

# Facilitated Sensemaking

## A Strategy and New Middle-Range Theory to Support Families of Intensive Care Unit Patients

Judy E. Davidson, RN, DNP, CNS

### PRIME POINTS

- Patients' family members may experience anxiety, depression, and symptoms associated with posttraumatic stress during their loved one's critical illness.
- Facilitated sensemaking is a new middle-range theory to guide nursing interventions to help patients' family members make sense of what has happened and of their new roles.
- Middle-range theories are developed to guide practice directly at the bedside.
- Nurses are encouraged to test the theory by using research methods.

Mrs Garcia is visiting her husband in the intensive care unit (ICU). He is in a coma after a motor vehicle crash that resulted in head injury. She sits in the room hour after hour, rocking in the hard small chair, saying little, and wringing her hands in worry. Each time the alarms go off on the monitor, she startles in a vain attempt to locate the source of the sound and its meaning. She pushes the call light when the nurse does not attend to the alarms immediately, irritating the nurse with the frequent calls. Mrs Garcia's fear is palpable. When asked by the nurse, "Is there anything I can do for you?" she says simply no in an unconvincing voice, with a wanting, lost look, unable to find the words to express her needs.

In this article, I describe facilitated sensemaking, a new middle-range theory aimed at supporting family members of ICU patients. The primary

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goal of the model is to prevent adverse psychological outcomes. Throughout the article, facilitated sensemaking is applied to the case of Mrs Garcia and her family to illustrate the interrelationship between the concepts of the theory. Links between the central concept of facilitated sensemaking and the theories from which it was derived are also explored. The Garcia family is a composite case formed from actual observations gleaned from the original testing of the model.<sup>1</sup>

### Helping a Patient's Family Use Facilitated Sensemaking

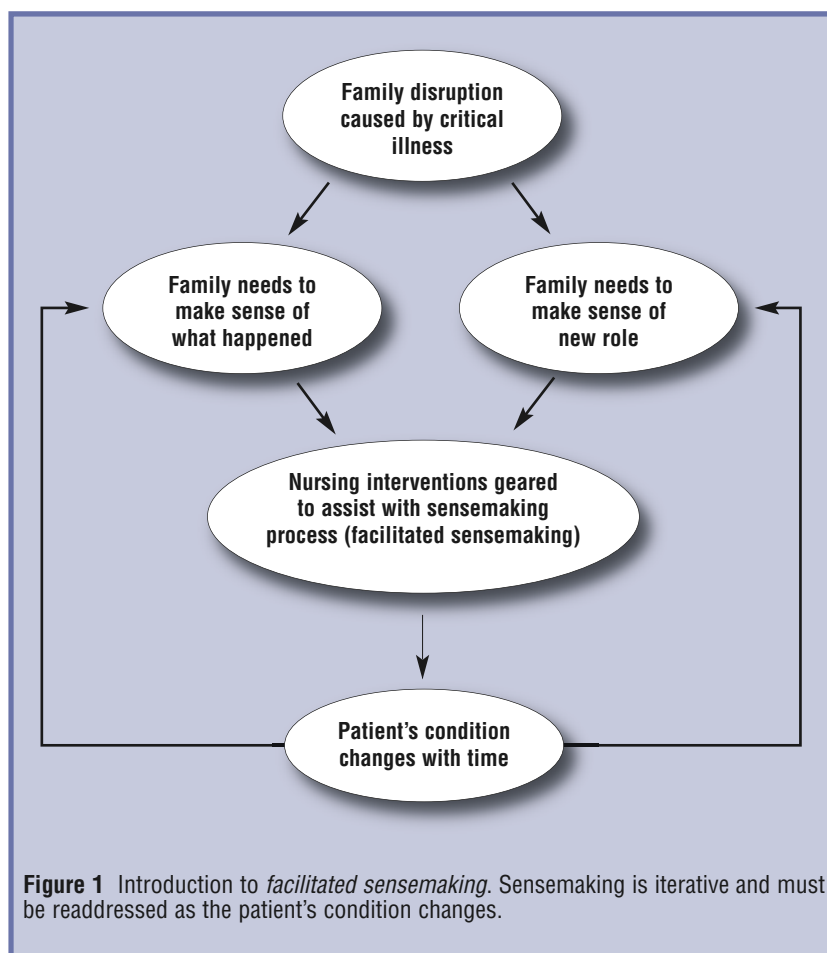
Have you ever worked with a patient and at the end of the shift felt that caring for the patient's family was the hardest part of the day? Have you watched patients' family members misinterpret events and with that misunderstanding or distortion, experience undue stress, angst, or grief? Have you wondered, What can I do to help them through this? It is proposed that family members need to make sense of the situation and of their new caregiver role. Left unchecked, this lack of

understanding may impede a family member's ability to cope with critical illness. The unplanned and serious nature of critical illness makes coping with the situation challenging. The theory of facilitated sensemaking provides a set of nursing interventions to help patients' family members make sense of what has happened and of their new role as family members of someone with a critical illness.

