

# A Taxonomy of Supports and Barriers to Family-Centered Adult Critical Care: A Qualitative Descriptive Study

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## Abstract

Family-centered care (FCC) improves the quality and safety of health care provision, reduces cost, and improves patient, family, and provider satisfaction. Despite several decades of advocacy, research, and evidence, there are still challenges in uptake and adoption of FCC practices in adult critical care. The objective of this study was to understand the supports and barriers to family-centered adult critical care (FcACC). A qualitative descriptive design was used to develop a taxonomy. Interviews and focus groups were conducted with 21 participants in Alberta, Canada, from 2013 to 2014. Analysis revealed two main domains of supports and barriers to FcACC: *PEOPLE* and *STRUCTURES*. These domains were further classified into concepts and subconcepts that captured all the reported data. Many factors at individual, group, and organizational levels influenced the enactment of FcACC. These included health care provider beliefs, influence of primary versus secondary tasks, perceptions of family work, nurses' emotional labor, and organizational culture.

## Keywords

critical care, family-centered care, patient and family engagement, family involvement, family nursing, professional-family relations, qualitative study

Family-centered care (FCC) has been defined as a philosophy of care that is “grounded in mutually beneficial partnerships among health care providers, patients, and family” (Institute for Patient- and Family-Centered Care [IPFCC], n.d., para 1). FCC, and its related term patient- and family-centered care (PFCC; Kuo et al., 2012), reflects a paradigm shift from considering patients and families as passive recipients of health care, to including them as active collaborators, with mutual power sharing (Park et al., 2018). More than 30 years of health care research has demonstrated that PFCC practices improve safety and quality, decrease costs, and increase patient, family, and provider satisfaction (IPFCC, 2017).

Specific to adult critical care, substantial evidence exists about the positive impacts of care practices that are family centered (Davidson & Hudson, 2020), for example, with family member presence during resuscitation (Afzali et al., 2020; Oczkowski et al., 2015; Rubin et al., 2020); participation in rounds (Cypress, 2012); and involvement in providing patient care (Hetland et al., 2018). There now exists a greater understanding of critical care family members (Kynoch et al., 2016; Vandall-Walker et al., 2007), their roles (Al-Mutair et al., 2014; Boyle, 2015), their needs (Davidson & Hudson, 2020), and the impact critical illness has on them. Indeed, the prevalence of

postintensive care syndrome in family members (Wolters et al., 2015) has reinforced the imperative that health care professionals (HCPs) support family members dealing with critical illness (Bailey et al., 2010). A recent systematic review (Goldfarb et al., 2017) and literature review for proposed practice guidelines for FCC in critical care (Davidson et al., 2017) underscored that outcomes of FCC practices are overwhelmingly positive, with few studies showing adverse effects.

Despite this growing body of evidence, communication with family and family-centered adult critical care (FcACC) has not been universally embraced and is often inconsistently adopted (Davidson & Hudson, 2020; Kleinpell et al., 2018; Vandall-Walker et al., 2007). For example, researchers have examined nurses' attitudes (McConnell & Moroney, 2015), HCP communication with family members (Schubart et al., 2015), and factors influencing family member involvement

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in care (Hetland et al., 2017). But few studies have focused on multidimensional factors that influence the adoption of FcACC (Mitchell et al., 2016).

Nursing practice is inclusive of the family (Canadian Nurses Association, 2015; International Council of Nurses, 2021), albeit at varying degrees according to the practice setting and the competencies of the nurse (International Family Nursing Association, 2015; Shajani & Snell, 2019; Wright & Leahey, 1990, 2013). As the most ubiquitous group of health care providers, nurses have the potential to significantly affect family member's health and their experience of the health care system. Furthermore, it is an expectation that nurses have competencies to support family members, to "enhance and support family health" (International Family Nursing Association, 2015, p. 1). The purpose of our study was to address the following research questions, from the perspective of registered nurses (RNs) working in critical care settings:

**Research Question 1:** What are the barriers to adopting FcACC practices?

**Research Question 2:** What are the supports that enable FcACC practices?

## Method

In this qualitative descriptive study (as described by Sandelowski, 2000, 2010), we examined data gathered through individual interviews and focus groups with critical care nurses. We decided on this approach because it is pragmatic (Neergaard et al., 2009) and fits well with the purpose of our study. Using this approach, we were able to explore and gain deeper insights (Neergaard et al. 2009) into the supports and barriers that nurses faced through semi-structured interviews and focus groups. Ethics approval was received from Athabasca University and University of Alberta (#12-71 & Pro00040707). Throughout this article, the terms "family" and "families" refers to family member(s) of critical care patients. Family was defined broadly as any two or more people who define themselves as family (IPFCC, n.d.).

## Participants

Invitations to participate were mailed out by the provincial nurses' association to 60 critical care RNs. In addition, invitational posters were emailed to critical care managers to share with staff. Further recruitment was achieved through word-of-mouth and snowball sampling. Participants were given the option of participating in an individual interview or a focus group, and requests were accommodated for their preferences. All attempts were made to conduct interviews and focus groups in person; however, due to weather and long distance travel constraints during winter months, three interviews were conducted by phone. An additional 36 participants had agreed to attend a focus group, but due to weather conditions were not able to attend.

