoing part) of a longer treatment journey (Cypress, 2014; Foster, Young, Mitchell, Van, & Curtis, 2017; Gage, 2013). Facilitating early therapeutic support of families assists with de-escalating acute psychological responses, enabling families to more ably support themselves, and in turn be more available to support the child (Flynn et al., 2015; Hsiao et al., 2016; Marsac, Kassam-Adams, Delahanty, Widaman, & Barakat, 2014; Porter, Cooper, & Taylor, 2014). The reasons critically ill children are brought to EDs are wide-ranging and complex. Each case can involve an equally wide-ranging diversity of social histories and psychosocial needs and these will respond to stressful events in individual ways. These multiple variables create challenges in tailoring support to each family; however, this does not mean that care models could not be inclusive of this diversity of need. This review aims to consider available models in the published literature, and consider what a best approach or care model might look like.

Methodology

This review asked the question 'what psychosocial care models, frameworks or interventions are available in the literature to guide an effective response to families of critically ill children in pediatric emergency settings?' It aimed to scope available literature, exploring evidence-based or evidence-informed guidelines for psychosocial care models specifically designed for use with families within a pediatric ED resuscitation setting. As there were insufficient sources utilising an experimental design to undertake a thorough systematic review, a scoping review design was chosen. Arksey and O'Malley (2005) recommended method for undertaking a scoping literature review is recognized as providing a structured framework for narrative interrogation of available evidence (Arksey & O'Malley, 2005). Table 1 outlines search terms used. As per Fig. 1, papers were sought through searches of the four largest electronic health and allied health databases (Medline, PsychINFO, CINAHL and SocIndex) in the first half of 2016.

Table 1
Search terms.

	Key concepts	Alternate search terms for concepts, using truncation * and wild cards # or?
Concept 1	Families	Family Parents Carers
AND concept 2	Paediatrics	Paediatrics
AND Concept 3	Emergency department	Accident and emergency Resuscitation/resus
AND Concept 4	Care model	Practice guidelines Clinical practice guidelines Protocol/s Care pathway/s Model of care Intervention/s
OR Concept 5	Psychosocial care	Psychosocial intervention Crisis intervention Psychological first aid Communication Support Help Care
OR Concept 6	Critical events	Crisis/crises Emergency/emergencies Social trauma Disaster Crisis intervention Acute stress
OR Concept 7	Social work	Social worker/s

The inclusion and exclusion criteria are described Fig. 2; please note that only papers from the last ten years were included in the review. This does not discount the value of older research, which is referred to in background literature, but aims to align the review as closely to contemporary practices and policies as possible. After applying the criteria outlined in the aforementioned table and figures, nine articles were included in this review.

Results

Study Characteristics

Of the nine papers included in this review all proposed a care model; eight of the papers are from the United States of America and one was from Australia (refer to Table 2). Four of the nine articles tested their proposed model (Curley et al., 2012; Mangurten et al., 2006; Mian et al., 2007; Porter et al., 2014), with all using a mixed quantitative and qualitative methodology in their research design. Sample sizes were mixed but not insignificant. Of the four testing a model, two papers considered experience of clinicians and families following the implementation of their model (Curley et al., 2012; Mangurten et al., 2006); these

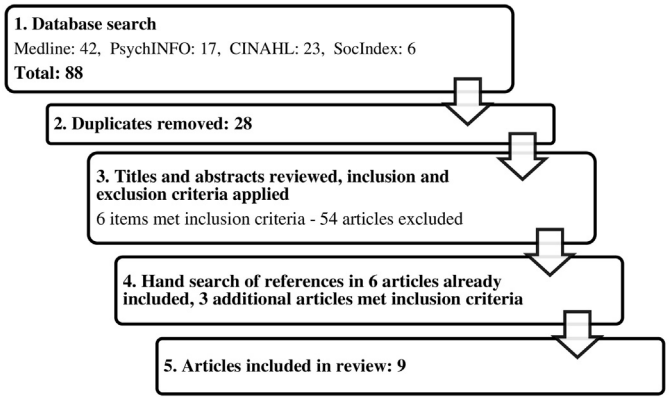

Fig. 1. Search strategy.