The term *facilitated sensemaking* was chosen to describe both a set of nursing actions and the process that the families go through. If a patient's family is cared for in a structured way to meet the 2 sensemaking goals—making sense of what is happening and what the family should do now—the family members may be healthier and able to adapt to the situation in a more positive way than they would if they did not meet the goals. Sensemaking is an iterative process and must be repeated as a patient's condition changes (Figure 1).

### Middle-Range Versus Grand Theories

The word *theory* comes from the Greek word “to see” or “to view” and implies speculating about or seeing something in a new way.<sup>2</sup> According to Chinn and Kramer,<sup>3(p91)</sup> a theory is “a creative and rigorous structuring of ideas that projects a tentative, purposeful, and systematic view of phenomena.” Middle-range theories



**Figure 1** Introduction to *facilitated sensemaking*. Sensemaking is iterative and must be readdressed as the patient's condition changes.

are developed to guide practice directly at the bedside.<sup>3,5</sup> They are more focused than grand theories are. Grand theories provide a framework for describing, predicting, explaining, or prescribing within nursing practice as a whole. Compared with grand theories, middle-range theories focus on a single aspect of practice and thus are less generalizable. Because they are narrower in scope and more concrete

than grand theories, middle-range theories also are easier to test by using research methods.

Practicing nurses may find middle-range theories directly applicable to patient care and more prescriptive than grand theories. New nursing theories bring together familiar concepts, often in the form of prescriptive interventions, to achieve a health-related goal. For instance, Roy's grand theory<sup>6</sup> proposes that families must adapt to a new situation but does not define what a nurse must do to assist the families. The middle-range theory of facilitated sensemaking explains in detail how to assist a family as the family members adapt to critical illness.

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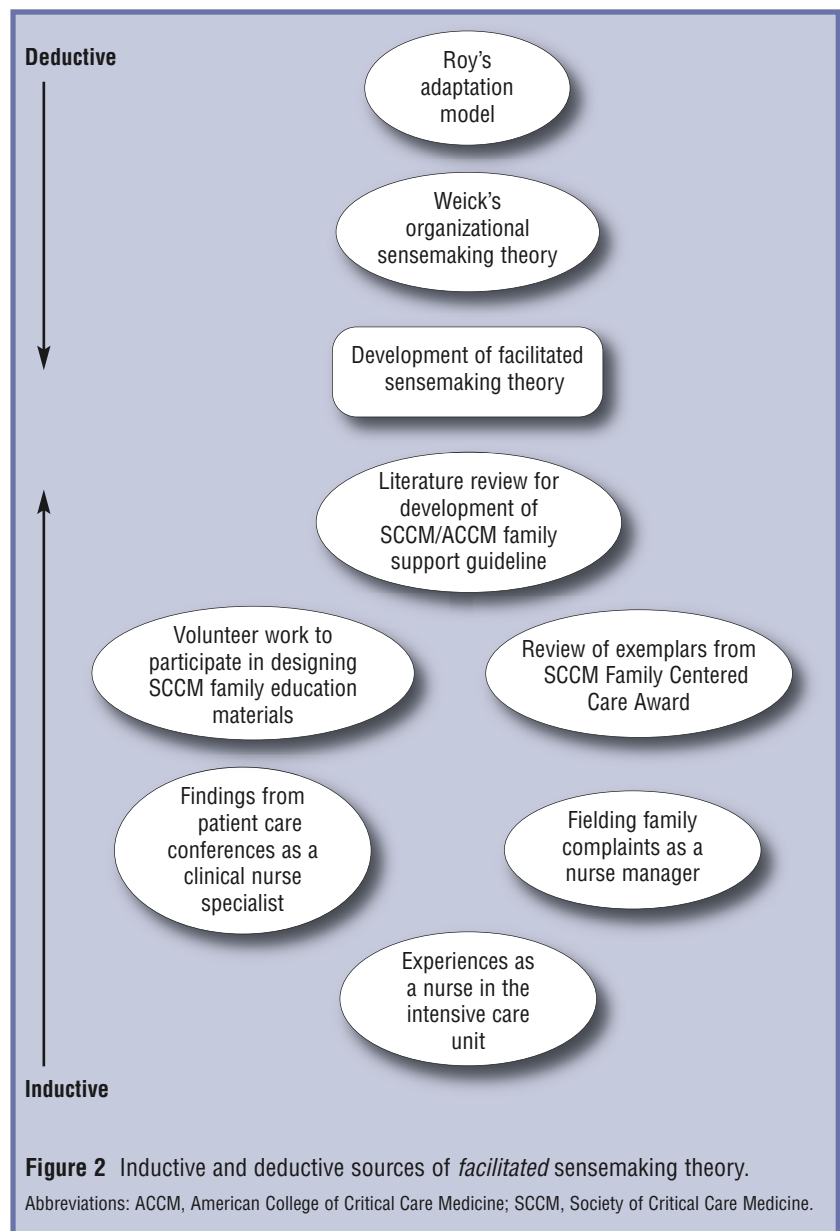
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## Theoretical Underpinnings of Facilitated Sensemaking

### Roy's Adaptation Model

Middle-range theories can be derived from a grand theory and applied to a specific situation, with concrete interventions.<sup>5</sup> Facilitated sensemaking is a derivation of Roy's adaptation model<sup>6</sup> and Weick's theories<sup>7,8</sup> on organizational sensemaking. In Roy's adaptation model, a grand theory that applies to all nursing practice, illness causes a disruption in life. The disruption requires a period of compensation. This period leads to adaptation. The adaptation may be positive or negative and complete or incomplete, depending on the period of compensation. The Roy adaptation model explains why family members must compensate for the situation but not what to do to help them. Roy's adaptation model provides the framework on which the actions for facilitated sensemaking were built (Figure 2).

