Meeting the needs of patients’ families in intensive care units


Abstract
A review of articles published between 2000 and 2013, retrieved from several databases, was conducted to identify research findings regarding nursing interventions intended to meet the needs of the family members of patients in the intensive care unit. The dimensions of need identified were support, comfort, reassurance, information and closeness, with reassurance, information and closeness being the most important. Overall, the needs of patients’ family members were unmet. The results of studies revealed that providing families with proactive communication strategies and information via brochures or leaflets, developing education programmes and establishing family-centred care may be effective in increasing family members’ satisfaction, improving their understanding of the patient’s condition and decreasing anxiety and depression, and post-traumatic stress disorder. Consequently, nurses should promote comprehensive family-centred care by using the best evidence to meet families’ needs. However, more experimental studies are required to determine the effectiveness of specific interventions.

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et al 2005, Obringer et al 2012). This indicates the need to establish an updated body of knowledge for ICU nurses about best practice in meeting family needs in the ICU.

The objective of this review was to identify effective interventions designed to meet the needs of families of critically ill adult patients in the ICU. The conclusions provide recommendations to clinicians with regard to best practice in this area.

**Literature search strategy**


**Needs of intensive care unit patients’ family members**

A growing body of literature is available in which the needs of ICU patients’ family members are explored, examining the viewpoints of both relatives and healthcare professionals (Kosco and Warren 2000, Bijttebier et al 2001, Kinrade et al 2010). Most research has used quantitative methods and Molter’s (1979) Critical Care Family Needs Inventory, either in its original or translated form (Appleyard et al 2000, Auerbach et al 2005, Freitas et al 2007, Hinkle and Fitzpatrick 2011). However, only a few studies have used the Needs Met Inventory (Browning and Warren 2006) to determine frequency of meeting needs (Kosco and Warren 2000, Lee and Lau 2003, Maxwell et al 2007, Omari 2009).

Five domains of family need have been consistently identified within the quantitative studies. These domains are the need for support, comfort, reassurance, information and proximity (Lee and Lau 2003, Browning and Warren 2006, Paul and Rattray 2008, Khalaila 2013). Conversely, qualitative studies have identified different domains of need (Takman and Severinsson 2006, Fry and Warren 2007, Linnarsson et al 2010). For example, a meta-synthesis of qualitative research studies on family needs and experiences generated six categories of need: uncertainty and emotional upheaval; information; balancing hope with reality; the desire to protect and guard one’s relative; forming an alliance with the caregiver for crucial support; and the degree of supportiveness or disequilibrium of the family’s social network (Linnarsson et al 2010).

**Importance of family needs**

The importance of family needs from the family perspective is well documented in the literature. Most of the literature emphasised that families need to know about their loved one’s condition and to be assured that he or she is receiving high-quality care (Leung et al 2000, Gavaghan and Carroll 2002). The need for information, closeness and reassurance were identified as family priorities frequently and consistently (Lee and Lau 2003, Chiu et al 2004, Al-Mutair et al 2013, Khalaila 2013), whereas comfort needs and support needs were the least important (Bijttebier et al 2001, Holden et al 2002, Verhaeghe et al 2005) (Table 1).

**Meeting the needs of family members**

Another aspect represented in the literature is the perception of family needs as having been met. Several studies examining needs, met and unmet, showed that healthcare personnel almost always fail to meet the needs of family members of critically ill patients (Holden et al 2002, Verhaeghe et al 2005, Maxwell et al 2007). According to the literature, this may occur because ICU nurses and physicians do not perceive family needs accurately (Davidson 2009, Buckley and Andrews 2011), or staff fail to support the family (Obringer et al 2012). Staff also often fail to recognise how a relative’s active presence in the ICU may benefit the patient (Azoulay et al 2003, McAdam et al 2008). Other reasons may relate to disagreement among healthcare providers regarding meeting certain needs, such as the presence of a relative during resuscitation and other invasive procedures (Al-Mutair et al 2013), or family presence during ward rounds (Cypress 2012). Lack of time by overburdened care staff (Bijttebier et al 2001) and poor communication skills and insufficient training in managing family needs (Azoulay et al 2000, Holden et al 2002) were also revealed in the literature.
## TABLE 1

