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Family Meetings Made Simpler: A Toolkit for the ICU

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Abstract

Although a growing body of evidence has associated the ICU family meeting with important, favorable outcomes for critically ill patients, their families, and health care systems, these meetings often fail to occur in a timely, effective, and reliable way. In this article, we describe three specific tools that we have developed as prototypes to promote more successful implementation of family meetings in the ICU: 1) A Family Meeting Planner; 2) A Meeting Guide for Families; and 3) A Family Meeting Documentation Template. We describe the essential features of these tools and ways that they might be adapted to meet the local needs of individual ICUs and to maximize acceptability and use. We also discuss the role of such tools in structuring a performance improvement initiative. Just as simple tools have helped to reduce bloodstream infections, our hope is that the toolkit presented here will help critical care teams to meet the important communication needs of ICU families.

Keywords

intensive care; family meetings; communication; quality improvement

Introduction

The ICU family meeting is an essential forum for communication and decision-making about appropriate goals of care for critically ill patients, who typically lack capacity to participate and must rely on family members or other individuals to serve as patient surrogates.¹ In these meetings, clinicians can review the patient's condition, treatment, and prognosis and elicit patient values, goals, and preferences, as reported by the family. Beyond exchange of information, families value explicit acknowledgement of emotions, support for decisions, and reassurance that neither they nor the patient will be abandoned, even if life-prolonging treatments are withdrawn.¹ By participating in family meetings, interdisciplinary ICU teams offer a broader range of knowledge, perspectives, and resources to support emotionally-burdened families.

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A growing body of evidence has associated the ICU family meeting with important, favorable outcomes for patients, families, and health care systems.²⁻⁵ As demonstrated in a series of recent studies, a scheduled and structured approach to these meetings appears to be effective.^{2, 5} For example, implementation of family meetings within the first three ICU days for patients at highest risk for poor outcomes achieved significant reductions in ICU length of stay and conflict over care goals.⁵ At three month follow-up after an intervention that included proactive, protocol-guided, meetings and distribution of an informational leaflet, bereaved families of patients dying in the ICU had lower prevalence and severity of post-traumatic stress disorder, anxiety and depression, compared to controls.²

Though the evidence to support the benefits of family meetings is substantial, these meetings often fail to occur in a timely, effective, and reliable way. Over 90% of respondents to a national survey of ICU directors endorsed scheduled meetings of an interdisciplinary team with families of critically ill patients, but such meetings were conducted in 35% of respondents' ICUs.⁶ A "Care and Communication Bundle" of quality measures, which was developed for the Voluntary Hospital Association (VHA), Inc. "Transformation of the ICU" project, includes the documentation of a family meeting before ICU Day 6.^{7, 8} Before a quality improvement initiative, performance on this measure occurred for only 40% of patients in a geographically diverse group of 16 ICUs in community-based hospitals.⁷

Barriers to implementation include practical burdens such as time involved in scheduling, conducting, and documenting an ICU family meeting.⁹ In a recent report, we suggested strategies for overcoming some of these barriers.⁹ Here, we provide three specific tools as prototypes to promote more timely, reliable, and effective implementation of ICU family meetings: 1) A planner; 2) A guide for families; and 3) A documentation template. We describe the essential features of these tools and ways that they might be adapted and used to meet the local needs of individual ICUs. We also discuss the role of such tools in structuring and promoting a successful performance improvement initiative.

Description of the Toolkit

Tool #1: The Family Meeting Planner (Appendix A)

By definition, an interdisciplinary ICU family meeting involves multiple members of the clinical team. Families value participation by a senior physician, either the ICU attending, primary care physician or both, and the family meeting quality measure in the VHA "Care and Communication Bundle" requires this.^{7, 8} Another specialist may at times be an appropriate participant. If a nurse with knowledge of the patient and family is available, the nurse's presence is also important. Others who may make useful contributions include pastoral care representatives and social work professionals. On the family side, the patient's designated surrogate needs to be identified at the earliest opportunity and be present at the meeting. This individual will often be joined at a family meeting by others whom the patient or surrogate also considers important. The meeting thus becomes a complex organizational challenge, requiring identification and notification of the appropriate participants and coordination of multiple schedules.

