Staff Perception of a Family Communication Facilitator Intervention in the ICU: A Qualitative Study

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INTRODUCTION

Families of critically ill patients: Communication needs and challenges

More than 5000 Intensive Care Units (ICU) in the United States house the most critically ill patients of our health care system. These patients are often so sick they cannot make decisions for themselves. With little warning or preparation, family members become the surrogate decision makers in high stress situations and unfamiliar environments. These families face numerous challenges during their loved one's hospital stay. Communication issues with hospital staff rank high among those challenges [1], and family dissatisfaction has been associated with poor communication. [2] Levy and McBride's review of the quality of care in the ICU concludes that families want to be involved in decision making, yet communication with physicians remains a problem. [3] Families report that they often are unable to understand the information that is provided to them by their ICU physicians [4] and that it is difficult to arrange timely conferences or discussions with their physicians and other clinical staff. [5] [6] [7] In research with focus groups of ICU nurses assembled to discuss their attitudes toward communication with families, nurses articulated the need to establish trust with the families of ICU patients, but also felt that limited time and lack of knowledge about the families often stood in the way of establishing trust. [8] All of these barriers to communication may result in conflict between families and staff. In one study, 48% of families reported conflict with staff, and nearly half of families reporting conflict with the clinical staff in the ICU stated the conflict was due to communication issues. [9] By contrast, other studies have shown effective communication may establish common ground and shared understandings that reduce conflict and promote patient-centered, family focused care. [10] [11]

After a patient's discharge from the ICU, families are at risk for stress-related illness. Communication problems with hospital staff while the patient is in the hospital may contribute to these problems. A study in 2003 found a moderate to major risk of post-traumatic stress syndrome in 33% of the family members who were the main decision maker for their critically ill family member. [12] Fifty percent of family members of patients who died had posttraumatic stress reaction, as well as 28.9% of family members of surviving patients. [12] Rates were higher for those that thought the information they received was incomplete. [12] Siegel et al. found depression, anxiety, and panic disorders occurring commonly in next-of-kin of patients dying in the ICU. They noted that conflict with staff related to communication could be one predisposing factor. [13] Other studies have shown that increased communication with family produced higher family satisfaction and less stressful emotional outcomes for the family [14] [15] [16]. These data suggest that a need exists to find ways to improve communication with families of patients who are critically ill in ICU settings.

Clinician communication, collaboration and trust

One enhancement to communication includes the establishment of trust, not only between family and staff, but interprofessionally. Trust among colleagues is a key piece in the process of collaborative practice and effective sharing of important information. Other positive components to successful communication are staff that place a high value on communication with each other as well as families [17]; and interprofessional awareness of each other's roles. [18]

Collaborative teamwork in the ICU, i.e. where physicians, nurses and social workers work and share information with the aim of creating consensus and common goals, has been increasingly recognized as enhancing care for patients and facilitating communication with families in the

ICU [19]. Similarly, studies have shown that families and patients support the use of liaison roles to advance the delivery of palliative care [20].

Staff attitudes towards teamwork and communication are just as important for enhancing collaboration. Ewing et al. examined attitudes of staff towards a palliative care team in an acute care setting and concluded that additional work was needed to successfully integrate the palliative care team [21]. Pottie et al. examined physicians' perspectives, using focus groups and individual interviews, on the experience of integrating pharmacists into family practice teams. Twelve months post-integration, they found a general acceptance of the pharmacists despite the persistence of operational challenges including finding the time to understand the pharmacist's role. [22] Finally, additional qualitative and quantitative studies that have examined attitudes, interrelationships, and communication issues between ICU physicians and nurses reported issues of time and trust affecting communication. [1] [23] [7] [24] [25] [26] However, hospital health professionals' experiences and attitudes towards the addition of an additional team member to specifically facilitate communication between family and staff have not been addressed.

Family Communcation Study (FCS)

Improving communication between clinicians and families using a communication facilitator—an additional staff member trained in mediation and communication—is the subject of an ongoing clustered randomized trial, the Family Communications Study (FSC), at Harborview Medical Center. Harborview, a Level 1 trauma center in Seattle, Washington is a trauma and burn center serving a multi-state area. As a result, patients in the ICUs at Harborview are often the most critically ill of any hospital in the area, and families of these patients experience considerable stress. In the FCS study families of eligible patients too critically ill to make

decisions for themselves are randomly assigned to the intervention or to a "usual care" group. For families in the intervention group, facilitators provide communication support that includes initial interviews of the families to identify concerns, meetings with clinicians to communicate those concerns, attendance at family conferences and follow-up with the family as long as the patient remains in the ICU. [27]

Self-Efficacy Theory

The theoretical foundation of the FCS intervention is based on self-efficacy theory. [28] [29] [27] which has been used to guide interventions for changing a wide range of health [30] and clinical behaviors. [31] In this theory, the impetus for change resides in the individual's efficacy expectations, that is, his/her "confidence in his/her ability to take action and persist in action." [29] Although primarily an individual-specific construct, self-efficacy does not arise out of the individual alone, but develops in part from the interaction and experience of the individual with the environment (e.g. hospital, ICU). This paradigm for understanding behavior change has been applied to clinician behavior to explain the empirical data on clinical guideline implementation. [31] In this framework, aspects of efficacy expectations including familiarity, awareness, agreement, outcome expectancies, and motivation are associated with clinicians' willingness to adopt guidelines. These researchers also identified external supports related to environmental and organizational factors that facilitate the implementation of clinical guidelines. [31] Finally, the framework suggests that these efficacy expectations result in three components of measureable outcomes that influence change: knowledge, attitudes and behavior. [27]