## Data Collection

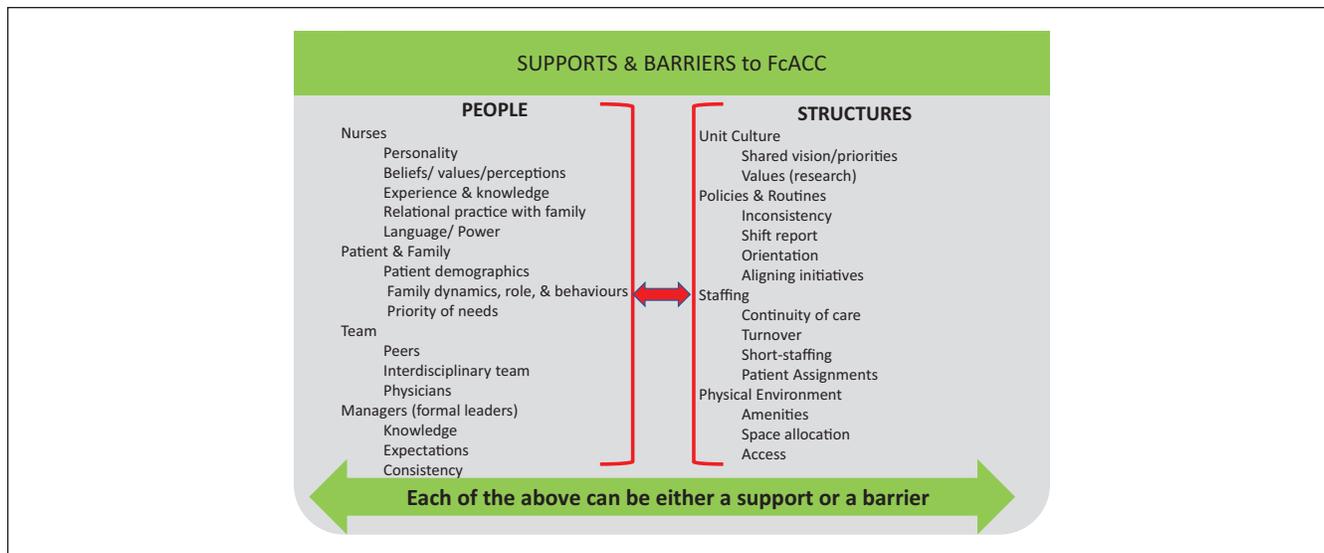
Written, informed consent was obtained from all participants prior to the start of data collection, after the purpose of the study was explained. Each participant received a copy of the study information and consent form. Interviews and focus groups were audio-recorded, transferred securely to and from a transcriptionist who anonymized the data. An interview guide was used (see Appendix), and while each interview covered the questions from the guide, additional information was also discussed when revealed by participants. Interviews followed natural conversational patterns, rather than rigid structure. The original interview guide developed for ethics board approval was generally followed for all the interviews. All four authors were involved in data collection, which took place over the phone, in the participants' home, or in a private area in the participants' workplaces, with only the interviewers and participants present. The first and second authors are experienced qualitative research interviewers and mentored the third and fourth authors regarding interview processes, which included attending the first interviews they conducted. Participants were interviewed once, with no follow-up interviews conducted. Interviews or focus groups lasted between 45 min and 2 hr. Participants did not receive copies of the transcripts to review or comment on.

## Data Analysis

All research team members reviewed each transcript to identify overlapping and unique concepts, using constant comparison techniques (Strauss & Corbin, 1998). Any field notes, made immediately after the interviews, were also discussed in team meetings. During the research team meetings, minutes were taken, and analysis decisions documented.

After the first two interviews, a coding structure was developed and modified based on new data. Initially we reviewed transcripts identifying what the nurses reported as supports, and what they reported as barriers. As the list of supports and barriers increased, we categorized similar topics and realized that one topic may be a support as well as a barrier (i.e., presence or absence of policy on visiting hours). To manage and organize the data, we began formatting as a taxonomy moving from detailed quotes, to topics/subconcepts/concepts that captured several similar ideas. Taxonomies allow for development of a common language that represents numerous components (Bradley et al., 2007) and "provide a foundation for the development of conceptual description and models, theories, or working hypotheses" (Sandelowski & Barroso, 2007, p. 200). We strived to stay close to the data, with limited theoretical interpretation (Sandelowski, 2000, 2010) and agreed on content and placement of data in the taxonomy.

Data (exemplary quotes) and codes were managed in Excel spreadsheets. Data collection ceased with theoretical saturation (Bradley et al., 2007)—when, upon reviewing the



**Figure 1.** Taxonomy of Supports and Barriers to FcACC.

transcripts generated thus far, and the ongoing analysis, we had collected a breadth of ideas supported by data and were gaining limited novel ideas in interviews. Once data collection was completed, the team deliberated and reached consensus on the final domains, concepts, and subconcepts that were further synthesized into a taxonomy format, presented in Figure 1.