Beyond assembly of the group, the ICU team needs to plan the content of the family meeting. It is important for the family to understand essential features of the critical illness, the condition of the patient at the time, intensive care treatments being provided or proposed, and expectations by the team for the patient's recovery. This may require preliminary discussions with various clinicians, particularly if they will not be present at the meeting, as well as gathering of other data. In addition, the meeting will permit clinicians to explore the expectations of family members and their knowledge of patient preferences. To prepare for discussion in these areas, the ICU team, prior to the family meeting, should investigate whether the patient has an advance directive or treatment preferences.

From the beginning of the patient's stay, the ICU team needs to provide the family with communication that meets their information and emotional needs. This may be difficult for a busy ICU in which throughput is increasingly prioritized, life-threatening episodes are routine, clinicians are often occupied with procedures, documentation and administration are burdensome, and families may be distanced by restrictive visiting policies. Nevertheless, the ICU must plan for formal communication with families, particularly for patients whose prognosis for survival or functional recovery is poor. One strategy to improve the efficiency and effectiveness of family meetings is to target specific, high-risk subgroups such as patients admitted from a skilled nursing facility or from another unit after a long hospital stay; those with global cerebral ischemia following cardiopulmonary resuscitation or with advanced malignancy; older adults with significant co-morbidities; those expected to need critical care for a protracted period; and those close to death or unlikely to recover.^{2, 4, 5, 10}

The Family Meeting Planner shown in Appendix A is intended to address these challenges. In a brief and straightforward format, this tool sets forth a sequence of activities commencing when the patient is admitted to the ICU and culminating in a documented family meeting no later than the fifth ICU day. (Another interval could be chosen for the meeting; Day 5 was selected for VHA's initiative through a process described elsewhere.⁷) Initially, the tool prompts the ICU to identify and focus on patients who are likely to require at least 5 days of critical care therapy. The next task is to identify the patient's medical decision-maker and additional family members or others who are closely involved. The ICU must also identify members of the clinical team who ideally should attend. Scheduling should then proceed without delay, to ensure that arrangements can be completed by the targeted day.

The Family Meeting Planner asks the care team to clarify the meeting goals and prepare an agenda. This process helps to ensure that clinicians leading the meeting are informed and organized in their approach, and to promote consensus within the team about the content of communication to the family. Although a separate tool is suggested below for organizing and documenting the discussion when the meeting occurs, the Family Meeting Planner includes prompts for these activities to serve as a reminder and record for the entire family meeting process. A key feature of this tool is the requirement that responsibility for each task be clearly assigned to a specific individual, whose name is entered as the assignment is made. The responsible individual documents completion of the task on the same tool as the process continues.

The Family Meeting Planner need not be included in the patient's medical record. It is envisioned as an administrative tool for internal use by the ICU team to trigger and track essential steps. In our experience with a range of ICUs, a successful strategy gives to nursing staff or social work the primary role in completing this tool. Nurses typically have the closest and most consistent contact with ICU families and ongoing opportunities not only to observe which family members and clinicians visit the bedside but to hear what is communicated and understand their needs. In general, nurses also welcome responsibility for promoting communication between families and the clinical team, which they value highly.

Tool #2: Guide for Families (Appendix B)

Disturbing evidence has emerged about the level of ICU family comprehension of even basic information about the patient's condition and care.^{11, 12} For example, half of families in a university-affiliated ICU with full-time intensivists could not answer correctly whether the patient's condition was grave (risk of hospital death) and could not select from a list either a single organ involved in the patient's illness or a single treatment the patient received in the ICU.¹² In our qualitative research, family members of patients in the ICU for 5 days or more described such a poor understanding of these issues that they found it nearly impossible to make informed decisions about treatments and care goals.¹³ Both qualitative and quantitative studies addressing patients requiring prolonged critical care treatment document that families lack information they need for decision-making about intensive care therapies.^{11, 14, 15}

Although the effectiveness of clinician communication influences family comprehension, the family itself also plays a role. Adult learning is optimized when the learner identifies goals and questions of importance in advance.¹⁶ This is likely to be true for "education" of the families of patients in the ICU, and advance preparation may be particularly important in their situation, which is complicated by emotional distress. Families burdened by anxiety, depression, and grief, typical in the ICU,^{17, 18} will have difficulty focusing on, listening to, and understanding what is said in an emotionally-charged meeting. They may also forget or feel reluctant to raise their own concerns. In addition, in the absence of deliberate investigation prior to the ICU meeting, the family may fail to gather all available information about values, goals, and preferences expressed by the patient previously. Yet this information is needed to ensure that the patient's goals and values guide the discussion and ultimate decisions.