In the case example, Mrs Garcia is experiencing a disruption now that her husband is in a coma. She is trying to come to terms with what this situation means to her and her family. She wonders, What should I be doing to help him? What should I do now? How do I keep on living? Roy's theory explains that Mrs Garcia is in the process of coping with the situation but not what the nurse should do to help her cope. To bring Roy's theory closer to the bedside, facilitated sensemaking advocates that although nurses cannot make the injury go away, they can provide concrete activities that Mrs Garcia can do to help during this time, activities Mrs Garcia would not have thought of on her own. The intervention set of the model (Table 1)



proposes that Mrs Garcia be taught to help with meaningful activities at the bedside, such as applying lip balm, assisting in passive range-of-motion exercises, or giving a hand and foot massage, to give her a purpose in her new role.

### Weick's Organizational Sensemaking Theory

Mrs Garcia's sons and daughters are with her when the physician conducts rounds. The physician

comes in and explains how the motor vehicle crash resulted in a coma. The next day, all 3 family members have different explanations, none of which is a true description of the physician's medical language-laden description. Although the physician explained that recovery would take a very long time and that the exact prognosis could not be predicted, Mrs Garcia continues to ask when her husband is going to "wake up." Weick's orga-

**Table 1** Suggestions for bedside activities<sup>a</sup>

Purpose	Activity
Personal care/healing	Applying lip balm Giving a hand and/or foot massage Assisting in passive range-of-motion exercises Praying if spiritual assessment indicates prayer is appropriate Engaging in cognitive exercises with cards, dominoes, or word search puzzles
Bring normalcy into the room	Reading aloud Talking about daily events Bringing in cards/pictures from home

<sup>a</sup> These activities are primarily meant to give a patient's family members purpose while they visit and suggest actions to help them define their new roles. Involvement in cognitive exercises that use familiar tools provides a means to personally gauge a patient's progress toward recovery.

nizational sensemaking theory can help refine the intervention set proposed for nurses to assist the family when situations like this one occur.

Weick is not a nurse, but an organizational theorist. In 2 books, *Sensemaking in Organizations*,<sup>8</sup> and *Making Sense of the Organization*,<sup>7</sup> Weick describes the concept of sensemaking as it relates to how leaders shape organizational image in a way that relates to family members such as Mrs Garcia. Weick explains that employees, like patients' family members, receive many cues from the work environment. The cues are sorted to form an impression of the workplace. Several employees may attend the same meeting, and each one may sort the cues differently, resulting in different perspectives of what happened. Strong leaders help employees with cue sorting to form a positive image of the organization yet recognize when the cues suggest a need for action. In facilitated sensemaking, nurses proactively take cues from the environment and sort them for a patient's family, helping the family members make sense of what is going on.

Further, Weick<sup>8</sup> explains that a company's vision of itself is largely

based on perceptions formed by leaders through organizational sensemaking. Leaders form strategies to cull key messages to communicate to employees to form a collective conscious while filtering out distortion and misconception. This formation of group thought is described as organizational learning. Sensemaking is explained as dynamic, never-ending, reflective, and creative. Reflection is vital to the process, and as Weick describes, people need to look back on what they have done to know who they are. Reflection is the key to understanding.

In facilitated sensemaking, a nurse would sort cues repeatedly as a patient's condition changes and take an active role to make sure that the patient's family members are receiving consistent messages from the health care team. In addition to explaining events as they happen, the nurse uses reflective inquiry at the end of each visit to clarify misconceptions about the events of the day.

Weick<sup>8</sup> uses a medical example to describe the sensemaking process: A radiologist noticed that the images on many radiographs did not match the cause of injury reported by emergency department physicians, who

had made their diagnosis on the basis of interviews with the patients involved and the patients' family members. Looking back, the radiologist collected similar radiographs, noticed a pattern in the findings, and formed a theory that the injuries were inflicted, not accidental. The emergency department physicians did not want to believe the radiologist's theory. The radiologist persisted over time in describing the inconsistencies between the break patterns and the histories. Eventually, the patterns of abuse were accepted. The rate of acceptance increased remarkably when the radiologist gave the pattern a name: battered child syndrome. In this example, the radiologist used a creative process of reflective cue sorting. A nurse may apply this principle by giving names to what is happening.