The decision to organize the findings into two broad domains reflects the numerous deliberations among all research team members regarding the individual agency to enact FcACC versus the influence of external, environmental, or system factors on enactment of FcACC. We agreed that the final, two, broad domains would be called *PEOPLE* and *STRUCTURES*. While this decision did not intentionally reflect any explicit theory, it did likely reflect our previous abstract knowledge of the literature and personal experiences (Paley, 2017), and thus was further explored in the discussion.

**Findings**

A total of 21 people participated. Ten individual interviews were conducted, two focus groups with three participants, and one focus group with four participants. This included participation from 19 RNs, a family advisor,<sup>1</sup> and a respiratory therapist (RT) at seven different urban tertiary care facilities (*n* = 16), and two regional hospitals (*n* = 5). One participant of 60 responded through the mailed invitation; two participants responded to posters. The remaining were recruited through word-of-mouth and snowball sampling. Demographic information on the sample is presented in Table 1.

Two overarching, although related, domains—*PEOPLE* and *STRUCTURES*—were identified as underpinning the barriers and supports for FcACC practice (see Figure 1).

Within the *PEOPLE* domain, we identified concepts related to individuals and groups, and their relationships. The *STRUCTURE* domain included organizational factors that reflected larger system influences. Despite being presented as discrete, these domains and related concepts overlapped.

*People*

A range of individuals and groups positively or negatively influenced the practice of FcACC—patients, family members, HCPs and teams, and unit leaders. In addition, these *PEOPLE*, collectively or individually, had varying degrees of influence on the second domain, *STRUCTURES*

*Patient and family.* Participants suggested that patients and families influenced enactment of FcACC based on factors such as the patients’ age, admission diagnosis, acuity, length of stay, priority of care needs, family dynamics, beliefs, roles, and behaviors. Nurses noted that “who the patient is” to the family, often influenced how nurses interacted with family. For example, long-term admissions often resulted in staff getting to know relatives and children, encouraging children to be present and even play at the bedside.

I-7: She had just had her first baby . . . So, she had a husband and a baby and her Mom . . . and everyone just saw how traumatic an experience it was for this girl. Her Mom wanted to be there for her every step of the way. Her husband had to look after this young baby at home. So, I think they [the staff] just wanted to be very accommodating to her.

Some participants identified specific cultural beliefs which led them to be more flexible with the number of visitors allowed at a time, and to recognize the importance of certain rituals during crisis.

**Table 1.** Sample Characteristics.

Demographic variable	Sample, <i>n</i> = 21
Gender	Female: 17 Male: 4
Age	28–58 years old
Years of experience	1–4 years: 2 5–10 years: 10 11–15 years: 5 16–22 years: 3
Individual interview participants	10
Focus group (3) participants	11
Highest level of education	Diploma: 2 Bachelor's degree: 16 Master's degree: 3

FG2:2 I've been told they [Indigenous families] like to "keep the home fires burning," so they have to sit around and watch and make sure that the patient's okay. Often they're not coming in the room, they're staying in the waiting room . . . taking up our waiting room and [another unit's] waiting room.

Although most participants advocated for family involvement at the bedside, this was tempered by considerations of patient and family preferences, availability of family, challenging family dynamics, and legal restrictions. Some families did not want to be involved and some patients did not want family present. Participants also reported struggling to contact family members in some instances. Some family members got "riled up" and were not that helpful, but others were "God sends" in being able to help calm the patient. Some family members were perceived as abusive and difficult to work with, although participants interpreted this as often due to a lack of information or to previous nurses not setting boundaries with the family.

I-1: The family can be very trying . . . There have been families that swear at the nurses, threaten to sue, just go off on tirades about everything . . . making crazy accusation.

Finally, participants spoke of balancing meeting patient and family needs. While most stated that patient needs could usually be managed along with those of the family, the needs of the patient took precedence. Sometimes, participants had to balance the priorities of one family with those of another family, such as which family got access to the designated family lounge.

Although some participants agreed that families were helpful and could save time, others stated that they could also take more work and time—" . . . they'll call the nurse just to move the blanket" (I-1). It all depended on the intersecting contexts of the patient, family member, and nurse. Including family members in rounds saved physician's time, as scheduling family conferences was often not needed. "Then it doesn't add time to the doctor's day" (I-1). However, some

participants reported that rounds took more time if the family were present.

Some nurses suggested that having family present during busy times, such as during admissions or procedures, made it harder. Other nurses thought having family present provided them with an opportunity to collect more information and thus, know more about the patient than they would have otherwise.

I-3: It is hard to involve family when we are in the throes of resuscitation. Because honestly, we're trying to get tubes in and get people stable; trying to . . . answer questions for family is tough . . . I don't mind if they're there, but it's not a point in time when we can be teaching and explaining.

Overall, FcACC was considered easier when family members were helpful, and harder when they were not.

**Nurses.** Nurses' personalities, beliefs, values, experiences, knowledge, and relational practices influenced the enactment of FcACC. Participants reported that critical care tended to attract individuals with a certain type of personality, described as "a very controlled, methodical, well-organized individual, who sometimes doesn't enjoy when curve balls are thrown at them [by family]." There were several personal and contextual factors that influenced how individual nurses were able to engage with families. Some stated they needed to have enough maturity in their own life to relate to and appreciate another's feelings.

