Open ICU
Family-Centered Approach
“not just for kids”

our journey for a shared care model

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Assistant Nurse Manager
Critical Care
July 9, 2010

The presenter at this session does not have disclosures
Objectives

- Describe what Patient Family Centered Care (PFCC) is and is not
- Identify the need & opportunities to improve the experience of ICU care for patients and families
- Develop clear patient-family centered improvement aims that are focused and shared
Seattle, Washington
Agenda

Before & After

Our Interdisciplinary- Collaborative Journey for Patient Family Centered Care

- Access
  - Physical
  - Information
  - Shared Decision Making
- Multidisciplinary Rounds
- RN shift report
- Family staying the night in the room
- Family Conferences
Perceived Barriers to liberal access

- Physiologic Stress for Patient*
- Barriers to Provision of Care*
- Exhaustion of Family and Friends*
- Exhaustion of Bedside Clinicians
- Patient Privacy
- Staff Safety
- Risk of malpractice allegations

*Berwick JAMA 2004;292:736-737
What I Want & What I Feel *

- Get to bedside, I want to stay at the bedside – please don’t send me away after 5 minutes
- Know that things are done after 2200 – "not just the night shift"
- Honesty
- Coordination between MD and RN
- How can I help?
- Greeted by somebody who is knowledgeable, cheerful, and can help me find out the info I need.
- Orientation to hospital – where is everything
- Lack of control
- Battling with grief
- Tired, Anger, Confusion
- Nervous of bad news
- Dealing with family dynamics – How can I deal with my family?
- Do I know what my loved one really wants? What are their wishes? Am I strong enough to do what s/he wants?
- Information and face time with the physician
- A plan
- No pain and suffering for my loved one – managed
- Emotional support for all involved
- Do and do not want any discussion about DNR.
- Consistent visitation. Please do not change from RN to RN.
- How is the info passed between care teams? Hand off?
- Family meetings
- Information needs to go through POA/spokesperson only – customized information based on patient’s wishes
- A welcoming care team – be happy and greet me
- Access to computer to allow communication with other family members – communication portal
- No further preventable problems.
- I want staff that I want.
- What’s the progress of the patient and how did we get here?
- When I’m not at the bedside will I be contacted immediately if there are changes?
- I want to be part of ICU rounds
- Results of labs and the physician to review with me
- Sense of confidence in the care team

*Healthcare Professionals surveyed from previous presentations
### 8. If I had a loved one in a CCU I want to have the option to stay in his/her room

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<tr>
<th>Response</th>
<th>Response Percent</th>
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<tbody>
<tr>
<td>only during strict visiting hours</td>
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<tr>
<td>most of the time except when I am told to leave at specified times such</td>
<td>30.0%</td>
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<td>as MD rounds, RN shift report, procedures and at the request of any</td>
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<td>clinician</td>
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<tr>
<td>at all times except for genuine privacy and safety concerns</td>
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Comments 10
WELCOME TO CCU
Access

Removal of Physical Barriers

Aim to “Open the CCU Doors”

Berlin Wall
Problems after implementation

- Family way finding difficulties
- Patient Privacy Concerns – real/perceived
- Challenges for RN staff to get work done
- Interruptions with many family members asking for condition update
If this is your first time at CCU, please check in at the Nurse Station.

Phones are disabled. Do not use.
If this is your first time in CCU please check in at the Nurse Station.

OUR UNIT IS COZY
PLEASE ONLY
THREE VISITORS
AT A TIME

Welcome
to
Critical Care
NORTH
Nurse Station

First time visitors, Go to the SOUTH Nurse Station

Patient Rooms
CCU 24 - 32

CCU 24
Attention

Please restrict cell phone usage to lobbies, the skybridge, and any outside areas.

EMERGENCY IN PROGRESS
PLEASE USE PHONES AND CALL FIRST
Welcome

Critical Care Unit: In this time of need, we include the patient’s family and friends to help us create a healing environment.

How you can help
To ensure patient privacy and safety:

- Identify a family spokesperson
- Follow proper hand hygiene
- No more than 2 visitors at a time
- No lingering in the hallways – Keep clear for patient safety and privacy
- No food allowed, covered beverages only
- If curtain or door is closed, 🚫 DO NOT ENTER Room. Please go to nurse station for assistance
- No cell phones in patient rooms or hallways
- For emergency assistance, please use bedside nurse call or go to the nearest nurse station
How did we communicate and engage the staff with the “change”?