Sensemaking is more than providing information, it is providing an interpretation of the situation and the surroundings. For Mrs Garcia and her family, the nurse can facilitate sensemaking by pointing out the intracranial pressure (ICP) value on the monitor, explain the concept of brain pressure in simple terms, clarify that a value greater than 20 is not good, and state that the goal is a lower value. The nurse can further explain that the physician's statement of "a long time" in recovery may mean many months.

Weick<sup>7</sup> explains that the way people act creates unique value and meaning for the action. Action is a key component of sensemaking because without action, there is little to reflect on to define the event. Actions become part of the event itself and contribute to understanding the crisis.<sup>7</sup> In facilitated sensemaking,

meaning needs to be given to the role of a patient's family members. Giving family members opportunities to be involved will help them through the crisis. Therefore, bedside activities help family members define their new role and also provide them a context for evaluating change over time. It is easier for Mrs Garcia to appreciate a change in cognitive ability if she has tried to engage her husband in conversation than if she passively sits in a chair by his side.

Mrs Garcia is no longer the wife and mother, cooking dinner each night and working as a short-order cook in a restaurant by day. She needs to discover how to act in this new situation in a way that gives meaning and value to her new role as the wife of a critically ill husband. If she performs meaningful activities in the ICU, she can look back on the actions to enhance her understanding of the new role and the crisis at the end of a visit. Although less risky, not taking action may result in confusion during crisis.<sup>7</sup>

In addition, knowing that helplessness is 1 of the 3 antecedents to the symptoms required for the diagnosis of posttraumatic stress disorder (PTSD),<sup>9</sup> it is proposed in facilitated sensemaking that actions performed by a patient's family members at the bedside minimize helplessness and may thereby minimize the likelihood of adverse psychological events. Weick<sup>8(p7)</sup> states, "Sensemaking is tested to the extreme when people encounter an event whose occurrence is so implausible that they hesitate to report it for fear they will not be believed." In the ICU, what is seen and what the health care team does may be implausible, unbelievable, or incomprehensible to the lay public.

In the Garcia family case, Mrs Garcia can be given a list of things she can do to help at the bedside, such as talking in soothing tones to her husband to bring normalcy to the environment and engage his brain in activity. She can also be trained to do passive ankle flexion and foot-pumping exercises to decrease the risk of blood clots, and hand and foot massage to heal through loving touch. She can be educated that her assistance is welcome as long as the ICP value is not higher than 20 and that the room should be made as quiet and soothing as possible if the ICP is too high.

The Garcia family will need assistance with cue sorting (eg, recognizing a high ICP value), thereby adding *facilitated* to sensemaking<sup>1</sup> (also J. E. Davidson, D. Agan, J. Murphy, and P. Gutierrez, unpublished data, 2007). Family members who do not ask questions may remain silent because they lack the ability to form questions. Mrs Garcia may have said no when asked if she needed anything because she did not know what she needed or did not know whether asking was appropriate. A patient's family members may actually fear reporting their concerns or perceptions of reality. Fear and horror are 2 of the 3 symptoms required for a diagnosis of PTSD.<sup>9</sup> The theory of facilitated sensemaking explains that reflective inquiry (guiding a patient's family to review and clarify events) may decrease horror and fear associated with the ICU experience. Horror and fear are not operationally defined because they are subjectively defined by each family member. As is common with the concept of pain,<sup>10</sup> if a family member states that he or she

experienced horror or fear, the perception is accepted. The primary long-term goal of facilitated sensemaking is to prevent adverse psychological sequelae such as anxiety, depression, and PTSD, but use of the model may also result in other positive outcomes, such as satisfaction or comfort (Figure 2).

## Pathophysiology of PTSD and Link to Facilitated Sensemaking

Patients with PTSD may have witnessed a traumatic life-threatening event that has caused fear, horror, or helplessness.<sup>9</sup> When a person witnesses a traumatic experience, the brain decodes the event. The hippocampus collects the sensory data, and the amygdala attaches an emotional label to the experience. If the emotion is fear or horror, the pituitary gland (also part of the limbic system, along with the hippocampus and amygdala) receives a signal to initiate a fight-versus-flight response, releasing stress hormones. The prefrontal cortex cannot process the extreme experience. The processes by which a person would normally learn from and contextualize the experience are overwhelmed with the flood of stress hormones, so the negative affective (conditioned) response remains the only available reaction when the person is reexposed to the same stimuli.<sup>11-13</sup>

The interventions in facilitated sensemaking may minimize the risk of PTSD by engaging the prefrontal cortex and/or by minimizing release of stress hormones. If the prefrontal cortex is not engaged, and all of the experience is brand new and horrifying, an abnormal patterned

response arises, leading to the symptoms associated with PTSD: avoidance, numbing, hyperarousal, and repeated thoughts or nightmares. Conversely, when the prefrontal cortex is engaged with familiar activities during the event, learning from the event and assigning rational meaning to the experience may be possible, resulting in normal instead of exaggerated activation of the pituitary gland and prevention of abnormally patterned responses. The familiarity of caring for a loved one keeps prior learning active.

