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POINT OF VIEW

Challenges in the implementation of strategies to increase communication and enhance patient and family centered care in the ICU

Desafíos en la implementación de estrategias para aumentar la comunicación y mejorar la atención centrada en el paciente y la familia en la UCI

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Family meetings in the intensive care unit (ICU) are necessary but complex interdisciplinary communication processes.[1] Ideally, these meetings increase effective communication and help patients and families make major medical decisions.[2] Increasing effective communication is important for all patients within the ICU. Patients expected to recover need to know what to expect after their ICU stay. For dying patients, effective communication is also critically important, since staff, patients, and families help determine when and how to transition from aggressive to more palliative measures.[3] Because of these issues, it is no surprise that patients and their family members rate communication with clinicians as one of their most important needs.[4]

Consequently, various approaches have been implemented to increase communication, often by educating ICU staff communication techniques or by adding staff (i.e., patient navigators) to help assuage patient and family concerns. More frequently, strategies have focused on encouraging or mandating frequent family meetings with ICU staff.[5,6] While these strategies are all effective in increasing perceptions of communication frequency and quality, studies focused on clinical outcomes and financial costs have reported mixed results.

After determining substantial shortcomings in communication, decision making and outcomes, the first large-scale ICU communication trial randomized intensivists into two groups.[7] Practitioners in the intervention group were each assigned a nurse communication expert, who was responsible for interviewing patients and their families to determine their preferences, fostering the effective exchange of information, and setting up family meetings. Unfortunately, this intervention was ineffectual, leading to no changes in patient's communication perceptions or changes in patient outcomes. In contrast, a more recent randomized controlled trial utilizing skilled nurse and social worker communication facilitators did report benefits, mainly by decreasing ICU cost of care.[8] In addition, family members of intervention patients had less depression, anxiety and post-traumatic stress disorder symptoms 6 months later, which is very important.

Interventions utilizing other professionals to assist with communication have also been tried. Most notably, multiple studies utilized trained clinical ethicists to implement a proactive ethics intervention model to address ethical issues prior to potentially developing into patient–clinician conflicts.[9,10] Unfortunately, the ethicists did not lead to

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changes in ICU length of stay, mortality or resource utilization. In our institution, we also had similar negative results when we used chaplains to enhance communication and increase family meetings (author unpublished data 2016).

Finally, there are trials of interventions that did not need extra skilled facilitators. One trial emphasized early and frequent multidisciplinary meetings with attending physicians, which led to significant benefits, including a reduction in critical care use and decreased length of stay without an increase in mortality.[11] Another trial also showed benefits of frequent proactive family meetings in addition to providing supplemental bereavement brochures, which ultimately led to fewer aggressive interventions but with no differences in ICU length of stay. In addition, family members of these patients had lower 90-day rates of post-traumatic stress, anxiety, and depression.[12].

When trials are analyzed together in systemic reviews, enhanced decision-making strategies remained beneficial, especially in enhancing patient and family well-being. One review focused on four randomized controlled trials, three of which were individually discussed previously,[7,9,12] and concluded that communication facilitators decreased ICU costs and shortened ICU length of stays as well as decreasing anxiety in family members.[6] A more recent meta-analysis,[13] which focused on 5 randomized controlled trials and 14 observational cohort studies of patients at the end of life, revealed slight improvements in meeting documentation and lower costs with implementation of structured communication strategies.

In light of the available evidence, we believe that implementing strategies to facilitate frequent and effective family meetings is likely to improve communication with patients and families, and lead to improvements in satisfaction and lower costs. However, organizing family meetings is difficult due to a number of challenging barriers. In one survey of U.S. hospital practices barriers included different organizational priorities, inadequate time, financial constraints, and lack of training. The same study found that providing easy patient access to the electronic medical record, offering transparent medical cost information, providing enthusiastic clinician support, and explicitly acknowledging and appreciating differences in culture and language were important to enhancing patient and family satisfaction.[14] In contrast, satisfaction decreased in the presence of poor communication skills, or when provided incomplete or difficult-to-comprehend medical information, or when families inordinately waited prior to receiving distressing information, or when there were few mechanisms to provide emotional and spiritual support.[15] From a clinician perspective, staff communication skills and system factors were not thought to be important barriers. In contrast, intrinsic patient and family related factors were considered significant barriers preventing good goals-of-care discussions, mainly due to a lack of comprehension of medical issues and an inability to make important decisions.[16]

To date, various standardized and innovative techniques have been implemented to overcome these barriers. However, each institution has variable institutional, professional, and patient dynamics, emphasizing the need to identify specific hospital barriers prior to the implementation of new strategies.[17] Based on what we previously discussed, we believe that supporting frequent, interdisciplinary, proactive family meetings with early goals-of-care discussions can help to improve patient and family satisfaction and understanding. In addition, we support hiring extra personal skilled in communication, especially if these patient navigators have a background in social work or in nursing. Also, we emphasize the need for basic communications training, since ICU staff benefit from experiential training in participating and running effective family meetings, especially if learning sessions simultaneously include a variety of ICU staff disciplines. Finally, we support other important initiatives, such as providing brochures describing care in the ICU, and empowering patients and families to speak up about their care.

Conflict of interest

The authors declare that they have no conflicts of interest.

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