I-3: I would see it more as the nurse being confident, being content, and being a peaceful person . . . who has the emotional capacity to deal with the family . . . If they have stress at home, it's hard for them to give more . . . It's a different layer of giving of self. Some of these people [RNs] don't have it to give.

FG1-1: The old salty ones [RNs] that everyone says are scary, mean, old, totally Critical Care nurses . . . are firm with family . . . And honestly, more often than not, those are the ones who step up to the plate.

Some participants believed their job was to care for the patient AND the family, and so families should be involved from the beginning because they had a pivotal role to play in the patients' recovery. The more involved the family, the more informed their decisions. Several spoke of putting themselves in the patient or family member's place—considering how they would want to be treated (as a patient), and how they would want to be involved (as a family member).

I-5: There [are] two schools [of thought]: the family involved from the beginning, [or] not having to ever deal with families.

I-7: To have a successful recovery, I think the family plays a pivotal role . . . And I view the family as just part of the overall [who] deserves just as much of our attention.

There were varying reports of formal and informal education related to FcACC. Some participants had family nursing content in their preparatory BN programs; others had gone through in-services on the unit, while others had taken it upon themselves to learn more about FcACC. Those more experienced participants who recalled their undergraduate learning found it largely irrelevant because they were not taught by RNs with critical care experience with families. One participant emphasized the need for more hands-on practice and support for working with families because theory alone was inadequate without mentoring or role modeling in practice.

FG1-2: At [another hospital], they had a three-hour course on what family-centered care is, and we've had nothing here. [Instead], we've had [the direction], "So now we're letting the families in."

Several participants described novice critical care nurses as very task focused, less able to attend to families, even though they were more aware of FcACC because it was incorporated into their education programs. Others stated that once RNs had more experience, working with families became a rewarding challenge.

FG1-1: When you're new and you don't really know all the machines yourself, and you don't know all the protocols . . . you lose that ability to communicate because you're scared . . . As you get comfortable . . . you can focus more on the communication side of working with patients and their families

FG2-1: The newer nurses . . . I find they're better, more open to them [family] . . . because the issue right now is FCC. Even though I have 14, 15 years of experience . . . FCC was a foreign word when I started.

Participants stated that relational practices could either help or hinder FcACC; most agreed that it was not possible to have connections with all families all the time. Different nurses would make strong connections with different family members.

I-5: You'll see certain family members not want to leave the patient's side when certain nurses are working with them. And then, if you have a comfortable dynamic, they'll go home to sleep or have a shower . . . they feel comfortable [enough] to leave.

I-5: I find that families will find a nurse that they connect with. And then, although that might not be the nurse assigned that particular day, they'll seek them out to ask questions.

A notable finding was related to the use of language as evidence of underlying beliefs and exercise of power. Participants' frequent use of action phrases, such as "allow in" and "let in" and "kick out" in relation to family access to the bedside, spoke volumes of the power differentials and the exercise of that power, despite these same participants claiming to operate

from an FcACC lens. Numerous examples of this language are included in subsequent quotes included in this article.

**Team.** Most participants spoke about colleagues, physicians, and other members of the interdisciplinary team as FcACC influencers. For example, some nurses acted as role models or mentors of FcACC, while others provided examples of what *not* to do. The role of social workers chaplains, and unit clerks in supporting families was discussed. Social workers were perceived as being able to provide a level of support and information to family members but were not always available. Nurses appreciated when social workers completed a basic family assessment, such as a genogram or ecomap, to be included on the wall or in the chart. "Then in 30 seconds you knew who this patient's family was" (FG2-1). Similarly, spiritual care providers were perceived as instrumental to FcACC practice. Unit clerks were often the family's first point of contact and could "make it or break it" (FG3-1) for FcACC.

Participants expressed varying views of physicians' impact on FcACC, depending on whether physicians were available to answer family members' questions, involved family in rounds, and agreed to their presence during procedures and resuscitation. Physicians often provided the most continuity of care, which facilitated FcACC. Others stated that because nurses were at the bedside 24/7 as "the individuals always present" (I-10), taking care of the family was the nurses' role.

Some participants described how they would sometimes step in to help care for the family if a colleague was too busy with the patient, or when a designated role with the family was needed, for example, during resuscitation. In one focus group, participants agreed that having a designated family champion or colleague who could mentor other nurses would be helpful.

During the "monkey-gong show" (FG1-1) of admissions, many nurses reported keeping families out because they did not have time to answer questions or provide information. Other nurses found they could more quickly obtain needed information if family members were present during admission, as most patients were unresponsive. Some nurses had the perspective that "my job will be easier when it's easier for them [family]" (FG1-1).

**Managers.** As formal leaders in critical care, managers were also seen as being a barrier or support to FcACC, depending on their expectations and degree of flexibility. For instance, participants spoke of managers with master's degrees in family nursing who implemented family policies and education about FcACC for staff. Other managers "went too far" when the policies and expectations tolerated families being abusive toward staff. While some managers had very clear goals of family access within 10 min of admission, others supported nurses negotiating FcACC with each patient and family they encountered. Most participants reported that enacting FcACC

was a skill that was difficult for the manager to assess in terms of performance appraisals and job evaluation.

I-9: So, she doesn't always know what it's like to be at the bedside, so her expectations are unrealistic at times.