The familiar stimuli of applying lip balm and hand lotion prevent a situation from becoming completely unknown. The interventions make learning what is going on part of what is going on, a process for which the cortex is required. The activities provide a sense of agency that protects against helplessness. Minimizing fear of the unknown and horror caused by misconceptions may mediate activation of the pituitary gland, decreasing the release of stress hormones.

In a car accident, a rape, or an assault, usually no health care workers are present in the immediacy of the trauma to alter the way the brain imprints the memory of the event. In contrast to the situation in motor vehicle accidents, during critical illness, a nurse usually is present when a patient's family members are at the bedside interpreting what is happening around them. Nurses have an active part in this process. The trauma for the family is the critical illness. A misinterpretation of signals that results in a pathophysiological response could cause Mrs Garcia to form a reflex to release stress hormones with an exaggerated

fear response every time she hears a buzzer or bell that reminds her brain of the monitor alarms.

In the case of the Garcia family, the nurse has already explained the bedside monitor, alarm system, and important numbers to Mrs Garcia and the eldest son, the interim patriarch of the family. The nurse has demonstrated how family members can assist with passive range-of-motion exercises when they visit Mr Garcia and explains the importance of having him hear normal sounds such as family members discussing things important to him. The nurse now gives them a kit with lotion, lip balm, playing cards, word searches, and dominoes and explains how to use the articles during visits as Mr Garcia recovers.

Roberto, the eldest son, takes the kit and instructions out to the waiting area where members of his extended family are waiting. Mrs Garcia sits among them as Roberto begins. Roberto addresses the group with a strong measured voice, a voice that gives clear direction to the others. They are bathed in the calming image he creates of control of the situation and hope for recovery. He stands before them, pauses, takes a deep breath, and then gives each of them an instruction, holding the visiting kit in his hands:

We will divide the visiting between us. [Nodding to his mother] You are in charge of the praying. [She clutches her rosary, rolling the beads through her fingers and looks upward to him with faith in her eyes.] You [nodding at the cousins] will read to him from your school papers so that he

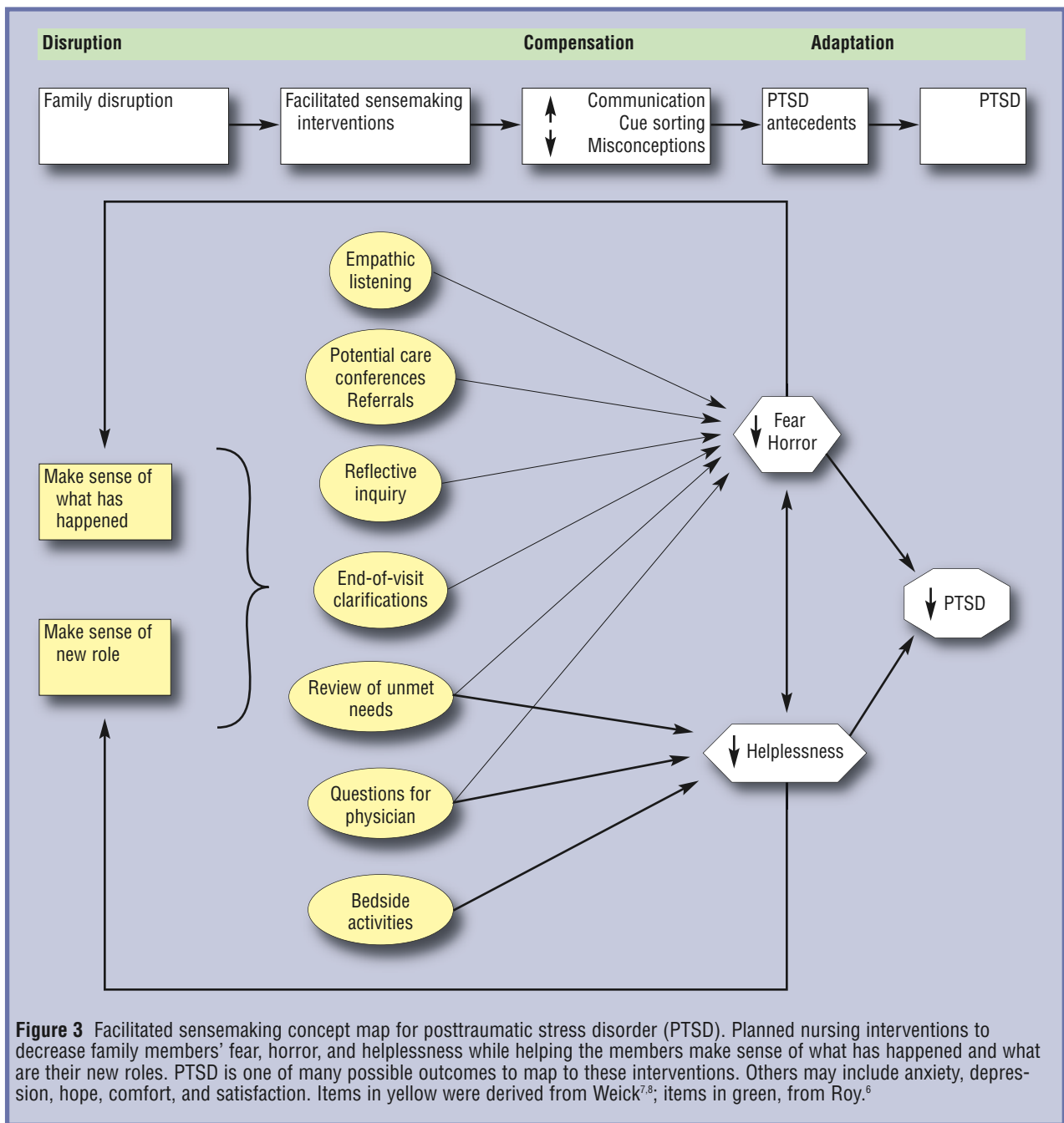
knows you are doing your work. You [addressing his sisters] will help with the lotion of his hands and feet, and I will show you how to move the joints to keep them strong until he is better.