The effectiveness of the FCS intervention will be evaluated by comparing the following family self-reported outcomes in the intervention group with the usual care group, assessed at 3 and 6

months after the ICU stay: 1) symptoms of anxiety, depression and PTSD; and 2) the quality of communication between clinicians and families. For patients dying in the ICU, families will complete an assessment of the patient's quality of dying and death. The validated measures used to measure these outcomes include: 1) anxiety- Generalized Anxiety Disorder Scale-7; 2) depression- Patient Health Questionnaire-9; 3) PTSD- the Post-Traumatic Stress Disorder Checklist Civilian Version; 3) quality of dying and death - the Quality of Dying and Death (QODD) questionnaire (QODD); and 4) the quality of communication – the Quality of Communication (QOC) questionnaire. Surveys sent to the families also allowed for comments about the intervention and up to this point, the comments about the facilitator which have been overwhelmingly positive. [27]

The FCS study recognizes that a key aspect of the success of their intervention is staff acceptance of the communication facilitators as useful and trustworthy parts of the clinical team. [27] Thus, a long term objective of the study is to demonstrate the feasibility of having a staff member who acts as a facilitator become a routine part of the clinical practice in the ICU setting.

This thesis describes themes uncovered through semi-structured interviews with physicians, nurses and social workers at Harborview Medical Center who were familiar with the FCS study and who could provide us with in-depth descriptions of their reactions to the facilitator intervention. We were interested in staff perceptions regarding the intervention's usefulness, it's contribution to improved communication with families and clinicians, and the potential role for an additional staff member that focuses solely on facilitating communication between families and staff.

METHODS

Design: In the context of an ongoing randomized trial of a communication facilitator intervention study, fourteen semi-structured qualitative interviews were conducted with ICU physicians, nurses, and social workers who had experience with the communication facilitator intervention to assess their awareness of, attitudes towards, and perspectives on the intervention and the role of the facilitator. The interviewer guide was developed by an interdisciplinary research team, which included a Masters of Public Health student, a social worker, two critical care physicians, and an educational psychologist. Questions were informed by, but not limited to, the self-efficacy theoretical framework on which the randomized trial was based. Some examples of the interview questions are: "How would you describe this intervention to a colleague?" and "How could this intervention be improved?" (see Appendix A) All study procedures were approved by the Human Subjects Division of the University of Washington and informed consent was obtained from all individuals. This thesis describes the findings from these staff interviews.

Participant Recruitment: The recruitment was purposive. Facilitators recommended nurses and physicians to be interviewed who had recently had a patient enrolled in the trial and with whom the facilitator had interacted. Facilitators were asked to identify a range of clinicians, including those with whom interactions had been positive and negative. After the facilitators identified potential participants, staff members were emailed a request for participation; then follow-up emails were sent to formally arrange an interview. All potential participants who were contacted agreed to an interview, and a time and place was arranged at their convenience. The four full-time social workers responsible for all four ICUs (Burn, Trauma, Medical/Surgical, and

Neurology) consented to an interview. The interview guide was approved by the Human Subjects Division of the University of Washington. All interviewees read and signed an informed consent form before the interview began.

Data Collection: We conducted the interviews using a semi-structured interview format that allowed us to explore the breadth of perceptions of the staff rather than imposing a set of likely responses a priori. [32] Initial questions were followed by open-ended probes that allowed the respondent to describe his/her experiences as they arose naturally in the interview.

The interviews were conducted by a Masters of Public Health student (AH). All participants were interviewed at Harborview Medical Center in a private setting. With one exception, all staff interviews were taped using digital recorders and transcribed verbatim. Because of equipment failure, hand notes only were taken for one interview. The interviews ranged from 20 to 45 minutes. Participants were identified in the interviews by their occupation and when they were interviewed—SW (social worker) 1-4, N (nurse) 1-5, and P (physician) 1-5.

Qualitative Analysis: We used methods based on grounded theory to analyze the data. [32] [33] One investigator (AH) read the interviews through several times to gain overall meanings and entered the data into a software program, Atlas-ti 6.2 [34] for storage, coding and analysis. The data were initially analyzed using "open coding"—breaking the data apart [33]—that was both descriptive and interpretative. As the interviews were coded line-by-line, we developed a coding scheme and codebook. These codes were then reviewed by the research team (n= 4) and reduced through consensus to codes that the team determined to be relevant and appropriate to the qualitative aims of the study. "Axial coding" that included linking the codes to each other, to circumstances and conditions was completed next by one investigator (AH) and reviewed by

another investigator (EN). Finally, interviews were summarized and recurring themes and commonalities of the staff's experience were identified across interviews. The final themes were reviewed and confirmed by members of the research team.