I-3: Our manager's amazing. She does rounds and chats to all the family and so they know . . . the process of what we're going to be doing in the ICU.

Clear expectations around FcACC could be an issue with frequent manager turnover, but this also meant that a new manager might be more supportive of nurses practicing FcACC, than was the previous manager. Most participants reported that FcACC was rarely assessed or evaluated in performance appraisals.

### Structures

A second domain labeled "STRUCTURES" captured those organizational and larger system factors that contributed to or prevented FcACC. These were generally contextual factors external to the control of the *PEOPLE* involved (families, nurses, teams, and managers), but that interacted with, influenced and were influenced by, factors in this domain.

**Unit culture.** The culture of critical care was reported to affect FcACC practices, as did the culture of specific units. Participants noted that it often took a group to maintain FcACC, as the "team needed to be on the same page" (FG2-2). Some participants had experience in neonatal or pediatric critical care areas, and reported that adult critical care had a different culture, where it was less clear how the family fits in.

FG3-3: It's about changing the culture of [adult] critical care that we need to move towards. It's a philosophy and a culture that gets embedded such that, when people are hired, they see the culture, they buy into it. It's easy and it makes sense. And it is around research and evidence-based practices.

Bringing about change would require consensus, a model or framework, support from leadership "high up," and managing change for physicians and nurses who have "a lot of say," and may be "stuck in their ways"; it would require an organizational culture that expects and supports FCC.

Several nurses reported that as a group, critical care nurses are used to reading research, and are open to discussing research and new ideas. They wanted to see FcACC practice explored more in research to better understand the impact, so as to provide the support needed for it to become an expectation: "Frame it under hard-core scientific [research] to get better buy-in" (I-3). One nurse stated, "we don't know the benefit, so we push them [family] to the periphery" (I-4).

I-5: Pull out the research and show the evidence for it [FcACC]. Because critical care minds tend to be more evidence-based

kinds of mind. They want to see proof, concrete information, values, numbers.

**Policies and routines.** Shift reporting, visiting policies, physician rounds, and unit orientation for family were the sub-concepts of the policy and routine in critical care. One aspect of policy that was frequently discussed, related to FcACC, was its inconsistent application. Some nurses believed that flexible rules allowed negotiation with each family to determine what would work, depending on patient and family needs. These nurses appreciated this autonomy. Other nurses found inconsistency frustrating—one nurse would allow only two family members in a room, and others allowed four or five. One nurse managed this variation by explaining to the family "this is how I play in the sandbox. In a few hours, it's going to be someone else's sandbox" (FG1-1); another suggested this variation was important "because my boundaries may be different from others' boundaries" (FG3-1). Families had reported that they were confused about how to proceed—for example, could they simply walk into the unit, or did they always have to call ahead? "Clarity and consistency in messaging to the family makes it simpler and easier" (I-3).

Shift report was another routine in critical care that could affect FcACC. Families were often discussed during shift report as difficult, and some nurses thought it important not to adopt the previous nurses' value judgments, instead wondering "what did we miss with this family?" (I-10).

FG1-3: I've been proven wrong too many times, so I just go in with a big smile on my face and introduce myself. The majority of the time it helps a lot: most of the time by the end of the shift they have turned around, they want you back.

FG1—1: The first time I meet a family—especially if I get report about, "So-and-so is difficult," or . . . you get the eye-roll—I go in and I introduce myself and I start out with, "I know you've been here for a bit, and I know . . . you're starting to get to know your way around the unit, but has anybody given you a tour of all of the things coming in and out of your family member, and what the monitor is?"

Some participants reported that their units had orientation information for families, which could include information on parking, food options, and visiting policies. It was useful when a social worker was available at admission to help the family navigate these kinds of things because "families don't want to look at a 15-page brochure" [FG2-2].

A final aspect of policy that influenced FcACC practice was how it was incorporated into other initiatives, such as palliative and end-of-life care in-services, updated delirium management policies, and rehabilitation programming. Including family in these initiatives seemed to be effective in promoting FcACC and were often hospital and province-wide programs.

**Staffing.** Nurses believed several aspects of staffing also affected FcACC, such as continuity of care, roles, scope of practice, short-staffing, and turnover. Being assigned the same patient over multiple shifts could potentially be a support or a barrier:

I-5: I think continuity [in staff assignment] provides the patient probably with a better level of care. Having said that, there's also the risk of becoming complacent as well . . . when you're with the same patient several days in a row, you get mentally bored . . . I think [for] the family . . . continuity certainly helps because they get comfortable with the nurse.

Some participants reported that having more than one shift with a patient and family was a rare, but important, occurrence. Others reported that in some challenging situations, even two shifts were difficult. With families that nurses found more challenging, they would work to engage with them and provide good care but were exhausted by the effort.

FG1-1: Sometimes it's like, I don't know if I can do this [for] 5 shifts in a row, even though they need the consistency. I've done my best all day, I can't do this tomorrow. It's emotionally exhausting.

Reasonable patient assignments were important. During transfers to other units, family members were needed to help with care and to smooth the transition and were thus more likely to be involved. Sometimes, nurses stated that when they were short-staffed, it was important to have family there because they needed family member assistance with providing care.

