EDITORIAL

Patients' Family Satisfaction in Intensive Care Unit: A Leap Forward

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Keywords: Care quality, Communication, Critical care, Family, Family-centered critical care, Family communication, Family presence, Family satisfaction, Non-survivors, Satisfaction.

Indian Journal of Critical Care Medicine (2022): 10.5005/jp-journals-10071-24120

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How to cite this article: Garg SK. Patients' Family Satisfaction in Intensive Care Unit: A Leap Forward. Indian J Crit Care Med 2022;26(2):161–163.

Source of support: Nil

Conflict of interest: None

Patients' experience, opinion, and satisfaction are nowadays considered as one of the important quality indicators for providing high-quality healthcare service. While this applies to most of the admitted patients, the scenario is quite different for the patients admitted to the intensive care unit (ICU). Most patients in ICU are critically ill, and on account of their illness, they are not able to actively participate in decision-making regarding treatments and medical interventions or to evaluate the care process adequately. Family members and relatives play a decisive role in such situations. Additionally, family members' needs and wishes are foremost regarding both their roles as an advocate for the patients and their own needs. Many families experience the time spent in the ICU as taxing and full of uncertainty regarding the intensive care patient's condition, treatment, and prognosis.[1] Family members narrate the experience and the sight of the intensive care patient as well as the vicinity of the ICU bed, as scary and fictitious.[1] They want to be included in patient care and decision-making processes.[1] Studies reveal that there may be a fair chance among family members of depression and, posttraumatic stress disorder (PTSD) during ICU stay.[1] Families' satisfaction with the care provided to the patient during an ICU stay can be an important chunk of information used in overall ICU quality strengthening, ensuring that the care given meets both the patient's and the family's needs.[1] A recent study found that higher family satisfaction in the ICU was associated with several domains of better organizational/safety culture.[2] Therefore, the satisfaction levels of patients' family members and assessing key parameters affecting their opinion about patient care are critical in revamping the quality of healthcare services.

In recent years, the patients' perceptions of quality of care or satisfaction and the opinion of their family have been considered significant and used as one of several internationally recommended quality measures for intensive care medicine.[1] The growing understanding of patients' affairs and their families during the ICU stay has resulted in more research on family satisfaction.[1] Family satisfaction in the intensive care unit (FS-ICU) questionnaire is a well-authenticated method to evaluate family satisfaction in ICU.[2] However, efficient quality advancement initiatives in ICUs must be based on easily quantifiable and distinct workable parameters.[2] The usual method to judge family members' opinions is data collection through various survey questionnaires or personal dialogues.[3] Family members' satisfaction with healthcare services depends upon the various characteristics such as correct information about the goal and plan of treatments; appropriate communication and updates about the patient condition; financial load on family members; family members' expectations; knowledge and information about critical illnesses; and continuously evolving dynamic medical interventions according to patient's conditions.

In this issue of the Indian Journal of Critical Care Medicine, Fathallah et al. aimed to ascertain the satisfaction levels of family members of patients admitted to the ICU and factors modifying their satisfaction levels.[4] The prospective study was conducted in a single-center medical ICU over a period of 20 months. The study included adult family members or relatives of patients who were admitted to the ICU for more than 48 hours. The data were collected using telephonic interviews with family members and the satisfaction score level was assessed using a survey questionnaire developed by the author's institution based on references with FS-ICU questionnaires and Critical Care Family Needs Inventory. The survey questionnaires were based on 32 multiple choice questions and the total score ranges from 32 to 160, starting from being extremely dissatisfied to being fully satisfied. A total of 112 families participated in the study with a participation rate of 81% with most members being first-degree relatives. The median satisfaction score in this study was 133.5 with a minimum score of 86 and a maximum score of 156. Eighty percent of the participants judged the therapeutic judgment to be excellent and 61% gave excellent ratings to the nursing care. Twenty-two percent of family members complained about the lack of medical devices and treatment facilities. Various factors that negatively influenced family members' satisfaction levels include the need for hemodialysis, medical sequelae at the time of hospital discharge, and family members' education levels.

The result of the study is comparable to other studies assessing family satisfaction levels with the patients admitted

to the ICUs. In the present study, bed visits were not allowed in most cases and surprisingly it did not affect the family members' satisfaction levels compared to other similar studies. The communication with family members and the transfer of information were quite satisfactory. The researcher found that the use of noninvasive ventilation was associated with a higher level of family members' satisfaction, and they also found that the distribution of information brochures was reassuring to the family members. The author concluded that the family members of the patient admitted to their ICU were satisfied with their communication and therapeutic interventions.