RESULTS

Participants

Participants were all employees of a Level 1 trauma center in the Pacific Northwest and worked in one of four intensive care units of the medical center. Four social workers, five nurses, and five physicians were interviewed. Participants reported a range of experience in intensive care from four to over forty years. Physician specialties included neurosurgery, internal medicine, and pulmonary and critical care medicine. Two of the physicians were women and three were men. All five nurses were female and worked only in the ICU. The social workers—three female and one male—provided services to patients and families receiving care both on the ICU units and acute care floors.

Themes

We identified the following themes: 1) Staff perception of the facilitator role as facilitating communication between family and staff; 2) Staff perception of the facilitator role as providing practical and emotional support for the family; 3) Staff perception of the facilitator role as providing practical support for the staff ; 4) Staff interest in expanding facilitators' roles and responsibilities

Staff perception of the facilitator role as facilitating communication between family and staff

As illustrated in Figure 1, participant interviews revealed that the staff experienced the facilitator as being a communication liaison. Facilitator communication involved three different parties: a professional staff person, the facilitator and the family member. The facilitator, working as a liaison between parties, was available to transmit information either from staff to family or from family to staff.

Figure 1 Facilitator as communication liaison between family and staff

Facilitator providing information from the family to the staff: Staff experienced the communication function of the facilitator as providing "case definition"—initial information about particular families' needs. For example, a facilitator met the family and identified a family need to the social worker before the social worker was even aware of the family's presence in the hospital:

> SW2: A family wanted … they wanted to be on a housing list and she didn't know how that worked, but she knew that social workers were involved. And she referred the family to me.
>
> Interviewer:…and you hadn't talked to the family yet?
>
> SW2: Right, I hadn't talked to the family yet. I hadn't had a chance to even talk to them.

They also saw the facilitator as someone able to provide on-going and follow-up information to the staff about the family as issues arose, not simply being responsible for creating an initial contact between staff and family. This physician had contact with the mother of a patient for many days and felt like she had a strong relationship with that family member, but the physician was made aware of a new issue by the facilitator:

> P5: The mom had a big issue about the patient being moved out of his room to a different room. And I think I got a heads up from [the facilitator] …that she was having adjustment problems with that. So that as helpful.
>
> Interviewer: Right, so you got…
>
> P5: So I knew before I got to the room.
>
> Interviewer: Right. Exactly.
>
> P5: I knew what the issues were.… So it was nice, because that's something I don't usually talk with families about even though I do know from some of the satisfaction work that the hospital does that that's definitely a red flag for families when patients move a lot.

In this conversation with a nurse, the nurse emphasizes the role of follow-up by the facilitator as an essential component.

> N4: And maybe check back with the family to make sure. Because sometimes I think the follow-up is really important. Because sometimes you think communication is going well and it's not.

In another interview, SW4 also states that

> SW4: …in the midst of whatever a family needs they [the facilitator] are very good at letting us know if there are any questions or there is something the patient needs immediately, getting the nursing staff or whatever that might be.

Facilitator providing or clarifying information from the staff to the family: Staff perception of the facilitator's role, or potential role, in providing communication from the staff to the family was often seen as helping clarify details of the hospital experience or, in a limited way, providing information on the medical status of the patient. A social worker stated that this was a significant contribution that the facilitator was able to make:

> SW2: having another person make sure the family members understand what's going on. That's probably the biggest piece of it.

Interviewees were more cautious about allowing the facilitators to relay or clarify medical information. In response to a discussion about who the facilitator might be, N2 stated that "as long as it's someone in the medical field. They can explain a little bit more." She would trust the facilitators "with simple things, but there are many things only the nurses and the doctors who have spent enough time with the patients and the family can help."

Interviewees noted that the facilitators provided a role model for improving their own communication skills. By observing the facilitators interact with families, N1 noted that she learned new ways to approach families.

> N1: Well, I am, on a personal level and professional level, I can always be better at communicating. So I love listening to other people give feedback and the way they go about asking questions. And talking…start with the small stuff. And pretty soon the deep stuff just comes. You don't even have to dig. It just starts to come…So I learned a lot about how to get that from the families.

Some staff members also noted that the presence of a communication facilitator helped them become, and stay, aware of the importance of communicating and supporting the family as well as creating an atmosphere of family-centered care. P1 states that "the study brings an awareness.

If somebody thinks this is interesting enough to ask a question about [family communication], maybe I ought to think about it" and that it becomes a "learning device."

Staff perception of the facilitator role as providing practical and emotional support for the family

In addition to enhancing communication between families and staff, the interviewees described the facilitator as providing emotional and practical support for families.

Figure 2 Facilitator as emotional and practical support person for family

In this support capacity, as illustrated by Figure 2, the facilitator directly supported family. They were not acting as liaison or conduits for the transmission of information between two parties, but were providing "assistance or comfort," what the staff generally termed as "help", directly to the family in a role independent from other staff.

N1 talks about families of critically ill patients who needed some extra emotional support.

> N1: It's really hard when you have everyone talk about what would be acceptable terms and you have one family member who says "I can't do this. I can't lose him. I can't live without him…And that's where I think the

> [facilitator] is helpful in just helping people talk through that.