**Physical environment.** Participants described many aspects of the physical environment as being both barriers and supports to FcACC. Participants who worked in newly designed units reported the benefits.

These new rooms could fit 18 people!" (FG1-1). While in other spaces it was tough: "We haven't thought logistically 'how is this going to work for a loved one?'" (I-10). Some noted: "we have no room . . . Our unit is so full of people and stuff that it's a challenge" (I-3).

Often physical structures, such as large stop signs at the doors to the unit, locked doors, and requiring permission to enter, were barriers to FcACC. Nonetheless, these barriers were perceived as necessary for the safety of staff and other patients, infection control precautions, and respect for privacy and confidentiality of other patients. Sometimes, family members would need to leave the patient room when a procedure or assessment was being completed because of space constraints.

I-1: During rounds, they will kick all family out, just for the privacy of other patients . . . in the new unit it doesn't need to be [done] so much, but in the old unit, it totally did, because [with]

all six or seven patients in the hallway, you could hear about the one patient.

Despite these unit access and size limitations, they could be easily managed, and most participants reported open visitation policies, with few restrictions. In addition, other physical amenities were specifically designed to support families. Several nurses described large family waiting rooms, with kitchen areas, warm blankets, and even chairs at the bedside for family to sleep, as key amenities. Some units had lockers for families, computers for their use, and a place to shower. Individual patient rooms, rather than beds or pods with curtains, were also thought to support FcACC by providing privacy and space. Other tangible items that were viewed as a supportive to FcACC practices were providing journals for families to record their thoughts, and orientation binders/folders of information to read.

The relationship between the *PEOPLE* and *STRUCTURE* domains was expressed by one participant: "we can have the best strategy in the world, but if it doesn't mean anything to the patients and families, we've failed" (FG2-3). This reflects the idea that regardless of the unit culture, policies, staffing levels, or physical environment, FcACC practices still needed to be what an individual family found useful.

## Discussion

Our findings align with those of previous research that revealed that supports and barriers to implementing FCC have individual, group, and organizational components (Coats et al., 2018; Hetland et al., 2018; McAndrews et al., 2020). We did not find that our participants spoke extensively about ethical issues, burnout, and moral distress as impacting FcACC, although burnout in critical care nursing is certainly known (Jackson et al., 2018). These additional factors were included in McAndrews et al. (2020) literature review and model development for nurse-promoted engagement with families in intensive care units.

Nurses in our study reported that their individual beliefs were important for implementing FcACC, but they were limited by other factors such as unit culture, family, patient, environment, and resources; this is congruent with other findings (Hetland et al., 2018). These factors overlap and interact. For instance, McConnell and Moroney (2015) found fluctuating involvement of family members when FcACC practices were dependent on individual nurses' beliefs and attitudes, and not supported by unit or organizational policy or guidelines. This might account for some of the variability in practice, particularly in countries that report long-standing implementation of FCC (Kleinpell et al., 2018). The attribution of enabling factors to either individual or organizational factors seems to reflect a common dichotomy in explanations for human behavior (Baron et al., 2001)—specifically whether nurses have the personal agency to enact FcACC or whether external unit factors play a larger role.

Research on emotional labor may help to explain how the individual and the organization *both* contribute to create conditions that support FcACC. Lopez (2006) posited that organizations can create *opportunities* for relationships to emerge, but that does not mean being prescriptive in how employees engage with clients, but rather leaving these relationships to emerge at the individual level. This may explain why some nurses wanted autonomy to implement FcACC and so were comfortable with variability in care provision. Perhaps the context for developing relationships with families is set by the organization, but more authentic personal relationships develop between a specific family and a specific nurse.

The idea of primary versus secondary tasks in work captures a range of explanations of the barriers and supports reported by our participants. High-demand jobs generally require that workers focus their energy on the most “pressing, proximal, and urgent” activities (Dai et al., 2015, p. 846)—the primary tasks. Consequently, health care workers experience fatigue and diminishing self-regulatory resources when faced with multiple, competing goals. This affects performance of secondary tasks. Primary tasks in health care include disease diagnosis, patient assessment, and medication distribution (Dai et al., 2015). In a critical care environment, nurses face intensive daily demands, and a focus on these primary tasks could potentially drain self-regulatory resources, inducing physical and emotional fatigue, leaving nurses with less capacity to engage meaningfully to support families. Several participants alluded to these ideas of fatigue, work demands, and competing goals, as barriers to providing FcACC—particularly when staff new to critical care have a steep learning curve, focused on mastering many skills. FCC seemed to be considered by many to be a secondary task—A “nice to do” rather than a “need to do.” However, for some, the two levels of tasks were inseparable, indicating the need for further exploration of this theory as it relates to FcACC.