Preparation of the family can also help to maximize the efficiency of a family meeting. These meetings are often lengthy and emotionally difficult for clinicians, creating a disincentive for busy practitioners to conduct them and potentially diverting attention from essential aspects of patient care and unit administration. Without a clear agenda, the conversation is more likely to wander, while the family fails to comprehend or convey important information and the purposes of the meeting are never achieved. The Family Meeting Planner (Appendix A) prompts the ICU team to establish a meeting agenda and prepare appropriately. But the family has its own agenda that will also need to be integrated, along with information about the patient that only the family may be able to provide. In

addition, most families know little if anything about what to expect from an ICU meeting. Tasking them with preparatory activities can help to educate families as well as to structure the meeting and narrow its focus on those topics most important to them, thereby increasing the chances that these concerns will be addressed.

The *Guide for Families* included as Appendix B is designed to assist families in preparing for a meeting with clinicians in the ICU. It begins with a brief description of the nature and purpose of such a meeting. The tool then suggests that the family advise the ICU team of which family members and which members of the clinical team should ideally be present, listing not only the doctor and nurse but also social worker and chaplain, who may serve as important additional resources for family support and guidance. Next, the Guide gives a checklist of important categories of information about the patient's illness and treatments, so family members can review what they know (and don't know) and be ready to report, verify, complete and update this information at the meeting. The Guide goes on to focus on family concerns and feelings, which physicians may often miss opportunities to address, and which families may even hesitate to share, although evidence suggests that family satisfaction is enhanced when they contribute a larger proportion of what is said at the ICU meeting and when their emotions are acknowledged.¹ Families are asked to write down "concerns, worries, fears or other feelings" as a way of encouraging them to make these more explicit, thus enhancing the likelihood that clinicians will address them when the meeting occurs and that families will feel they actively participated in decisions about the patient's care.

This tool also asks families to gather relevant documents, such as a health care proxy appointment or living will, which the patient may have previously prepared, or in some cases may now have capacity to revise or prepare for the first time. Besides writings, families are tasked to recall oral statements by the patient about treatment preferences. In these ways, the tool directs attention to the patient's wishes, which both the family and the ICU will need to respect. The Guide asks families to specify goals for the ICU meeting, so that the meeting can be structured to serve the interests of the family as well as those of the patient and the team, the family will be more fully engaged in the exchange of information, and the success of the meeting in relation to goals can be evaluated. Specific benchmarks for the family are provided at the end of the tool, which lists essential elements of a successful ICU meeting and encourages follow-up to address remaining questions and concerns.

Tool #3: Family Meeting Documentation Template (Appendix C)

The third tool we provide is a template for documenting the family meeting in the medical record (Appendix C). Such documentation serves several important purposes. First, the medical record is the central venue for communication among clinicians across the range of disciplines and specialties that are involved in caring for a critically ill patient. For those not participating in the meeting, the note conveys important information about who was present and what was said. The note records what the family has reported about the patient's preferences for intensive therapies and, perhaps most importantly, documents the overall goals of care as established at the meeting after integration of the medical information, perspectives of patient and family, and recommendations of the ICU team. It also offers an opportunity to review and improve performance.

In the format we have suggested, the meeting template can also serve as a framework for the discussion itself, reminding clinicians to cover essential elements including the patient's condition, treatments, and prognosis as well as the needs and preferences of the patient and family. Discussion of these elements provides the foundation on which realistic and appropriate care goals can be established. Thus, the clinician leading the meeting may bring the template and refer to it, although it would likely be distracting for all present if the clinician actually writes the note at the same time. The template will prompt not only communication of information by the ICU team but also queries to elicit information and concerns from the family. This note also addresses the family's understanding of what has been discussed, which is important to review explicitly when the meeting is to conclude.

The meeting note also provides a basis for reimbursement of physicians for this important professional service. According to current guidelines from the Center for Medicare and Medicaid Services, time spent communicating with family members can be billed under Current Procedural Terminology (CPT) codes for critical care (99291, 99292) if the patient is unable to participate in decisions about treatment and the family meeting is directly relevant to patient care or medical decision-making for that day. The meeting note can establish these elements and the duration of the discussion, which will contribute to total time for critical care services – measured initially as any amount from 30 to 74 minutes, and beyond by additional 30-minute increments. Although it is hoped that in the future, time spent providing emotional support to an ICU family will also support a claim for critical care reimbursement, this is not yet the case. Until then, reference to such support is included in the template as a reminder for clinicians, but is specifically excluded from tabulation of the time involved in a family meeting.