Following-up and checking in with the family was also a way in which the facilitators provided important support to families even when no specific information was conveyed. A social worker explains:

> SW2: I just know one family where she's had a long…because the patient's been here for a very long time. And, I think it's always just helpful for any family to have somebody else that they connect with within the hospital, so, I think, in that respect, it's been very helpful.

Staff perception of the facilitator role as providing practical support for the staff

The interviewees described the facilitator as providing practical support for the staff.

Figure 3 Facilitator as support person for staff

This recognition of support was often talked about in terms of the broader issues of time, trust and confidence among colleagues, and the staff member's own role on the ICU team in relation to the families.

Time: Practical support was often described in terms of time. Staff described having "lack of time" and the facilitator "having the time" for certain tasks. Physicians recognized that they often did not have the time to sit down with families in order to better understand their

problems. Nurses frequently mentioned how busy they were and dealing with a family might not be a priority. When focusing on the facilitators, staff recognized how facilitators could relieve this burden of "lack of time" and were looked at as an added value, a resource that "had the time" to deal with families so staff could focus on the patients. As the nurse below articulated, the facilitator helped ease that burden.

> N3 And it's sometimes nice to have an extra person there because I am so busy with medical care, I don't have time always even if I wanted to, to sit down and just talk. Sometimes I can steal a few minutes, but it's always at the cost of time that I need to spend somewhere else.

N2 concurred that the facilitator "helps the family to calm them down, to answer some of the questions, detailed questions, details we cannot provide because we are way too busy."
The staff also mentioned by the facilitator could speed up or smooth out a process, "saving time" for the staff. Physicians mentioned that the facilitator saved them time by alerting them to family needs quickly. They did not have to search out the families. The facilitator had already done this.

Trust and confidence: Confidence in the facilitator's role as a support person—to do a job that would enhance the efficacy of the ICU team as a whole—was implicit in many of the interviews. Staff trusted the facilitators' opinion about the need for additional information between family and staff. They also trusted the usefulness of substantive information the facilitator brought to them about the family. More than one physician had confidence that they would find information about the families interesting or useful. P2 stated that "anything you can get is good", elaborating that the facilitator providing "some information and insights into family

dynamics or what particular family members are thinking about would be potentially useful." P4 had confidence in the facilitator to relay trustworthy information about how to approach families:

> P4: I think [it's very] helpful …if [the facilitator] is interacting with the family in a different way for us a get a sense of what the family's understanding of what they're telling them. To actually get a sense of what they're perceiving.

SW2 also implies that confidence in the facilitator's perceptions:

> SW2: I think that a lot of times we'll chat, and exchange pertinent information back and forth. Sometimes they are aware of some aspect of family dynamics that I may not have been aware of, to help me to know that information and be able to do a better job of working with the families.

Staff's own role: The interviewees often described the facilitator's role as complementing and supporting the staff person's role. N1 commented that she had other responsibilities in the ICU and that "it was reassuring to know that the family was being taken care of [by the facilitator]. A facilitator may add another dimension to the mostly medical role of the staff. P1 stated that s/he felt "support" when the facilitator was able to identify a need when the physician was not "always in a position to detect that [need]." P4 agrees:

> P4: And I think that the family may respond…maybe this is just me thinking…the family may respond, I mean maybe would respond differently to a physician versus another provider.

SW 3 supports the theme of the facilitator having a complementary role in relation to social workers.

> SW3: I mean, sometimes it works out when [the facilitator] is meeting with their family, because they are coming from a different point of view, they're not coming from the point of view of the social worker… So I feel like we might miss something… when [the family] meets [the facilitator] then they may not have that type of reaction to them and be able to open up more.

Staff interest in expanding facilitators' roles and responsibilities.

In response to semi-structured questions about ways to improve the facilitator's role as well as which families they could imagine benefitting from a communication facilitator, most interviewees mentioned a desire to expand both the support and communication functions to benefit both staff and families. Physicians, nurses, and social workers were interested in more consistent feedback from the facilitator about family state of mind or potential problem areas or misunderstandings. For example, one nurse talked about wanting more feedback than she had gotten from the facilitator to ease her own work.

> N3: [facilitator feedback] makes your job easier … but if I can improve communication, it makes it easier for me to do my job. So I would totally be open to more feedback, or insight.

Many interviewees were interested in the facilitator charting their interactions with the families so they could have an alternative way of finding out additional information if the staff did not personally meet with the facilitator. According to study protocols, the facilitator could not provide notes in the patient's medical record, so the team had no way of tracking the facilitator's findings unless the facilitator used another method to contact them. Other staff mentioned that, ideally, the facilitator would be present on ICU staff rounds.

Interviewees expressed interest in having the facilitators provide staff with support that included, but went beyond, communication. For example, they suggested having the facilitators provide practical support for the medical team, including making processes in the hospital smoother and

releasing the nurses from time constraints. One physician saw the facilitator potentially being responsible for coordinating communication and support actively for the medical team.