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Five most important needs</th>
<th>Five least important needs</th>
</tr>
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<tbody>
<tr>
<td>Leung et al (2000)</td>
<td>China</td>
<td>To have questions answered honestly. To know the expected outcome. To know which staff members could give what type of information. To have information given in understandable terms. To see the patient frequently.</td>
<td>To have a pastoral visit. To be told about other people that could help with problems. To be told about someone to help with family problems. To have a place to be alone while in the hospital. To be assured it is all right to leave the hospital for a while.</td>
</tr>
<tr>
<td>Bijttebier et al (2001)</td>
<td>Belgium</td>
<td>To have questions answered honestly. To be assured that the best care possible is being given to the patient. To know the expected outcome. To have information given in understandable terms. To be called at home about changes in the patient’s condition.</td>
<td>To have a pastoral visit. To be told about chaplain services. To have good food available in hospital. To have comfortable furniture in the waiting room. To feel it is all right to cry.</td>
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<tr>
<td>Freitas et al (2007)</td>
<td>Brazil</td>
<td>To see the patient frequently. To feel that hospital personnel care about the patient. To be told about transfer plans while they are being made. To be assured that the best care possible is being given to the patient. To know how the patient is being treated medically.</td>
<td>To be told about religious services. To help with the patient’s physical care. To have comfortable furniture in the waiting room. To visit anytime. To have a place to be alone while in the hospital.</td>
</tr>
<tr>
<td>Omari (2009)</td>
<td>Jordan</td>
<td>To be assured that the best care possible is being given to the patient. To feel that the hospital personnel care about the patient. To feel there is hope. To have questions answered honestly. To have the information given in understandable terms.</td>
<td>To be alone at any time. To have a place to be alone while in the hospital. To feel it is all right to cry. (Only three needs cited)</td>
</tr>
<tr>
<td>Kinrade et al (2010)</td>
<td>Australia</td>
<td>To have questions answered honestly. To visit any time. To be assured that the best care possible is being given to the patient. To know specific facts concerning the patient’s progress. To know the expected outcome.</td>
<td>To be alone at any time. To be told about pastoral services. To have someone be concerned with their health. To have comfortable furniture in the waiting room. To be encouraged to express emotions.</td>
</tr>
<tr>
<td>Hinkle and Fitzpatrick (2011)</td>
<td>United States</td>
<td>To be assured that the best care possible is being given to the patient. To know exactly what is being done for the patient. To have questions answered honestly. To know why things were done for the patient. To feel that the hospital personnel care about the patient.</td>
<td>To have someone to help with financial problems. To have a place to be alone while in the hospital. To be alone at any time. To talk about negative feelings such as guilt or anger. To be encouraged to cry.</td>
</tr>
<tr>
<td>Khalaila (2013)</td>
<td>Israel</td>
<td>To have the waiting room near the patient. To have visiting hours start on time. To visit at any time. To have visiting hours changed for specific conditions. To have questions answered honestly.</td>
<td>To have explanation of the intensive care unit environment. To feel it is all right to cry. To have someone to help with financial problems. To talk about what happened. To have a telephone near the waiting room.</td>
</tr>
</tbody>
</table>
Additionally, the literature demonstrated that needs most met and least met were inconsistent in different studies worldwide. While some scholars found that closeness, information and assurance needs were most frequently unmet (Bijttebier et al 2001, Omari 2009, Al-Mutair et al 2013), others found that reassurance, closeness and information needs were met most frequently, with support and comfort needs met least often (Lee and Lau 2003, Browning and Warren 2006). Other scholars who studied differences between perceived importance and perceived needs met, found that mean scores on closeness, information, comfort and reassurance subscales were lower for needs met compared with the importance of needs, mostly referring to the need for closeness (Khalaila 2013). Nevertheless, the majority of the researchers agreed that most unmet needs referred to hospital furniture, proximity of the waiting room, telephone and toilet, and ICU policy on visits (Lee and Lau 2003, Browning and Warren 2006, Khalaila 2013) (Table 2).

