Family care in intensive care units

Critical illness, and subsequent hospitalisation, in an intensive care unit (ICU) is a stressful situation that disrupts the family system. Families experience emotional, physical and psychological reactions as they are confronted with the separation of family members, uncertainty regarding prognosis and recovery, unfamiliar surroundings and a potentially overwhelming financial burden. Recent studies suggest that with preventive strategies such as family-focused professional care and early intervention, the incidence of family dysfunction can be minimised.

The ongoing intensity and impact of the ICU environment strains families' coping abilities and causes feelings of disorganisation and anxiety. This often results in depression, impaired ability to cope with adjustments and inability to remain independent. It may also be transferred to the patient, increasing the patient's stress.[1] The incidence of family member stress is obvious throughout the critical illness trajectory,[2] and is highest at the time of admission, begins to plateau on day 6 and drops considerably by day 28.[3] ICU healthcare professionals must therefore include family members as recipients of care, not just the critically ill patient. Without adequate support, otherwise-healthy families might show stress through somatisation and negative affective and behavioural responses.[4]

The needs of critically ill patients and their family members have been studied extensively over the past 40 years. The most commonly cited needs are cognitive, emotional, social and practical.[5] Despite recognition of these needs, ICU healthcare professionals have not been consistent in their ability to meet them.[6] Research findings also reveal a pattern of healthcare professionals supporting (although inconsistently) family members' information needs better than their comfort needs.[7] Incongruence between family members' perceptions and those of healthcare professionals has also been documented.[8] Healthcare professionals tend to forget, delay or avoid interactions with family members in order to maintain their focus on technological care. Furthermore, healthcare professionals tend to see patient and family needs through their own lens, without an appreciation for cultural uniqueness and diversity,[9] further suggesting that healthcare professionals are lacking in cultural sensitivity and competence.

Studies also suggest that this inconsistent family support by healthcare professionals is attributable to lack of time and skill, paucity of multicultural research-based knowledge, difficulties in interacting with families as a result of fear of emotional involvement and perceived inadequacy of interactional skills.[6,9,10] Consequently, problems may develop, such as family needs being overlooked or relegated to the background, and interventions initiated that are not meaningful or beneficial to the family.

A preventive approach is vital to help families faced with this experience, in order to modify the stress created by critical illness. This will not only help them receive and comprehend information, but also to maintain an adequate level of functioning, use their coping skills more effectively and provide support for their loved ones.

In the current issue of *SAJCC*, de Beer *et al.*[11] report on a grounded theory qualitative inductive study developed in the context of family care. 'Empowerment' emerged as the central category, accompanied by four subcategories. These are 'information sharing', 'proximity', 'garnering resources' and 'cultural and religious co-operation'. A theory can identify important categories and subcategories that provide an extension of knowledge derived from research into the clinical practice setting. The authors state that this middle-range theory not only addresses the multicultural and diverse South African (SA) context, but will help ICU healthcare professionals to provide effective family care that addresses the delicate and unique needs of the families of ICU patients. In this study, empowerment describes the process of helping families to achieve an enhanced capacity to cope with the 'cognitive, emotional and physical ICU environment challenges' during a critical illness situation. Information refers to the exchange of necessary facts about the critical illness between healthcare professionals and family members, which allows family members to become more involved in the process of care for their family member. By gathering material and non-material resources, family members will achieve reassurance and the hope for themselves that everything possible is being done for their loved one. When healthcare professionals display a 'sense of awareness, respect and understanding of attitudes, values and beliefs of family members' during a critical illness, then cultural and religious co-operation can be achieved. Foundational to the delivery of family care is a partnership that develops between family members and ICU healthcare professionals that allows them to possibly make the ICU experience more manageable.

The authors acknowledge the limitation that the study was conducted in one central urban area in the KwaZulu-Natal Province region. However, this theory highlights the fact that family care requires a co-operative approach between healthcare professionals and family members characterised by partnership and trust, while also allowing it to be situated within our culturally diverse SA context. Future research is needed to test the theory in other public and private institutions in rural and urban provincial contexts. Further research should also encourage the development of a systematic multi-phased intervention programme set within the constructs of this family care theory, to enhance family involvement in care, and to develop evidence-based outcomes for family care.

Finally, we commend the authors for their sincere commitment and scholarly contribution to family care in ICU.

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