> P5: One thing I think that would be helpful is, to have someone paying attention to how often the family [is] sitting down in family care conference with a multi-disciplinary group. And I think investing in that as a role that a facilitator
>
> AH: Tracking how long it's been…?
>
> P5: Yep. And reminding the team that it's time to do that again. To have that be, and even organizing, setting up the meeting. Saying okay, it's time again. It's been a week. The patient's still in the ICU. Let's get the nephrologist and the cardiologist and the neurologist and the pulmonary team and social work and RT and let's all sit together and talk about what's happened this week. I think it would be helpful both in physically organizing that, but also just being that reminder that it's time again.

When asked about which families should have the benefit of a facilitator, interviewees also saw the potential for expanding the role of the facilitator to apply to families of other patients besides those critically ill. They thought that many other families could benefit from an extra staff person even if the patient was not critically ill:

> N4: Most [families] could use it. I think when you have some patients who have a burn, a stroke, respiratory arrest, cardiac arrest. [Patients] who have been fairly healthy and now are going through a major change in their life [and who are not necessarily critically ill]

Interviewees also thought that all types of families should be offered the benefit of the facilitator, not only those families that are perceived of as "difficult" or having problems.

> SW1: I think sometimes the team identifies someone as a problem family and they throw all these people at them, social work, and I think everyone should get those resources.

P1 concurs, stating that s/he is "concerned about the quiet people. They don't normally interfere but they are in a lot of pain."

Cautious attitudes toward the facilitator role and responsibilities: The facilitator role was not universally embraced by the interviewees. A small minority of interviewees expressed ambivalence towards some aspects of the facilitator role or were unenthusiastic about adding another staff person to the team.

A physician and a social worker indicated ambivalence about the need for a facilitator because they felt they already fulfilled the role. SW4 felt that adding a facilitator made "too many cooks in the kitchen" and expressed the hope that the nurses would call the social worker directly if there were any problems with families. The social worker felt confident that she knew how to deal with families, had the time to get the information she needed, and did not need additional communication input. S/he did not need additional support. S/he was concerned that there was no accountability for the facilitator's actions. P3 mentioned that the facilitator and s/he were in "parallel roles:" s/he "did some of that stuff" himself, and states that in his/her role as a consultant his/her "involvement with families is intense and ongoing".

Some interviewees perceived the facilitator as potentially overstepping their role. This staff was more comfortable envisioning the facilitator as a neutral conduit for transmitting the need for follow-up by other staff rather than acting as an advocate for the families. P2 stated that s/he was not entirely comfortable with the facilitators' communicating substantive medical information back to the families and indicated a lack of trust that the facilitators could do this objectively and in support of the medical team:

> P2: One concern I would have is I think people often develop their own opinions about what should happen in a particular situation and so someone, for example, may feel very strongly that this person is X number of years old, and so many co-morbid conditions, so why are we going to continue on, and that may very well be their opinion, but it may not be where the family stands or

> it may not be something that I was going to recommend. What could be really harmful is if in this facilitators' communications with the family, they were to start contradicting what the team was going to say.

SW3 felt that at times the facilitator expressing opinions to the family, especially at family meetings, was something s/he was not comfortable with because "it was more confusing" and "unsettling" to the family. At family meetings with the medical team, s/he felt that the family should have an opportunity to focus on what the physicians had to say and not be distracted by comments from others. SW3 went on to say that s/he felt family would be better served is the facilitator remained a neutral observer in a meeting with physicians, so "[the facilitator] could see things without taking part."

DISCUSSION

We explored physician, nurse, and social worker attitudes towards a communication intervention for families and clinicians in the ICU that involved a trained communication facilitator. Based on self-efficacy theory, we posited that a facilitator who provided timely and individualized communication to families would not only enhance outcomes for families but would also encourage and enhance family and clinician communication behaviors.

Our findings suggest that the intervention was generally well-received on the part of the clinicians, and the facilitator was seen as a resource for both staff and family. Interestingly, the type of professional interviewed did not matter—across the board, most nurses, physicians, and social workers viewed the facilitator as a means for providing improved communication with families. Staff from all professions expressed equal enthusiasm about the idea of a communication facilitator. From the perspective of self-efficacy theory, staff expectations about

better communication with and support for families were positively influenced by the presence of the trained facilitator. This finding is significant because other studies have shown that collaborative communication—communication between staff and families and intraprofessional communication—improves outcomes in end-of-life care as well as family and clinician satisfaction. [14]

However, it is also important to note that those who were reluctant to include a facilitator, that is, who were not confident in the positive benefits of an additional staff member dedicated to family communication, were not limited to one profession. This finding suggests that it may be individual characteristics, rather than professional training, that determine which individuals are reluctant to see the value in a facilitator. Resistance of the staff to utilize a facilitator could serve as a barrier to improved communication. [35]

Interviews also revealed that the staff viewed the facilitator as more than a conduit for information exchange between parties but as also playing a supportive role for families and staff. Because increased family satisfaction in the ICU and better health outcomes for the families may depend on more than efficient transfer of information, the facilitators' role in providing support may make a critical and important contribution. [36] Emotional and physical support, such as having a staff member available, listening to feelings, and helping with practical matters in the foreign atmosphere of the hospital may also contribute to decreased stress on families.