### Interventions used to meet family needs

The nursing literature contains various clinical practice guidelines and recommendations for meeting the needs of families in the critical care setting (Davidson et al 2007, Kynoch et al 2011) (Box 1). However, several limitations related to the process of guideline development were

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Top five needs that were met most</th>
<th>Top five needs that were met least</th>
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</thead>
</table>
| Kosco and Warren (2000) | United States (US) | To have the bathroom near the waiting room.  
To know the patient’s prognosis.  
To be assured that the best care possible is being given to the patient.  
To see the patient frequently.  
To feel there is hope. | Not cited. |
| Lee and Lau (2003)     | China       | To know the expected outcome.  
To be called at home about changes in the patient’s condition.  
To talk to the doctor every day.  
To be assured that the best care possible is being given to the patient.  
To know how the patient is being treated medically. | To talk to the doctor daily.  
To visit at any time.  
To help with the patient’s physical care.  
To feel it is all right to cry.  
To talk about negative feelings such as guilt and anger. |
| Browning and Warren (2006) | US         | To know exactly what is being done for the patient.  
To know how the patient is being treated medically.  
To be assured that the best care possible is being given to the patient.  
To know why things were done for the patient.  
To know about the type of staff members taking care of the patient. | To talk about negative feelings such as guilt and anger.  
To talk about the possibility of the patient’s death.  
To visit the patient at any time.  
To speak with the same nurse every day.  
To have good food available in the hospital. |
| Omari (2009)           | Jordan      | To have someone be concerned with their health.  
To have friends nearby for support.  
To see the patient frequently.  
To have another person with you when visiting the critical care unit.  
To have visiting hours start on time. | The specific items were not cited in the article.  
Eleven needs were never met: support (six items), information (three items), comfort (one item), and proximity (one item). |
| Khalaila (2013)        | Israel      | To be assured that the best care possible is being given to the patient.  
To have good food available in the hospital.  
To have friends nearby for support.  
To feel that the hospital personnel care about the patient.  
To know about the type of staff members taking care of the patient. | To be present in the intensive care unit during physician rounds.  
To be present during patient resuscitation.  
To have the waiting room near the patient.  
To have a toilet near the waiting room.  
To have comfortable furniture in the waiting room. |
identified, including a lack of consultation with patients and families and a lack of high-level evidence of results for meeting the needs of families in the ICU.

Within the literature, six experimental studies were identified that examined and evaluated the influence of the recommendations on family outcomes, such as family satisfaction and depression (Table 3). These studies included three RCTs (Azoulay et al 2002, Lautrette et al 2007, Yousef et al 2012) and three studies with a quasi-experimental design (Appleyard et al 2000, Chien et al 2006, Mitchell et al 2009). Of the three RCTs, two examined family satisfaction as the primary outcome (Azoulay et al 2002, Yousef et al 2012), while one investigated the psychological outcomes of the interventions, for example, the incidence of post-traumatic stress disorder (PTSD) and symptoms of anxiety and depression (Lautrette et al 2007). Two quasi-experimental studies investigated the effect on family satisfaction of interventions to meet the needs of the family in ICU (Appleyard et al 2000, Chien et al 2006) and a third quasi-experimental study examined positive outcomes, such as respect, collaboration and support (Mitchell et al 2009).

One of the RCTs was performed in 34 French ICUs and compared family comprehension of diagnosis, prognosis, treatment, and satisfaction with information provided by ICU staff. The families in the intervention group received a family-information leaflet in addition to standard information. The results showed that family members were more satisfied and received more comprehensive information than the control group (Azoulay et al 2002). A second RCT was conducted in a neurosurgery ICU in Iran. In the intervention group, some interventions, for example provision of clear explanations, honest answering of questions, assurances that the patient was being provided with the best care, and provision of information regarding the ICU and its equipment, were performed. In the control group, only routine actions were carried out. The results showed that the satisfaction score significantly increased after the intervention, as compared to the control group (Yousef et al 2012).

Another RCT involved bereaved family members from 22 ICUs in France (Lautrette et al 2007). It examined the effect of using a proactive end of life conference and a brochure on the psychological outcomes for families in the ICU. The results showed that improving communication by using case conferencing as well as an information leaflet decreased the risk of developing symptoms of PTSD, anxiety and depression (Lautrette et al 2007).