The intersection between the influence of the organization and individuals on enactment of FcACC needs further exploration. Undoubtedly organizational circumstances influence human behavior (Paley, 2014), but the beliefs of health care providers also influence how they relate to and engage with families (Bell, 2013; Thirsk et al., 2014). We questioned whether some of these beliefs, about the role of family members in FcACC, affected nurses’ experiences of work demands, emotional exhaustion, and draining self-regulatory resources, and thus their performance of secondary tasks related to families. Their beliefs about family could influence whether caring for families is viewed as a primary or secondary task. One such belief may be about the position of family in the hierarchy of the health care team. Are families seen to be valuable, proactive members with important *work* to do for the patient, family, and team, if given the chance (Vandall-Walker & Clark, 2011), or as needy, passive, or demanding recipients of care? These contrasting beliefs would lead to very different experiences of work for both the nurse and family. When nurses perceived family were engaged in critical work related to their loved one in critical care, there was a

leveling of the power differential (Vandall-Walker & Clark, 2011), and a more nonhierarchical relationship (Wright & Leahey, 2013). There is also a suggestion that burnout is mitigated by meaningful family-nurse engagement as partners (Mitchell et al., 2009), if one accepts that “partnerships result from power sharing and negotiation” (p. 149) as posited by Gallant et al. (2002). The nurses’ beliefs could be influenced by many factors, including personal values, unit culture, socialization into the profession, and education.

There is some evidence that families may also have a preference for the type of relationship that they have with health care providers, with a preferred way of engaging in decision-making which may or may not align with the collaborative, shared decision-making focus of FCC (Falke & Lawson, 2015). This speaks further to the necessity for FcACC strategies that match the preferences and needs of the family.

Some participants reported that family nursing or FcACC was included in their preparatory education or in orientation/in-service. Davidson et al. (2017) stated that although communication training for clinicians improved clinician-reported communication skills and comfort, only modest quality was found from third-party measures. Family-related outcomes were rarely measured or were inconclusive about improvement in clinician communication skills. While communication programs are recommended, further research is needed to determine what is effective (Davidson et al., 2017). The language used by some nurses—and the underlying beliefs and values that this language reflects—may indicate how nurses are socialized into the profession and into believing that FcACC is a valuable, important, and a necessary component of their role.

As previously noted, participants reported that continuity in patient assignments could be both a barrier and a support. They noted that it may be easier to develop and maintain relationships with the family over a longer time but that there is a risk of complacency. Others reported that the shorter length-of-stay of many patients did not support the development of relationships with families (McConnell & Moroney, 2015). One could extrapolate that lack of continuity would lead to the same issue. Recent guidelines provide no recommendations about consistency in staffing as promoting FcACC due to lack of evidence (Davidson et al., 2017).

Several nurses suggested that the culture of critical care supported an interest in research and incorporation of research into practice. In a recent systematic review (Goldfarb et al., 2017) and a clinical guideline document (Davidson et al., 2017), it was found that most research on FcACC practices presented limited evidence and were primarily descriptive or qualitative studies. The lack of quantitative results to confirm economic and organizational outcomes of FcACC in addition to outcomes for patients, families, and nurses may well be affecting the adoption of FcACC, particularly in a culture that expects research to inform practice. Kokorelias et al. (2019) emphasized that most FCC models were developed from pediatric populations and fail to acknowledge the added complexities of adult patient populations such as family conflict, confidentiality, and cognitive capacity. They

further conclude that more evaluative studies are needed, something that was also reported by our participants. Park et al. (2018) suggest that although patient and FCC is viewed as high-quality care, there are numerous definitions, scopes, populations, and interventions, which leads to lack of consistency. These factors—poorly defined and adapted FcACC models and a lack of evaluative research—may potentially be the most significant barrier.

Many of our participants offered insights into the practices that comprised FcACC. These included things such as providing information to family, getting information from family, allowing family access to the patient, and including the family in care, rounds, and resuscitation. It also included nonnursing activities such as presence of visitor lounges and interactions with other members of the health care team. Many of these activities align with the core concepts of PFCC, including promoting dignity and respect, sharing information with patient and families, encouraging patients and families to participate in care and decision-making, and collaborating in the delivery of care (IPFCC, n.d.).

Some of our participants reported taking family nursing courses in undergraduate education or having managers who completed family nursing education in their graduate education. Bell (2013) offered that family nursing can be distinguished from FCC as it includes therapeutic conversations, that arise out of relational practice between nurses and families, which focus on understanding the impact of illness and alleviating suffering. These types of nursing interventions were not as clearly reflected in our participant's descriptions, although admittedly they were also not the focus of the questions asked in the interviews. There has been recent research examining nurse-led interventions with families in critical care, using therapeutic conversations and focusing on family functioning as an outcome (Ahlberg et al., 2020). These might be considered family-as-unit-of-care interventions, whereas much of what our participants described could be considered family-as-context for nursing practice (Wright & Leahey, 1990). Vandall-Walker et al. (2007) and Vandall-Walker and Clark (2011) describe the “work” that family members do when a loved one is admitted to critical care. In their view, critical care is an environment where the patient will always be the focus for the nurse, and while nurses have a role to support family in the work that family members need to do, the motivation for the nurse and the family member remains on the well-being and needs of the patient.

### Limitations

Data for this study were collected several years ago. While recent literature reflects that our findings are still relevant and needed, it may be that there have been further shifts in nursing practice with families in critical care that is not reflected here. Given recent literature review (McAndrews et al., 2020) and clinical practice guidelines (Davidson et al., 2017) on the topic, however, we believe these findings remain a useful contribution.