The interviews also support the idea suggested in other research that not only is collaboration important to enhance communication with and support of the family, but the team dynamic is also extremely important. [37] Interprofessional relationships can be complex, particularly in the environment of the ICU where staff experiences stressors that include includes emotional,

communication, and collaboration issues. [38] [39] [40] In these interviews, all ICU staff consistently mentioned concepts such as trust, time, and their own role when discussing the intervention and the facilitator. They were clearly cognizant about the interrelational aspects of their work.

Since different health care professionals (e.g., nurses, physicians, social workers) on the same team often look at the same phenomenon and interpret them differently [41] , the role of an additional professional may present challenges to interdisciplinary collaboration. Despite this potential barrier, the overall attitude of confidence in the facilitator that our participants reported was hopeful because it signaled a willingness to add a facilitator to the team of experts in the ICU. However, some staff were wary about the facilitator having a role in interpreting or clarifying medical information to the family. This may bring up an issue about whether the background of the communication facilitator should be a medical one, such as a nurse liaison, or whether a trusted non-medical person sufficiently trained in communication skills would be acceptable to the staff.

Other negative or neutral reactions also point to problem areas in collaboration. Concepts relating to successful teamwork, such as trust and the staff person's perception of their own role, also came up in the negative or neutral reactions to the facilitator. These reactions highlight the need to carefully educate current staff about the role of a new staff member in order to facilitate the buy-in of the current staff. Emphasizing the shared objectives of every member of the team and what each member brings to the team may help mediate those negative reactions. [42]

Limitations: Limitations of this study include the small number of staff interviewed and a potential sampling bias. The staff who were interviewed had the most contact with the

facilitators, and those staff tended to be the most positive. The study did not attempt to contact the staff that had no contact with the intervention or the communication facilitator. Their views on a new staff member or the relevance of family communication are unknown. A second limitation is that the staff indicated their openness to the intervention and the facilitator, but the interviews did not explore how often the staff actually acted on the information or truly used the facilitator for support. These interviews explored attitudes or self-reported experiences; actual behaviors were not observed. Finally, staff may have had reasons to be verbally more positive about the experience than they actually were. Observing the staff over time would be one way to overcome this limitation, but it is not in the scope of the FCS study that focused on family health and satisfaction outcomes.

Recommendations: Based on the interviews of the staff, the creation of a staff position that addresses communication and support for families in the ICU appears to be a promising avenue for enhancing collaborative communication and family-centered care. Staff saw the facilitator role as supporting the staff in the areas of communication and support to the family. However, care should be taken to facilitate buy-in of all staff. Though negative opinions were infrequently expressed in these interviews, more negative attitudes might be encountered by those who were not interviewed. Careful communication to staff about the facilitator role is recommended. This communication should emphasize the direct positive value of the presence of facilitator in terms of the staff as well as the families. Even if initial buy-in is present by current staff, facilitators should be fully integrated into the staff. Ideally, they should have the privilege of communication avenues available to the clinical staff—such as adding notes to the medical record and being present on staff rounds—to ensure the staff is continually aware of their presence, experiencing directly what the facilitator has to offer.

Families of critically ill patients face great challenges. A new staff role that focuses on these family challenges and at the same time enhances the work life of the staff has a great chance of success, a potential win-win situation.

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APPENDIX A: INTERVIEW GUIDE FOR STAFF

Start with some kind of prologue in which we identify a patient that the clinician has seen who received the "intervention" (i.e., either PACT or the facilitator in the adult ICU).

- Recently you worked with XX family who had a facilitator/PACT team member assigned to them as part of a study. (For Adult ICU – show picture of Patsy or Jessica or both) If you had a colleague who asked you, how would you describe this facilitator intervention with family X?

- How would you evaluate the helpfulness or non-helpfulness of the intervention?

    - Probe: Ask about the opposite (helpfulness or non-helpfulness) if they don't mention it.

    - Probe: If person discusses helpfulness to family, inquire about helpfulness to team, and vice versa.

    - Probe: Do you see differences between families who have received the intervention and those that haven't?

- Under what circumstances do you feel that an intervention like this should be initiated?

- How could this intervention be improved?

    - Probe: What do you think the main issues were in decision-making with this patient and family? Did the intervention address these?

    - Probe: What do you think the main issues were in communication with this patient and family? Did the intervention address these?

- This intervention is based on three components: a) improving communication about decision-making with family members and supporting family in the decision-making process; b) adapting our communication approaches to individual family member needs; c) and using the principles of mediation to help resolve conflicts that can occur in the

ICU. I'd like to ask you about each of these three components In what ways did the intervention help:

a) improve communication about decision-making with family members and support for the family in the decision-making process?

b) adapt your communication approaches to individual family member needs?

c) mediate any conflicts within the family, within the team, or between the team and the family?

APPENDIX B: CODEBOOK

THEMES CONCERNING STAFF KNOWLEDGE OF OR EXPERIENCE WITH FACILITATOR AND INTERVENTION

General awareness (That's what they do, right? I think that's what they do)

AWARE: Staff member indicates an awareness of the specifics of the intervention. Knows about facilitator roles and/or speaks to general knowledge about intervention. Mostly responses to the question "How would you describe this intervention to a colleague?" Positive awareness statements.

Example: "Basically, that they get involved with um critically ill folks up here and they help to make sure that they're getting all the information from the medical team and understanding what's going on with the patient."

