

COMMENTARY

Sleepless nights in the ICU: the awoken family

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See related research by Day *et al.*, <http://ccforum.com/content/17/3/R91>

Abstract

Having a loved-one in the ICU is a traumatic experience for family members that can lead to a cluster of psychological complications, recently defined as post-intensive care family syndrome. In a previous issue of *Critical Care*, Day and colleagues stressed the severe sleep disturbance and fatigue experienced by a majority of ICU patient family members. However, despite this burden being well characterised, the best preventive coping strategy remains undetermined.

In a previous issue of *Critical Care*, Day and colleagues [1] investigated sleep, anxiety and fatigue in family members of patients admitted to the ICU. Using validated self-report tools, the majority of family members of ICU patients reported moderate to severe sleep disturbance and fatigue. This newly recognized family burden may have dramatic consequences as sleep deprivation may interfere with their decision-making and care-taking abilities. These findings emphasize the immense turmoil experienced by family members and suggest that surrogate decision makers could be temporarily incompetent, raising issues about the shared decision-making model [2].

Perhaps, more so in intensive care than in other medical disciplines, relatives of critically ill patients play a key role during the long ICU course. They frequently play both caregiver and surrogate decision maker roles. Thus, the patient-physician relationship moves to a family-patient-physician-nurse relationship, making the ICU environment quite unique. Among stakeholders, each party may suffer from stress. Neglected for too long, the damaging psychological consequences of an ICU stay on physicians [3] and on relatives are now better characterized [4]. As underlined by Day and colleagues [1],

family members of ICU patients have frequent intense sleep deprivation and are exposed to symptoms of anxiety and depression that could lead to psychiatric diseases such as panic disorder, post-traumatic stress disorder [5], or complicated grief [6].

As the aging population requires more critical care and ICU mortality decreases, family members will increasingly have opportunities to share in the care of their loved one [7]. Managing a relative's burden remains the main issue. We advocate that our ICUs have enough resources to prevent post-ICU burden. This requires communication strategies and improved behaviours. For instance, seeing family members sleeping in the waiting room is, unfortunately, a frequent occurrence for night shift clinicians [8]. We have to admit that most of our ICUs do not offer accommodation for family members, and a change in ICU design that integrates night accommodation for family members is warranted and unrealistic at the same time. Instead, several simple measures, mostly based on improving communication strategies and on family-centred ICU organization, have shown an ability to improve family burden. To be effective, interventions must be feasible, easy to reproduce, accessible, resource minimising, and easily integrated at the bedside. Informative hand-outs for educating families about critical illness and intensive therapies, as well as proactive and effective communication strategies fulfil these requirements [9]. As suggested by 25% of the respondents in the study of Day and colleagues [1], improving the frequency and the quality of the information related to their loved ones could allow them to leave the hospital during the night and improve the quality of their sleep. Simple changes in ICU structure, including but not limited to open visitation policies for families and rooms dedicated to family conferences, could also possibly have a beneficial impact on family anxiety and satisfaction. Additionally, flexible visitation in the ICU setting provides the family with opportunities to maintain social links (child care, professional activities, social commitments, and so on). These changes could enable them to manage daily life while allowing them breathing space. Free visitation policies are also an opportunity to alleviate their guilt. This is particularly true for families with ICU patients with lengthy ICU stays.

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Multiple risk factors of family burden have been identified, and preventative strategies rest on multifaceted programs. Thus, rather than a single intervention, we believe implementing multiple simple and accessible interventions (that is, family information leaflets, routine family conferences, daily family rounds, structured information, unrestricted visiting hours, regular nurse-family-physician meetings, family care specialist nurses, and so on) may prove effective in preventing post-intensive care family syndrome. We are at a time where a qualitative 'care bundle' for family members has to be implemented in our daily practice. In addition to reducing sedation intensity in critically ill patients, we should find ways to provide healing information to family members and encourage them to safeguard their sleeping time. Studies to improve sleep quality in family members are warranted.

Competing interests

The authors declare that they have no competing interests.

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