

**POSITION**

**STATEMENT**

**Partnering with Families in Critical Care**



## **ACCCN Position Statement - Partnering with Families in Critical Care**

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## **Introduction**

The Australian College of Critical Care Nurses (ACCCN) is the peak national professional nursing association representing critical care nurses in Australia, and strives to improve care and outcomes for critically ill patients and their families.

This ACCCN Position Statement, *Partnering with Families in Critical Care*, sets out standards for critical care units (CCUs), critical care nurses and critical care nurses' education in the context of patient and family care within a CCU. These standards are based on the best evidence available and follow consultation with key stakeholders, including forums with critical care nurses and health care consumers.

## **Background**

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed National Safety and Quality Health Service (NSQHS) standards to drive the implementation of safety and quality systems and improve the quality of health care in Australia (ACSQHC, 2012). The ten NSQHS standards provide a nationally consistent statement on the level of care consumers can expect from health services (ACSQHC, 2015).

The Commission identifies that health services that promote partnering with patients, families and other consumers improve the safety and quality of patient care. This principle is introduced in Standard 2, 'Partnering with Consumers'; the Commission also highlights families of consumers within eight of the other nine standards addressing clinical areas of patient care, thus emphasising the vitally important role that families contribute to health care outcomes.

The ACSQHC standards support the underlying assumption of this Position Statement that families play fundamental psychological and advocacy roles for critically ill patients, and that these roles support quality individualised patient care (ACSQHC, 2011). The ability to be physically close to each other is an essential requirement for both patients and family members, from social, psychological and physical perspectives.

## PARTNERING

## WITH FAMILIES

## IN CRITICAL CARE

The term ‘family member’ in this statement is defined broadly and includes whomever the patient considers a family member; it is not limited to legally or biologically related persons.

### Critical Care Units

All CCUs should provide the following:

1. A demonstrated philosophy of patient care that is person-centred and that values, respects and incorporates family participation and family presence for the benefit of the patient (Al-Mutair et al., 2013; De Silva, 2014; Entwistle & Watt, 2013; Kean & Mitchell, 2014; Levy, 2007; McAdam et al., 2008);
2. A policy on family presence that supports staff to structure care in ways that include cultural sensitivity and accessibility, individualised and timely communication plans, flexible contact details, children (Al-Mutair et al., 2013; Halm & Titler, 1990; Knutsson et al., 2004; Vint, 2005), pet guidelines (Connor & Miller, 2000) and technology communication aids to support an effective approach to communicating with patients, families and CCU staff;
3. General facilities that provide:
  - a. Family access to CCU areas at all times, including after conventional business hours, first priority given to patient needs,

together with security mechanisms to ensure staff and patient safety (Slota et al., 2003).

- b. Areas where families may await admission to see their patient relative with:
  - i. Close proximity to the CCU;
  - ii. A clear method by which to gain access;
  - iii. Written information about the CCU;
  - iv. A public telephone;
  - v. Comfortable chairs;
  - vi. Bathroom facilities.
- c. Meeting room(s) for private conversations with families.
- d. Sustenance available at all hours.
- e. Accommodation nearby where practicable.

### Critical Care Nurses

All critical care nurses should:

1. Demonstrate a philosophy of patient care that is person-centred and that values, respects and incorporates family participation and family presence for the benefit of the patient (Al-Mutair et al., 2013; Kean & Mitchell, 2014; Levy, 2007; McAdam et al., 2008);

2. Be supported or mentored by senior staff to provide individualised patient and family care throughout the period of CCU admission (Gill et al., 2015);
3. Recognise that the family 'knows the patient' and is thus a significant resource for helping to ensure the provision of individualised care (Azoulay et al., 2001; Luker et al., 2008; Williams, 2005);
4. Act as the patient's and family's advocate (Gill et al., 2013; Tanner et al., 2007);
5. As soon as practicable, establish and observe the patient's desires with regard to who visits, how often, and the extent of their participation in patient care (Davidson et al., 2007);
6. Where the patient is unconscious or unable to communicate, establish a substitute decision-maker for ongoing communications (Davidson et al., 2007; Gill et al., 2013);
7. Actively facilitate family presence at the bedside, including children if the patient or substitute decision-maker thinks it is in the best interests of the patient and the child (Kean & Mitchell, 2014);
8. Maintain patient and family privacy, respect, values and confidentiality;
9. Communicate effectively and frequently with the family, understanding that at stressful times, cognition may be impaired and memory diminished, and access interpreters when required (Davidson et al., 2007);
10. Recognise and respond to the importance of effective communication with the family at key events or moments in the patient's critical illness;
11. Establish and facilitate regular communication between the family and medical or other interdisciplinary teams within and beyond the walls of the CCU, understanding that when family needs are met, decision-making processes improve (Kryworuchko & Heyland, 2009).

### Critical Care Nurses' Education

Critical care nurses' education should incorporate the best and most current evidence into their formal and informal programs of study, and should include:

1. Adherence to a philosophy of patient care that is person-centred and values culturally sensitive family participation and presence, as determined by the patient (Gill et al., 2013);
2. Facilitation of family participation in patient care, recognising that it improves the safety and quality of care (Al-Mutair et al., 2013);
3. Advocacy for patients and families (Gill et al., 2013);
4. Recognition of family needs, assisting families to cope with the critical care environment and the patient's treatments and circumstances (Damboise & Cardin, 2003; Gill et al., 2013; Karlsson et al., 2011; Paul & Rattray, 2008);
5. Effective strategies that enable nurses to manage family members who may be refused entry due to violence or other threats to safety (Slota et al., 2003), together with mechanisms of de-escalation and conflict management within the CCU;
6. Provision of support to junior nurses in regard to strategies that facilitate effective communication and the development of family rapport in everyday and pivotal events (Clarke & Harrison, 2001; Gill et al., 2013, 2015; Linton & Farrell, 2009).

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