The template shown in Appendix C is adaptable for a paper or an electronic medical record and we have successfully introduced documentation based on this template in several ICUs. As discussed further below, adaptations for this as well as for other purposes will almost invariably be required to suit local needs and circumstances. In addition, since the family meeting note will become part of the medical record, it will need to be processed through and approved by the appropriate hospital regulatory bodies and to resemble other forms in routine use for related purposes.

Discussion

The quality of care provided to patients and families in ICUs, as elsewhere, depends not only on discovery of new scientific information but also on timely and reliable translation of this knowledge into practice. Strategies to ensure that patients receive recommended therapies include standardizing work processes and using checklists for critical steps.^{19–21} For example, these approaches have been used to optimize practice across a wide range of areas from reduction of catheter-related bloodstream infection to management of sepsis to prevention of ventilator-associated pneumonia.²⁰ ICU teams are turning increasingly to tools such as checklists, other simple forms, and streamlined protocols to promote application of existing evidence in clinical care and consistent adherence to standards.^{19–24} A series of well-conducted studies establishes the value of a scheduled and structured approach to the ICU family meeting.^{2, 5} The three tools presented in this article are intended to facilitate

clinical translation of this important research in the care of all critically ill patients and their families.

Tools used to increase the use of evidence-based therapies can also help improve the efficiency and effectiveness of communications. Although communication with families may involve more complexity, affect, and abstraction than other ICU activities such as inserting a central venous catheter, we believe that simple organizational strategies are still applicable and can contribute to improving the quality of care. Tools of the type we describe here have been used successfully to optimize communication among ICU clinicians about daily goals²⁴ and among multidisciplinary members of operating room (OR) teams about a range of topics related to patient safety.²³ Implementation of a Daily Goals Form²⁴ significantly enhances ICU team members' understanding of goals and reduces length of ICU stay. An OR Briefing Tool is helpful in mitigating risk from miscommunication.²³ For ICU family meetings, which typically take place in an emotionally-charged context, it may well be that a simple and straightforward approach, such as that reflected in the suggested tools, is most effective in facilitating and structuring communication. The tools are not a substitute for training of physicians in skills for communicating with families, which is indispensable, albeit challenging and time-consuming. Rather, the tools are practical aids, focusing attention on necessary tasks, reminding clinicians about the key components for task completion, and recording performance so that it may be monitored and used for administrative purposes and constructive feedback.

The tools we provide are prototypes and we encourage ICU leaders to modify them to fit their setting and resources. To be fully accepted and used, tools such as these must be valid, but they must also be part of a culture of safety that supports interdisciplinary teamwork, and clinicians should receive education and feedback about the benefits of the approach. Each institution, and even each individual ICU within a single institution, is its own "microenvironment," with circumstances, patterns, personnel, resources, and a culture that is unique. Thus, the expectation is that each of the suggested tools will require local adaptation. In fact, the process of adapting a tool is often essential for the tool's integration into clinical routines, since it is this process that initiates engagement of key clinicians.^{19, 21} The effectiveness of a checklist or similar practical tool in guiding behavior toward best practice is dependent on the commitment of clinicians to use the tool.²¹ Involvement of these users in development and refinement of workable tools is an important first step and should include members of all disciplines on the ICU team. Each tool should also be piloted to confirm its usability or identify ways it must be modified; piloting of the Family Meeting Planner may also be helpful in deciding where this tool should be located, since it will not be part of the medical record. With these prototypes, however, we hope ICUs will not need to start from scratch and therefore will find it faster and easier to proceed. Large translational initiatives in diverse areas of ICU practice, such as the VHA, Inc. Transformation of the ICU project⁷ and the Veterans' Integrated Service Network 3 ICU Palliative Care Initiative, have benefited from the availability of prototypical instruments such as these, which were then adapted as needed by individual ICUs. We hope to stimulate an ongoing process in which improved tools are shared through central venues across the critical care community.