Example: "It's just to help improve the way we communicate overall."

AWARENEG: Staff member indicates that they are not aware of aspects of the study. Negative words are used such as "don't" or "can't".

Example: "since I don't actually observe them interacting with people, I assume the families are getting what they need and it's a great concept but I'm not visibly there to watch them.

Example: "I can't recall whether that's been done or not. Because when I do this, other times I've been informed by the bedside nurses who experience this things directly"

Themes Concerning Attitudes/Experiences of Staff with the Facilitator intervention

1. COMMUNICATION:

COM is coded when the interviewee response concerns the experience of two or more parties and the transmission of information between parties; or the interviewee response concerns the theoretical need for information between two or more parties. Implicit in this code are the ideas of "transmission of information" and "two parties".

The code is then subdivided between staff and family: either the direction of the communication is towards the staff; or it is towards the family.

The code is also divided between an actual experience and general attitudes.

FAMCOMEXP is coded when the speaker explicitly talks about an experience with or knowledge of information from staff or facilitator being communicated to a family. The direction of the communication is towards the family.

EXAMPLE: I think it just really did take all of us just to talk and communicate with them.

In contrast, **FAMCOMATT** is coded when the speaker makes a general statement about his/her attitude or ideas about staff or facilitator communication with the families. How communication might affect the family. The word "hear" is related to communication or "express" or "communicate" or "understand."

Example: "Sometimes families are very easy to communicate with and others aren't, there's so much variability among patients and families."

Example: "Because it [communication] helps the family to calm them down, to answer some of the questions, detailed questions, details we cannot provide because we are way too busy."

STAFFCOMEXP: Staff member mentions communication between staff member and facilitator. Emphasis is the facilitator verbally bringing something to attention of the staff member. The direction of the communication is towards the staff.

EXAMPLE: "I saw this patient the morning of admission, and had given me the sense I had made an effective contact. But with the feedback I got, it needed follow through and that's how it was identified for me."

STAFFCOMATT: Statement about facilitator communication with staff or between staff. It is the speaker's attitude about staff communication with the family, but emphasis is not on what the family needs, but what the staff needs. How communication might affect the staff.

Example: "I think the more people there to help the doctors understand "you need to continue to have these conversations with the families" the better. (Though family is mentioned here, the emphasis is on the staff communication skills.)

Example: "having a sense of how to approach the family would be helpful."

2. **SUPPORT:** Support is another theme surrounding the facilitator's role. SUPP can overlap with COM, but SUPP is coded when the speaker mentions the facilitators performing other support functions besides active transmission of

information or the active transmission of the need for information. SUPP is defined as "giving assistance or comfort." It is less the idea of transmission of information from one party to another, but more the idea of providing direct assistance directly to one party. Or advocating for one party. For families, support could be sitting by the bedside and listening to a family talk. For staff, support could be helping articulate hospital rules to the family.

SUPP is also subdivided between staff and family; and experience and attitude.

FAMSUPPEXP Staff observation of family support by facilitator that is approving. Word "help". Or "support." Could be a more generalized statement that mentions other aspects of helping the family besides facilitating communication. A part of support is also advocacy, which is a less neutral stance.

EXAMPLE: They want their needs met and I think the facilitators are sometimes able to help identify some of those and send those out to resources that can deal with some of them.

EXAMPLE: "it's nice to have somebody that is not goal oriented to check in with the family and do those kind of things."

EXAMPLE OF AN ADVOCACY EXPERIENCE: "They're afraid of opening that communication. And I think that they, they talk with them so openly they make them realize that it's okay to ask questions. Communication is what we want here. And it's nothing for them to be afraid of, and nothing for them to think, oh should I do this or shouldn't I do this. So very much encourage. That we're doing this communication study and we want to, so they make them feel like more part of the whole group."
(In the example above, the nurse is talking about helping the families understand what they can do. S/he is talking about encouraging the act of communicating, not actually communicating anything at that point. I consider this advocacy.)

FAMSUPPEXPNEG: Staff observation of the facilitator providing family support that they do not approve of.

EXAMPLE: "When they come to a meeting, and everybody's there, family members, medical staff, myself, and um sometimes the research facilitators are there in the room as well, and they, a few times, they, became part of the meeting. And then began to talk with the families during the meeting, and offering, almost like facilitating during the meeting. And offering opinions and kindof directions, which, clearly, that's not their role."

FAMSUPPATT: A statement about the need (or not) for family support

Example: "I think they would benefit from it [the facilitation] too. I think everyone could benefit from additional support."'

STAFFSUPPATT: An attitude statement the facilitator and potential staff support, beyond communication issues.

Example: "They refused to follow our rules and regulations, They bring in children. You know, they, they just do not understand our policy. So, this is another situation when a trained staff could come in and take care of the family and explain the importance of no children, the importance of the sleep deprivations, why do we have quiet time, why is it important that we keep patients, minimum visitation."

STAFFSUPPEXP Staff indicates facilitator supported staff, helping them in some way. A general statement. The word "help."

EXAMPLE: **"**They're other cases I can think of where uhm the need for the communication was established by Jessica more than I was aware the need was there. So I think that was helpful."