As the family members listen, the fear is quieted, and a new feeling of purpose emerges with the plan. It is hoped that the memory of Roberto's actions, his ability to guide his family during this crisis, will imprint stronger on the brain than does the vision of the intracranial bolt and the jarring alarms ringing from the monitor.

## Development of the Theory of Facilitated Sensemaking

Theories provide a framework for the science of nursing and contain 4 basic elements: nursing, health, person, and environment.<sup>4,14,15</sup> In facilitated sensemaking, the theory is designed to identify specific nursing interventions at the practice level to maximize the health of the family members of ICU patients. A patient's family is defined according to the definition first published for palliative care<sup>16(p611)</sup> and adopted by the Society of Critical Care Medicine<sup>17</sup>:

Family is defined by the patient, or in the case of minors or those without decision-making capacity, by their surrogates. In this context, the family may be related or unrelated to the patient. They are individuals who provide support and with whom the patient has a significant relationship.



**Figure 3** Facilitated sensemaking concept map for posttraumatic stress disorder (PTSD). Planned nursing interventions to decrease family members' fear, horror, and helplessness while helping the members make sense of what has happened and what are their new roles. PTSD is one of many possible outcomes to map to these interventions. Others may include anxiety, depression, hope, comfort, and satisfaction. Items in yellow were derived from Weick<sup>7,8</sup>; items in green, from Roy.<sup>6</sup>

The family spokesperson is the primary target for the interventions of facilitated sensemaking, but all family members may benefit from this middle-range theory. The family spokesperson is defined as the person assigned to gather information about a patient's stay to keep the rest of the family informed. This person may or may not be the one

who is assigned the durable power of health care.

Theories are generated either inductively (from observations gathered through experience and the literature) or deductively (from other theories).<sup>5</sup> The theory of facilitated sensemaking has been developed from both directions (Figure 3). During the inductive process, and

the development of the family support guideline, a group of authors reviewed the literature on patients' family members in the ICU and sorted it according to subheadings (J. E. Davidson, D. Agan, J. Murphy, and P. Gutierrez, unpublished data, 2007). Within the subheading of family coping was a cluster of articles<sup>18-30</sup> pertaining to adverse

**Table 2** Randomized controlled trials investigating adverse psychological outcomes in family members of patients in intensive care units (ICUs)

Reference	Goal	Intervention	Country	Results
Kloos <sup>29</sup>	Decrease anxiety of family members of coronary artery bypass patients	Journal	United States	Not significant
Melnyk et al <sup>20</sup>	Decrease anxiety, depression, and symptoms of posttraumatic stress disorder in mothers of children in a pediatric ICU	Video, personalized instruction, written information	United States	Mixed
Jones et al <sup>25</sup>	Decrease anxiety, depression, and symptoms of posttraumatic stress disorder in relatives of adult ICU patients	Written information designed for a post-ICU clinic	United Kingdom	Not significant
Lautrette et al <sup>23</sup>	Decrease anxiety, depression, and symptoms of posttraumatic stress disorder in relatives of adult ICU patients	Written information and a structured method of case conferencing	France	Significant decrease in adverse outcomes

psychological outcomes that develop in the family members of a patient in relationship to their experience. The review of this research yielded the conclusion that between 33% and 80% of family members of ICU patients experience long-lasting (>90 days) anxiety, depression, and symptoms of PTSD. Only a few studies<sup>23,26,29</sup> have been published about attempts to intervene to minimize the occurrence of these symptoms. In a randomized controlled trial<sup>25</sup> in the United Kingdom, no difference was found in symptoms of family members' posttraumatic stress when a self-paced manual was developed for use in a post-ICU family clinic. The interesting theme in publications by Jones and colleagues<sup>25,31-34</sup> is that in the United Kingdom, post-ICU clinics exist. The clinics are run by nurses, and the assumption is that patients and their family members will have to adjust to what they have gone through; this practice is not prevalent in the United States. Other investigators<sup>20,23,25,29</sup> have evaluated interventions to decrease the impact of critical illness on the health of patients' families (Table 2). Although adverse psychological outcomes in

patients' family members have been explored in several randomized controlled trials,<sup>20,23,25,29</sup> each study involved different interventions in different populations and in different countries, and the results were mixed. Interactive approaches to improve communication may be more effective than written information alone in helping families.