Various psychometric assessment methods have shown that it is quite difficult to satisfy the expectation of family members of the patients admitted to the hospitals and it became more tedious with the patients admitted to the ICU with serious illnesses. This is because most of these patients are critically ill with multiple organ failures, have multiple systemic illnesses, and require multiple therapeutic medical interventions, which ultimately increases the treatment expenditure and their out-of-pocket expenses. Also, for those patients who succumb to their illness, despite all the extensive therapeutic management, it appears quite frustrating and futile to the distressed family members. Although literacy directly does not involve personal satisfaction level, it affects the free flow of information from caregivers to the patient relatives, as their understanding could be suboptimal. But the onus should be on the information provider to provide accurate and correct information to the family members in an easy-to-understand manner. The outcome of the patient and the total cost of the treatment may influence the family members' level of satisfaction with any healthcare service. Therefore, any mortality, morbidity, long-term disability, or interventions that increase the cost of the treatment may negatively affect family members' satisfaction levels. But these can be handled with proper communication and providing a realistic goal of treatment to the family members, matching with their expectations. On the contrary, Wall et al. showed that the families of the patients dying in the critical care unit were more satisfied with their ICU experience than those of ICU survivors.[5] Other researchers have shown that family satisfaction was independent of patient- or family-derived characteristics and patient survival status.[6] Depending on cultural and socioeconomic background, patients and their families have different perceptions about care and treatment and different feelings and demands from healthcare professionals.

The culture in the critical care unit is believed to be a notable attribute impacting family satisfaction. The facility of multidisciplinary family meetings improves family satisfaction in the medical critical care unit. These meetings might have motivated the medical personnel to emphasize the care of family members. In one study, "ICU waiting room environment" had the lowest score and was repeatedly described as a negative remark. Proactive policies such as communication intervention and palliative care improved family satisfaction, reduced the length of stay in the ICU, and increased the psychological quality of family members.

Schwarzkopf and colleagues united quantitative and qualitative research to examine family satisfaction in the ICU and thereby focus on scope for improvement.[7] A high satisfaction level of families does not mean that there is no room for improvement. Importantly, satisfaction with care is governed by expectations of that care.[2] A high score may therefore indicate low expectations, and rising expectations might reduce satisfaction. As there is growing awareness of patient- and family-centered care, satisfaction ratings may drop. Quantitative summaries of family satisfaction rating scales, even if relatively high, can be used to recognize means to further practice of care, establish benchmark comparisons, and decide whether changes are fruitful.[2] Several studies from various countries have highlighted the importance of using family satisfaction scores to identify likely areas to enhance care in ICU. These studies have revealed that decision-making directed toward the patient and their family, communication, respect, and concern were strongly associated with overall satisfaction.[2] The study by Schwarzkopf and colleagues contributes to this literature, identifying areas for improvement including consistency, clarity, and completeness of information; emotional support; and respect and compassion toward families.

Fewer studies have reported qualitative analyses of responses to open-ended questions, in which participants describe specific aspects of care that impacted their satisfaction and make recommendations for improvements. In Schwarzkopf's study, similar themes emerged from both quantitative and qualitative analyses. Integration of comments, positive and negative, with overall numeric patient satisfaction ratings provides context and an opportunity to target improvement efforts. Qualitative comments may have more face validity for physicians and may provide them with more actionable inputs for improvement than quantitative scores.[2] In one study, written responses were included for three open-ended items: Do you have any suggestions for improving care in the ICU? Do you have any comments on what ICU staff did well? Please add any comments or suggestions that you feel may help hospital staff.

There are several criticisms about assessing patient or family satisfaction as these surveys are based on subjective experiences. For example, patient or family feedback is not dependable because of a lack of formal medical training and could be confounded by elements that are not directly related to the quality process. Therefore, when carrying out a study on satisfaction and examining its data, the evaluator should be cautious about elucidating the results and making use of data.

The present study has a few limitations. It is a single-center study so the result of this study cannot be generalized. Moreover, the data were collected and assessed only quantitatively, so it may not reflect the entirely true picture. However, it was able to reproduce the comparable satisfaction score level among patients' family members, in patients admitted to the ICU. Complementing quantitative family satisfaction ratings with qualitative information may help better target improvement initiatives in the ICU. The use of an evidence-based structured communication algorithm may be a way to enhance families' fulfillment in intensive care patients with their participation in decision-making and their discernment of how well the multidisciplinary team works together. The execution of the family support coordinator involvement improved family satisfaction across a span of parameters. Although there were decreases in length of stay and costs, they were not statistically significant.[8] Further studies are required to understand whether intervention refinement could produce lower length of stay and costs. Attempts should be focused on upgrading factors that cause low family satisfaction when deciding quality improvement interventions for ICUs.

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