• Clarify Aim: “We will open the doors”
• Staff work group involved in process change
• Communicated plans through email and huddles
• Requested feedback and “did we get it!!”
1. Now that the CCU has more liberal family presence the physiologic stress on my patients has

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<td>remained the same</td>
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Comments: 7

2. Now that the CCU has more liberal family presence the ability to get my work completed has

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<td>stayed the same</td>
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<td>decreased</td>
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Comments: 5

answered question 20
skipped question 0
3. Now that the CCU has more liberal family presence the fatigue and physiologic stress on the families has

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Comments 4

answered question 20
skipped question 0

4. Now that the CCU has more liberal family presence privacy for my patients has

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<td>75.0% 15</td>
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Comments 7

answered question 20
skipped question 0

5. Because of the "open door" policy my concern for my own safety has

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<td>decreased</td>
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Comments 4
What have we done to help staff adapt to family presence in the ICU?

Prepare staff to be “on stage”

- Standard family orientation with “Hospitality Bag”, “Get to know me sheet”, “FAST” (Condition H), CaringBridge©
- RN “scripts” to manage family flow and assure privacy
- RN support for the rare truly difficult family
  - Executive leadership
  - Local leaders
  - Assistant Nurse Manager/Charge Nurse
Get to know me...

I LIKE TO BE CALLED: ______________

OCCUPATION: ____________________

FAVORITES...

TV SHOW - ________________

MUSIC - ________________

SPORT - ________________

FOODS - ________________

FAMILY & FRIENDS - __________________________________________

____________________________________________________________

PETS - ______________________________________________________

ACTIVITIES / HOBBIES - ______________________________________

THINGS THAT STRESS ME OUT - ________________________________

THINGS THAT CHEER ME UP - _________________________________

OTHER THINGS I'D LIKE YOU TO KNOW ABOUT ME -

____________________________________________________________

AT HOME I USE:

[ ] GLASSES

[ ] DENTURES

[ ] HEARING AID

[ ] CONTACT LENSES

[ ] CANE/WALKER

[ ] OTHER - ______________

MY REGULAR SLEEP SCHEDULE IS _______ to _______
How important is liberal visitation to families?
Family presence during Multidisciplinary Rounds ??
# Rounding Appointments

**(CCU - Multidisciplinary)**

Date: ____________

<table>
<thead>
<tr>
<th>Bed</th>
<th>Last Name</th>
<th>VM or GH</th>
<th>NOC Admit (19:00-07:00)</th>
<th>Order</th>
<th>Appt Time</th>
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What have we done at Virginia Mason to have families present during MDR’s?

• Prepare rounding team to have families listen to dialogue

• “I’ve not taken care of him/her before. I have no idea what’s going on.” does NOT work well with families

• Standardize process with explicit roles for each team member

• Script for families to ascent to the process
<table>
<thead>
<tr>
<th>CCU RN Handoff Tool (used in patient room &amp; face to face)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary Rounds-RN presentation</td>
</tr>
<tr>
<td><em>(facts/data only as requested below and keep 2-3 minutes with no narrative please)</em></td>
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</table>

| 1. General description of patient:                     |
| Name/age/ day in CCU                                    |
| Diagnosis/Reason for being in the CCU                   |

<table>
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<tr>
<th>DAYS</th>
<th>NOCS</th>
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| 2. Significant events of the past 24 hours:            |
| Significant radiological tests, surgeries, procedures, |
| Addition to increased pressures, increased oxygen needs |
| Code/MET call                                           |

| 3. Vital signs:                                        |
| HR, BP, RR, Temp (hemodynamic #s if applicable)       |
| (including highest temperature in past 24 hrs.)       |
| Urine output:                                          |
| --last 24 hrs -- last shift -- last hour               |

| 4. Current Oxygen Status:                              |
| Include vent oxygen settings                           |
| (using vent order)?                                    |

| 5. Lines:                                              |
| --PICC/Central Line/Arterial Lines and if needed??    |

| 6. Drips:                                              |
| CHECK VESICANT INFUSION SITE                          |
| --pressure/infusion with current levels               |
| --gastroporal control                                 |
| --sedation with current levels                         |
| --antiantrhymics                                      |

| 7. Current Ramsay sedation level?                      |
| sedation vacation if no sedation infusion and if done  |
| delirious vs. agitated vs. in pain?                    |

| 8. Description of skin and surgical wounds:            |
| --at risk for pressure ulcers or hospital acquired?    |

| 9. Current Activity Level and goal for the day         |
| (on Progressive Activity Plan?                         |
| At risk for falls-risk assessment?                     |

| 10. Nutrition status                                   |
| --g tube feedings and at goal tolerating?              |
| --swallow oral needed for PO intake                    |

| 11. Specific other patient concerns/recommendation     |
| Please show discretion if family on rounds            |
| --where are we going with this patient?                |
| --family issues and concerns needed?                   |
| --consults needed (CNI, MSW, ET, PT/OT)?               |

| 12. Biggest safety risks?                             |
| --Catheter/Device Infections                          |
| --Pressure Ulcers                                     |
| --Fall Risk                                           |
| --Delirium                                            |
| --High Risk Meds                                      |
How important is being present for multidisciplinary rounds to families?
Family presence during RN shift report
Family members stay in the room overnight
What have we done at Virginia Mason to facilitate families’ presence during RN shift change report?