ICUs need to remain focused on feasibility, perhaps the most important feature of any clinical tool and one that is especially important in the ICU, where time is short, the clinical team includes multiple members, the patient care workload is often excessive, and voluminous data and paperwork may be overwhelming. Thus, brevity and clarity should carry more weight in tool design and evaluation than comprehensiveness or extreme precision. Tools for the ICU should be simple, unambiguous and helpful to families and clinicians. Decisions about formatting and content will need to take these factors into account to maximize use of the tools, clinician satisfaction with use, and efficacy in achieving the intended purposes. For each item that is considered for inclusion, the question must be asked, does the value of this item justify the time that will be required to include it and to implement the activity it describes? Do delays or omissions or errors commonly occur in this step in the process? Other essential questions will be: Is the tool easy to read and follow? Is it clear regarding who needs to do what, when and how? Is the sequence it sets forth or seeks to document logical? Is the general format familiar to users? If the answers seem affirmative initially but the tool performs poorly or is underutilized in a pilot initiative, it will be important to understand the problems and barriers and revise accordingly until acceptance and implementation are maximized.

Streamlining of tools such as these will serve another important purpose. A tool that is too inclusive and detailed can engender resistance from physicians, who may perceive it as a restriction on their freedom to exercise clinical judgment on a case-by-case basis.²¹ Although physicians increasingly embrace the efficiency of templates for medical record documentation, they also value a flexible format that can accommodate their own approach and the circumstances of specific cases. Thus, we have sought to limit content to checkpoints of major importance to families that are commonly omitted, while preserving opportunities for clinicians to make individual adjustments and judgments. For example, the Family Meeting Documentation Template includes checkboxes for key topics but also allows for free text entries and for physicians to document reasons why specific topics were not discussed.

For the Family Guide, the ICU will want to determine whether the tool is clear and comprehensible to the target audience – families who visit that ICU. Issues presented in the ICU are complex, terminology is often foreign, and families come from a variety of educational and cultural backgrounds. It is important to ensure that a family-directed tool is accessible to persons with low health literacy, which occurs even among those who are well-educated, and is sensitive to cultural concerns.^{25, 26} In many hospitals, specialists in patient education are available to assist in this process. In our own ICUs, we provide a glossary of common ICU terms and devices as part of a basic informational brochure that is distributed to all families on the first visit to the unit.²⁷ This type of glossary could also be given with the Family Meeting Guide.

Finally, ICU leaders will want to pilot test all tools and monitor for unintended consequences. Such consequences are the norm rather than the exception when change is introduced in a work environment. Clinicians should monitor for them, mitigate their impact, and ensure that the net risk-benefit ratio favors benefit to patients, families and clinicians.

Conclusion

We have presented three tools that can be used to facilitate application of evidence-based practices for meetings of ICU clinicians with families of patients receiving critical care treatment. Ongoing and future studies using rigorous research methods will help to establish the effectiveness of these tools in improving patient-, family-, and clinician-focused outcomes as well as utilization outcomes for ICUs and hospitals. For the present, we offer these tools as prototypes and encourage their adaptation to meet local needs and to maximize acceptability and use. The overall goal of this “toolkit” is to improve communication between clinicians and ICU families. The methods are straightforward and practical. The Family Meeting Planner is a proactive tool that focuses on clinician and family preparation, arrangements and scheduling. The Family Guide seeks to prepare families and thereby to promote the efficiency and organization of the meeting, the family’s comprehension of essential information, and the ICU’s understanding of the patient’s values, goals and preferences. The Family Meeting Note is intended to help structure the meeting, remind clinicians to cover key topics and elicit family participation, communicate the content of the discussion to the entire healthcare team through the medical record, provide a basis for appropriate reimbursement of physician services, and serve as a data source for performance feedback and improvement.

For performance improvement, these tools can be used in conjunction with implementation of a family meeting quality measure, such as the measure included in VHA’s Care and Communication Bundle,⁷ now posted on the National Quality Measures Clearinghouse website of the Agency for Healthcare Research and Quality.⁸ The VHA measure determines the proportion of patients for whom an interdisciplinary meeting covering specified topics is conducted within five days after admission to the ICU. While it would be optimal for family meetings to occur with all families even sooner, we again emphasize the importance of feasibility, especially for an initial effort. Empirical data continue to show that many families never meet with ICU physicians, even when the period of critical care treatment is prolonged. Goal-setting for performance improvement should take this reality into consideration and attempt what may be achievable in the near term, with a plan to shorten the trigger interval later, after performance is consistent for the initial target. By applying simple tools like those that have helped to reduce blood stream infections, we hope to help ensure that ICU teams reliably meet ICU families’ communication needs.

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