Additionally, three quasi-experimental studies reported improved family satisfaction after intervention (Appleyard et al 2000, Chien et al 2006, Mitchell et al 2009). One of these studies investigated the effect of a needs-based education programme on family satisfaction and anxiety levels. The experimental group received a structured education programme, while the control group received the ICU nurses’ usual orientation lecture. Results following the needs-based intervention reported lower anxiety levels and greater satisfaction with regards to needs being met in the experimental group than in the control group (Chien et al 2006).

Further, pre and post-test design, without a control group, was used to measure the affect on family satisfaction at a nurse-coached volunteer programme in the ICU. Waiting-room volunteers comforted and supported families, liaising between ICU nurses and families, acting as an information resource for referrals and reminding families not to neglect self-care. The results showed greater family satisfaction with regard to comfort needs following the volunteer programme. Furthermore, the volunteers reported that the nurses became more communicative and more concerned about families’ needs (Appleyard et al 2000).

Investigators in a third, quasi-experimental study, examined the effect of family-centred...

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**BOX 1**

**Potential interventions to meet the needs of family members**

- Promote family-centred care.
- Discussion with a nurse on admission.
- Daily or routine meeting or conference between staff and family members.
- Allow family presence during procedures, resuscitation and rounds.
- Allow family members to help with essential patient care.
- Flexible or open visiting hours.
- Structured educational programme for families and nursing staff.
- Family involvement in the decision-making process.
- Use written materials, for example a brochure or personalised instruction.
- Use technology, for example videotapes or DVDs.
- Support group for family members.
- Provide comfortable and functional waiting rooms close to the unit.
- Use of volunteers to staff the waiting room.
- Refer families for cultural and spiritual support.
- Improve communication.

nursing on meeting family needs (Mitchell et al 2009). The experimental group was invited to assist with some basic care tasks for their relative, with nurse support, while usual care took place in the control group. The results revealed that the nursing intervention of providing family-centred care improved the respect, collaboration, support and overall satisfaction scores.

**Recommendations for nursing practice**

Several recommendations and interventions have been suggested in the literature to meet family needs in the ICU environment, particularly information needs. However, only a few experimental studies have examined the effectiveness of these interventions. Some of the interventions were beneficial for the family in terms of increasing satisfaction and reducing anxiety, depression and PTSD. Further experimental studies, particularly RCTs, are required to investigate the effectiveness of interventions for meeting the needs of the family in the ICU, in particular, comfort and support needs. However, healthcare professionals should establish their

<table>
<thead>
<tr>
<th>Study</th>
<th>Design and sample size</th>
<th>Intervention</th>
<th>Needs domain</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chien et al (2006)</td>
<td>Quasi-experimental with pre and post-test design. Family members (control = 32, experimental group = 34).</td>
<td>Needs-based education programme: the control group received the usual orientation and explanation; the experimental group received an individual education programme.</td>
<td>Information needs.</td>
<td>Reduced anxiety. Increased satisfaction of family members.</td>
</tr>
<tr>
<td>Mitchell et al (2009)</td>
<td>Quasi-experimental with pre and post-test design. Family members (control = 75, intervention = 99).</td>
<td>Family-centred care interventions: at the control site, patients' families experienced usual care; at the intervention site, patients’ families were invited to assist with some of their relative's care with nurses' support.</td>
<td>Closeness needs.</td>
<td>Improved respect, collaboration, support and overall scores of family-centred care.</td>
</tr>
</tbody>
</table>
practice with regard to family needs based on best evidence available in the literature (Box 2).

**Limitations**

Specific limitations must be taken into account in the current review. First, it comprised only a few experimental studies and, therefore, the effectiveness of the suggested interventions in terms of improving family outcomes is not fully known. Second, as each study used different interventions, study designs, and outcome measures, it was difficult to compare studies for each parameter and, therefore, meta-analysis of results was not possible.

**Conclusion**

Studies have shown that family members of ICU patients have a variety of needs, including that of support, comfort, reassurance, information and closeness. The need for reassurance, information and closeness were identified as the most important, with comfort and support ranked as least important.

The Critical Care Family Needs Inventory emerged as the most common and valid scale to identify the needs of the ICU patient’s family. Furthermore, the literature revealed that relatives and healthcare professionals differed in their perception of the importance of family needs. Therefore, it is important that critical care nurses continue to be aware of, and assess the needs of, each family member and promote family-centred care in the ICU as the standard of care.

**References**