• Prepare staff to be “on stage” much more of the time.
• Standard handoff process is necessary before this should be tested
• Provide scripting to reduce interruptions
How important is being present for nursing shift report for families?
Improving and standardizing physician-led end of life family meetings

*a shared decision making process*
Room for improvement

*Studies show:*

- >20% of US patients now die in ICUs
- Patients and families are not satisfied with end-of-life care
- Communication is consistently identified as the most important and least accomplished factor
- Pain management, as reported by patients and their families, remains inadequate during the dying process
- Formal training in end-of-life skills for critical care physicians & nurses is rare

*Levy MD, Critical Care Med 2001*
Importance of Family Conferences in the ICU

- 50% of family members experience significant *anxiety & depression*

- Family member distress have been linked to *unsupported difficult decision-making* regarding end-of-life care

- Evidence supports *better family satisfaction* when formal family conferences are initiated early and continued throughout ICU stay

- Shared decision-making was described as “one in which *responsibility for decisions is shared* jointly by the treating physician and the patient’s family.”
“VALUE”

Following these principles in a protocol was associated with decreased anxiety, depression, and PTSD in family members 3 months after patient death:

• V-value family statements
• A-acknowledge family emotions
• L-listen to the family
• U-understand the patient as a person
• E-elicit family questions

Curtis & White. Chest 2008; 134;835-843
Formal Family Conference Standard Work

Yes

Team Members

1. Formal family conference = detailed conversation about prognosis and care plan, recommended within 72 hours of admission on complicated patients. (Simple updates do not prompt this standard work)
2. Schedule meeting in clean conference room
3. Ask family beforehand to write down all questions they want to cover in meeting

Invite the following to the meeting:
1. Surrogates, involved family
2. RN (absolutely essential)
3. CNL
4. Palliative care/Spiritual Care if consulted prior or needed for this conference
5. Attending physician and residents
6. Contact primary care provider and specialists for input to ensure team unity

Pre-Meeting Huddle
1. Discuss prognosis as a group, identify leader of RN (Role is in support of leader).
2. Conflicting opinions within the team are welcome, but they should be addressed before or after the meeting.
3. Reminders VALUE
   - Value family statements
   - Acknowledge emotion
   - Listen
   - Understand patient as a person
   - Elicit questions for the family

During
1. Reassure family that primary team coordinates all aspects of care and tell family you appreciate them as part of care team, acknowledging their stressors
2. Let the family set the agenda by asking them what questions they have, answering each one
3. Use silence and open-ended questions to learn about the patient as a person
4. Explain important aspects of patient's care that were not covered by answering family questions
5. "Patient's spiritual needs?" discuss palliative care, remind family that treatment of pain and suffering should coincide with curative care, consider consults to these services
6. Summarize goals of care, reassurance of non-abandonment

Post-Huddle
1. Review checklist and address unchecked items. CNL presents documents conference in "Advanced Care Planning" folder. If CNL absent, RN or MD (Dictation code "69")
2. RN stays with family in conference room to discuss the dying process if patient transitions to comfort care, using palliative care, CNL, and ANMs as needed for help in educating family members

Feedback On the back of the sheet, please add any useful feedback on the family conference or improvements to this checklist and place in "Completed Family Conferences" folder in ANM office.

Patient Label

Team Members Present:

Date: ______________________ Start Time: ______________
CCU Family Conference - date/time __________

Faculty/Staff/Family members present:

MDs: ____________________ ____________________ (go label)
________________________

CNL: ____________________ M. S.W: ______________
Palliative Care: __________ Chaplain: ____________
R.N. ____________________
Primary Decision Maker (DPOE) Relationship: ____________
Other family members attending/relationship: ____________

Does the patient have Advanced Directive? Yes/No/Other: ____________

Conference Summary
Topics Reviewed:

________________________________________

Diagnosis/Medical Condition:

________________________________________

Prognosis:

________________________________________

Goal:

________________________________________

Code status:
- Full Code
- DNR
- Modified Code:
- Palliative Care Consult
- Comfort Care orders

Family Perspective:
Understanding of info given was: good/fair/poor/other: ____________
Family statements/questions/concerns:

________________________________________

Next family conference: No/Yes: ____________ (date)
Recorder of conference: No/Yes: ____________ (date/time)
Patient Family Centered is ….. not just for kids

Open CCU = Open Doors (physical barriers)
Open CCU = Access to Information
Open CCU = Open to the patient’s goals related to quality of life
Open CCU = Shared Decision Making
“Excluding loved ones sends the signal that we must have secrets, why else would we exclude them?

What "right" do we have to demand that family leave a loved one if privacy and safety are not a real issue. However we do have the responsibility to make this process work for staff as well as families.”

Dr. Michael Westley
Medical Director of Critical Care
Virginia Mason Medical Center