The idea that a patient's family members could experience PTSD was especially intriguing and was a large influence during the development of the theory of facilitated sensemaking. PTSD is diagnosed<sup>9</sup> when a person has experienced or witnessed a life-threatening event that results in fear, horror, and/or helplessness, and symptoms of intrusion, avoidance, and hyperarousal develop that last at least 1 month. Acute PTSD lasts 1 to 3 months; chronic PTSD, 3 to 6 months.<sup>9</sup> During the first month after a traumatic event, the same symptoms suggest risk for PTSD and a diagnosis of acute stress reaction may be made.<sup>9</sup> Symptoms experienced within the first month after a life-threatening traumatic event are common.<sup>35</sup> The process of facilitated sensemaking may reduce

the incidence of PTSD in patients' family members by intentionally providing interventions to minimize fear, horror, and helplessness (Figure 3).

The theory of facilitated sensemaking has undergone initial testing to demonstrate that patients' family members value and would use the proposed intervention set<sup>1</sup> (Figure 3, Table 1).

Content experts such as physical therapists, occupational therapists, and a neuroscience clinical nurse specialist were consulted during development of the intervention set. Family members of former ICU patients were consulted to review the plan and provide feedback during concept development. Doctoral students and theory professors also provided input. Staff nurses working in an ICU were asked for feedback on the model. They provided testimony that dealing with patients' family members was challenging and that the feeling of not knowing how or not being able to meet a family's needs increased daily stress on the job. Nurses also validated the need for a structure by stating that strategies to work with patients'

family members were not sufficiently covered in training.

### Specific Nursing Actions When Facilitating Sensemaking

The exact interventions proposed in facilitated sensemaking are divided into those that help families make sense of the situation and those that help give meaning to the caregiver role (Table 1). When making sense of the situation, a nurse would first get to know the patient's family members and then describe the cues in the environment, sorting out which numbers and noises are important and which are not. Early in the course of the ICU stay, the nurse would evaluate whether the family members understand what brought the patient to the ICU. To detect myths or distortions, the nurse would use a leading statement such as, "Mrs Garcia, tell me about how your husband came to the ICU." The nurse would clarify if needed and add important missing concepts. At the end of each visit, the nurse would provide clarification of the days' events. The method of doing this is also prescribed reflectively. For the best chance of finding misconceptions, dialog such as the following is suggested:

Mrs Garcia, before you go home, let's review what happened today. Given what we've talked about and what you've seen today, what are the most important things to share with the rest of your family?

The nurse would listen, clarify, or reorder the priority of events. During the visit, the nurse would assist the patient's family in

environmental cue sorting and would demystify the ICU experience with statements individualized to the patient, such as the following:

The top number on the heart monitor is the heart rate. It is OK if this number is anywhere between 60 and 100. [Review each visible number and acceptable values, saving the most important one for last.] I expect the numbers on the monitor to go up and down. This change means the body systems are talking to each other. If the numbers did not change at all, it would be a bad sign. I know those are a lot of numbers. The one that is actually most important to your husband is the blue one, labeled ICP. That is the brain pressure. It should always be lower than 20. If it goes over 20, we try to make the room as quiet as possible to calm him, and I will give him medicine to try to control it.

The nurse would also help determine if family members' needs are being met by proactively reviewing with the family a list adapted from the Critical Care Family Needs Inventory, designed by Molter<sup>36</sup> and Leske,<sup>37</sup> which has been validated over time<sup>37</sup> and repeatedly studied.<sup>38-56</sup> The list of family needs should include the need to sit vigil to protect the family, identified in a subsequent validation of Molter and Leske's work by Burr.<sup>52</sup> People in crisis may not be able to identify their needs independently,<sup>7,8</sup> and

nurses and physicians do not accurately predict a family's needs<sup>42</sup> and often underestimate the needs.<sup>44,46,57</sup> Therefore, because the nurse cannot presume to know what a patient's family members need and the family may not be able to articulate needs without guidance, providing the family a list to review is indicated. A preliminary test of using a family needs list revealed unanticipated needs, including referral to ancillary support services such as palliative care, medical social worker, case manager, and spiritual support services<sup>1</sup> (also J. E. Davidson, D. Agan, J. Murphy, and P. Gutierrez, unpublished data, 2007). These needs would not have been detected with an open-ended question.

Another nursing intervention to help a patient's family members make sense of what has happened is to assist them in composing questions to ask the physician. A review of the list of family needs may reveal that the family has not had enough communication with the attending or consulting physicians. On the basis of the needs assessment, the nurse can help the family write questions. If the family members are asked to draft questions in writing to review, the nurse can also sift out the questions that nurses are allowed to answer. For instance, the nurse might say,

Mrs Garcia, the doctors usually do rounds about 10 AM. It is almost 9. Let's get ready by making sure you have your questions prepared. Why don't you write them on this paper and I can review them with you before the doctors come.