EXAMPLE: "Well, it's helpful in the way that um by the fact that the family is in the research program that they will be able to remind the staff that maybe it's time to have another meeting. Or get together with the family."

STAFFSUPPEXPNEG: Staff indicates that the facilitator has not helped. Staff has had a negative experience with the facilitator or intervention.

EXAMPLE: "I have not seen them as a big help."

Themes Concerning General Attitudes of Staff about the Facilitator, Family, Other Staff, and the Organization (value statements)

VALUEFAC: Statement that indicates some value statement/judgment/description about the facilitator. Personal characteristics or skills.

EXAMPLE: "X had a really good rapport with the family."

EMPFAM: Staff member expresses empathy for specific family members or more generally for family situation in ICU. Staff member indicates an understanding of the family experience.

EXAMPLE: Most of the time providers have told families and patients what's happening but…

they can't hear it."

VALUEFAM Statement that indicates some value statement/judgment about the family. "They were very knowledgeable." Or a description of the family.

EXAMPLE: "Frequently their [the family's] concern for the patient is more manifested by personal needs.

VALUEORG Staff member makes a value statement referring explicitly or implicitly to the values of the organization

EXAMPLE: "Harborview has its issues. We're not perfect. [laughter] But I am pretty impressed with how they have pushed and I think have pushed and backed away a little bit and pushed and backed away a little bit."

VALUESTAFF Statement that indicates some value statement/judgment about the staff or a description of the staff.

EXAMPLE:" I don't think people listen as much as they should. In certain situations they don't do simple things like introducing themselves and getting introductions from the other family members. They don't set agendas for the meetings and a list of questions. There is a whole variety of things that people could do better."

Themes Concerning Abstract Concepts Relating to Facilitator Intervention

TEAM: Staff member acknowledges /disregards the idea of collaboration, of teamwork. Acknowledges/disregards the idea of interprofessional connection. Also, mentions another member of the team. Or problems with the team. Uses the word "we" when talking about a situation with a family.

EXAMPLE: "Several different people called me in on that case. One, I just happened to be there and the other was a surgical trauma resident. And then X. So I guess in a sense she did, call me back."

TIME Staff member comments about the use of time--either their own or the facilitators. Often indicated with the word "time."

EXAMPLE: "Because, as nurses, you know, you are too busy." [to always talk to the family.]

TRUST Staff member indicates trust or lack of trust of the facilitator. When staff member says that talking to or getting information from the facilitator would be helpful, with an example, or theorectically, this indicates trust. Or that they articulate positive things about the facilitator or the intervention.

EXAMPLE: "So I feel like we would miss something in there. Important. And then when they [facilitator] meet with somebody from study group then they may not have that type of reaction to them and be able to open up more."

EXAMPLE: N1: So I love listening to other people

Me: give feedback.

N1: Give feedback and the way they go about asking questions. And talking..

Me: So, even listening to them

N1: Yeah.

Me: Oh, that's cool.

N1: That, I've kindof learned a lot about, yeah, start with the small stuff

Me: Yeah, yeah.

N1: And pretty soon the deep stuff just comes. You don't even have to dig. It just starts to come.

Me: Oh, that's so interesting.

N1: So I learned a lot about how to get that from the families.

The study generally

IMPROVROLE: Staff member mentions an improvement for intervention . Could be something the facilitator is already doing, but they are not aware of it.

EXAMPLE: However, if they can be with us more available, they would be great facilitator to help us to coordinate the doctors, to give the family an earlier answer, an earlier report on the xrays.

WHOWHENINTERV: staff comments on for whom or when they think the intervention would be most useful.

EXAMPLE: “At what point, what type of families should you get involved with, It’s really, it’s more useful if you say you base it on the severity of the diagnosis, the condition the patient has, which is more challenging to the family. If there is a way we could provide them with more support, whether it’s with social work and other staff, it becomes very helpful. That’s the way.”

STUDYEFFECT: Staff member comments on the general effect of having a communication study.

EXAMPLE: P1: “I don’t know how that effects the study but does have an effect on my

Me: On your own behavior.

P1: It brings an awareness. If somebody thinks this is interesting enough to ask a question about, maybe I ought to think about it.”

Themes Concerning Staffs Own Behavior

STAFFROLE: Staff member describes own role.

EXAMPLE: “There are 50, 60 patients I try look in on.”

STAFFRELATFAM Staff comments on their relationship with a specific family or families in general. Not a value judgment.

EXAMPLE:“I rarely have issues with my families. They usually are okay with me but it’s challenging to keep those boundaries.”
EXAMPLE: “Because, in my mind, when I’m meeting with the families, I always have a goal.”

STAFFREFLECT: Staff reflects on self. An evaluative statement about performance. Or a reflection about their role or their place in an incident. They talk about what they do.

EXAMPLE: "I think I do okay."

EXAMPLE: “I tried to make it a therapeutic moment."

DESCRIPTIVE

INCIDENT Staff telling story about a particular family or incident. Mainly description. Or a description generally about what happens.

EXAMPLE: His parents really wanted to honor him and let let all of his friends and he was in his twenties and he had a gazillion friends, he'd grown up here, and it became where I realized his siblings hadn't come in in two days to see him.