While the constraints of weather and distance of travel resulted in a small sample, this was mitigated by the breadth and depth of the data collected. Two participants were not RNs. These individuals joined one of the focus groups, but the interviewer did not realize they were not nurses until the discussion was underway. The decision was made to include their data in the analysis, as they were useful, and affirmed a team decision that in the future, studies should include broader perspectives.

As with any descriptive approach, these findings may overlook certain perspectives because of the sampling techniques and voluntary nature of participation. Specifically, those people who chose to participate are likely interested in FcACC practice, whether they have positive or negative regard for it. Nevertheless, the primary goal was to use these perspectives to further explore explanations for why FcACC is not universally and consistently practiced. Secondly, we aimed to identify foci for future research to better clarify, understand, and test interventions to improve FcACC adoption in adult critical care.

The researchers' backgrounds and experiences influenced not only the topic of the study but also our own assumptions in the analysis. L.M.T. has clinical experience in family therapy and palliative care, and a research program on family nursing interventions, with primarily qualitative research; V.V.-W. has clinical experience in critical care areas and a research program in FCC, with primarily qualitative research; J.R. has clinical experience with adult populations in the intermediate level of care between critical care and acute care units and was mentored as a coinvestigator on this project; and K.K. has clinical experience in critical care and was working as a research assistant on this project.

### Implications for FcACC Practice and Research

While evidence-based FcACC practices are being widely recommended and adopted, understanding the potential barriers and supports to enactment are needed to help underpin these initiatives. Our taxonomy offers a comprehensive overview of many factors that may influence the implementation of FcACC practice, either positively or negatively. While the growing body of evidence in support of FcACC reinforces the recent development of practice guidelines, it is timely to consider the influences of *PEOPLE* and *STRUCTURES* on the enactment of FcACC. Upstream interventions, such as education, unit values clarification, and policy initiatives to support the enactment of FcACC are now called for. Researchers and clinicians should keep in mind that barriers and supports to FcACC are multi-leveled and include individual, group, and organizational factors. Interventions need to be more rigorously designed and evaluated, drawing from existing theoretical models (Moore et al., 2015), such as an organizational theory lens. Teaching and researching family nursing practices to support communication between nurses and family members in critical care would be a useful contribution to this area. For clinicians, there seems little reason to hold off on implementation of FcACC practices, and quality improvement projects should track key outcomes and

impacts and publish learnings for use in other settings. For educators, theory-based and practice-focused education programs with FcACC as a foundational thread should also involve tracking outcomes for students, nurses, patients, and families. For policy makers and administrators, evaluating the economic impacts of FcACC would be a significant contribution.

**Conclusion**

We know a lot about what nurses *could* be doing to provide FcACC—for example, providing information, allowing access and presence, involving family in care (Davidson & Hudson, 2020), and engaging with family members as partners in the provision of care. Based on our research, we extend this knowledge to include a broader understanding

of the factors that support these practices *to actually happen*. It is a beginning attempt to move from questions of “What should nurses be doing in their care of family members?” to “How do we support nurses to provide this care?.” The incorporation of organizational and management literature to better understand our findings provides a unique lens to frame our analysis and contribution. Specifically, further understanding emotional labor, how organizations support relationships between employees and clients, and how primary and secondary tasks are organized in nursing has significant implications for FcACC and family nursing practices in critical care environments, and elsewhere. Using frameworks and theories from other disciplines is imperative to understanding barriers and facilitators that affect nurses’ work (Wall, 2015).

**Appendix**

*Interview Guide*

**SAMPLE INTERVIEW/FOCUS GROUP QUESTIONS**

(The interview/focus group process will guide questioning. These are suggested questions for the researcher to consider.)

1. Please describe your understanding of family-centered adult critical care (FcACC)?
2. Why did you decide to respond to the call for participants?
3. Would you say you practice FcACC?

*and as appropriate . . .*

4. Why? Why Not?

Why?	Why NOT?
1. What helps you to provide FcACC?	1. What are your thoughts about FcACC?
2. Has there been a change in your provision of FcACC since you first began working in critical care? Why? or Why Not?	2. Has there been a change in your thinking about FcACC since you first began working in critical care? Why? or Why Not?
3. Did you learn anything about FcACC in your nursing program?	3. Did you learn anything about FcACC in your nursing program?
4. Do feel you have the autonomy to decide whether to provide FcACC?	4. Do feel you have the autonomy to decide whether to provide FcACC?
5. What strategies do you use to overcome barriers to FcACC?	5. What do you understand the family’s role to be?
6. What makes it difficult for you to provide FcACC?	6. Does your unit have open or flexible visitation?
7. Does your unit have open or flexible visitation?	
8. What do you understand the family’s role to be?	
9. Is how you enact FcACC assessed or commented on during your performance evaluation?	
10. Do you have any experiences with FcACC in other critical care units?	
11. What strategies do you use to overcome perceived barriers to FcACC?	
12. What strategies do you use to enhance supports for enacting FcACC?	
13. Is there an orientation program/pamphlet for families that is always covered and included in charting?	
14. Are there coffee and amenities readily available for family members in the waiting room?	

Note. FcACC = family-centered adult critical care.

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## Note

1. Attended a focus group based on word-of-mouth, as involved in family-centered adult critical care (FcACC) initiatives.

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