This can be done verbally for illiterate families; however, a written list is advocated whenever possible to be used when the family and the physician next meet or speak on the telephone.

Nurses are also encouraged to use a question such as, “Is there anything I can do for you right now that would make this a better experience for you given what you are going through?” In previous research (J. E. Davidson, D. Agan, J. Murphy, and P. Gutierrez, unpublished data, 2007), this question was quite helpful, especially for unpredicted needs. For instance, when a patient’s family member was asked this question, she replied (paraphrased) with her tongue stuck to the top of her mouth, “Water. The cafeteria is so far away and I do not want to leave. There is no water in the waiting room.” This reply shows that simple needs are often overlooked unintentionally.

Nursing interventions to help a patient’s family members make sense of their new role include preparing information to be passed on to other family members by the family spokesperson and identifying helpful bedside activities. Helpful bedside activities include simple actions such as providing a hand massage with lotion to promote healing through touch. The family members may be taught how to apply lip balm and/or keep the hand of an unconscious patient around a rolled washcloth to

prevent contractures. Range-of-motion activities as permitted by the patient’s condition are another option. A nurse might instruct Mrs Garcia as follows:

You can move all of the joints in your husband’s arms and legs and fingers and toes to help keep him from getting stiff while in bed. Why don’t I do one side and you do the other? After we do them together, you can do them whenever you’d like as long as the ICP stays below 20. Besides, moving his joints gives you a good excuse to hold him, which can be quite soothing to him.

The efficacy of these activities for patient outcomes is not as important as the concept of initiating activities for family members to keep them occupied at the bedside for diversionary purposes.

Family members who are inclined to prayer can be encouraged to pray at the bedside to promote calmness and healing. Encouraging prayer should only be done after a family assessment of whether this step is appropriate for their spiritual beliefs. Nurses should not proselytize their own religion. However, when a patient’s family members request prayer, and praying is acceptable in a nurse’s own belief system, prayer is within the scope of nursing practice.<sup>17</sup>

Informing a family that chaplains are available to support family members as well as to pray with them is advocated. With the family’s permission, a chaplain may assist in contacting the family

members’ place of worship, to provide earlier access to additional external family support. In a recent study<sup>58</sup> of religious needs at birth and death, clergy of all faiths who were interviewed agreed that nurses wait too long to suggest contacting the family members’ place of worship, and that if contact were made earlier, the family would be better supported.

Family members of patients who are recovering from coma, brain injury, or sedation can also be taught a variety of cognitive recovery activities based on principles of occupational therapy.<sup>59</sup> Common items such as word search puzzles, dominoes, and playing cards may be helpful for this purpose. For patients who are most affected and just emerging from coma or sedation, guiding the hand to point to a specific letter in a word search puzzle may be hard enough, with an instruction such as, “Mr Garcia, point to a letter A on this page.” As the patient’s brain recovers, family members can be instructed to ask the patient to find any words in the puzzle. When the brain returns to normal function, the puzzle can be used as originally intended. Dominoes and cards can be used by having a family member put a few on the bedside table and having the patient pick out the 2 or the 3. A moderate activity would be to ask the patient to place the tiles or cards in order, with the low numbers on one side and the high ones on the other side. When the brain is closer to full recovery, the dominoes and cards could be used in games as normally intended.

For patients who are unable to participate in activities, the brain can still be engaged by having



To learn more about family-centered care, read “Family-Centered Care: Meeting the Needs of Patients’ Families and Helping Families Adapt to Critical Illness” in *Critical Care Nurse*, June 2009;29:28-34. Available at [www.ccnonline.org](http://www.ccnonline.org).

family members read cards, letters, newspaper articles, or sections out of books; listening to music; or listening to television or radio. Some evidence<sup>60,61</sup> indicates that engaging in 2 cognitive activities a day in addition to other simple routines may decrease delirium in hospitalized elderly adults. Mentioning this finding to a patient's family may make the activities more meaningful and place greater value on the family members' participation.

The key point is not that these are proven activities to improve brain function, but that the activities give family members a purpose and value during visits to the patient, factors that may help the family adapt. In keeping with Weick's emphasis on the importance of action during crisis, bedside participation also provides the family a way to concretely gauge changes in cognition when coupled with reflective activity from the nurse. For example, a nurse might state,

Mrs Garcia, I noticed that today your husband could point to the letter G without your help. That is a big improvement over yesterday, isn't it?

## Summary

Facilitated sensemaking is proposed as a new middle-range theory to be used in the ICU to assist patients' family members; the primary goal is to minimize adverse psychological sequelae. This explanation of the theory provides guidance on how to involve family members at the bedside, illustrating principles of family-centered care. Family members have shown that they value, accept, and would use

the intervention set.<sup>1</sup> Facilitated sensemaking requires further testing to see if outcomes truly improve with this approach to family-centered care. **CCN**

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## Financial Disclosures

None reported.

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