Recently a nurse in the pediatric intensive care unit related her experiences as a member of a multidisciplinary team providing care in a complex and emotionally draining case involving the death of a child: “This one was rough on all of us, but because of our protocol, we all knew what we had to do and did it. When it was over, it helped us to cry together because we’ve all been down the same road. I know someone else understands where I’ve been, and where I need to go, and why.”

The stress of working in a critical care environment exacts its toll. As recently noted in editorials in the American Journal of Critical Care, stress can be exacerbated by perceptions of poor working conditions, which, in turn, may contribute to the challenges of recruiting and retaining caregivers. Complicating the labor shortage are shrinking budgets, which often lead to poor staffing ratios, inadequate numbers of support staff, and other limited resources. Technological advances continue to refine and alter the delivery of care for the most seriously ill patients, but the human factors that emotionally affect caregivers remain. Development of programs and support systems to address the personal costs of caring for patients continues to gain attention. In our experience, one intervention was the creation of a standardized protocol to improve the outcomes of organ donation by caring for the family members of patients with devastating neurological conditions. Further investigation of our implementation revealed an indirect bonus: stress reduction among critical care nurses.

A Strategy for Improving Organ Donation

Nationally, as the number of potential organ recipients soars, the number of organs available for transplantation remains insufficient. Each year, on average, 19000 patients are the recipients of donated organs, and more than 82000 await this gift of life. At Virginia Commonwealth University Health System, one strategy used to increase organ donation is the Family Communication Coordinator (FCC) Protocol, implemented in 1997. Use of the protocol is initiated on the basis of a standard clinical trigger (score ≤4 on the Glasgow Coma Scale). Once the protocol is initiated, unique responsibilities are assigned to the members of a multidisciplinary team composed of not only critical care nursing and medical staff but also organ procurement professionals and a dedicated chaplain.

As the family communication coordinator, the chaplain coordinates communication between patients’ family members and the healthcare team.

The chaplain, who acts as the FCC, attends to the spiritual and emotional needs of the patient’s family and coordinates the communication plan between the healthcare team and the family. Use of the protocol allows the nursing and medical staff to focus more freely on the needs of the patient. The coordinator of the organ procurement organization (OPO) serves as a resource to the medical staff and assesses medical suitability. The protocol ensures a “best practice” approach to the consent process, which includes an approach that is both private and “decoupled.” In such instances, the OPO coordinator is introduced to the family only after 2 conditions are met: brain death has been declared and explained by the physician, and the FCC chaplain has verified that the patient’s family understands that the patient is dead. According to the protocol, the OPO coordinator is the person designated to request organ donations.
With the protocol, critical care professionals work under clear guidelines that facilitate more consistent communications and interactions with patients’ families and with one another. During the 5 years since the program was implemented, outcomes of organ donation improved markedly, with consent rates increasing from 46% to 56%. However, through conversations with critical care nurses, it became clear that the nurses recognized an indirect benefit of the protocol: an improved and less stressful work environment.

The FCC Protocol and Stress

In response to our conversations with critical care nurses, we explored the link between use of the protocol and stress reduction in a retrospective study of 19 nurses who had experience at our hospital before and after implementation of the protocol. Using a theoretically based, often used survey, we measured role stress in terms of role ambiguity (unclear professional responsibilities), role conflict (competing professional responsibilities), and role overload (too many professional responsibilities). The results clearly confirmed our premise. Nurses reported significantly lower role ambiguity. With the protocol, they had clearer performance goals for themselves as well as for other members of the team. With the protocol, their reported role conflict also dropped significantly; with a clear clinical trigger, no conflicts arose about when to initiate contact with the OPO, and competing responsibilities were diminished once the coordinator arrived. Nurses, in particular, were less stressed by the tension that they think makes team members more aware, and more appreciative, of colleagues’ contributions. As one nurse commented, “This is certainly a team effort—and I’m glad to be a part of it!”

Even more telling were interviews with these same critical care nurses. They were satisfied with their jobs, and satisfied with the protocol. However, their satisfaction was more a function of the presence of the protocol than of their experience with it relative to the number of cases in which the protocol was used. The nurses also spoke positively of their protocol training, which they think makes team members more aware, and more appreciative, of colleagues’ contributions. As one nurse commented, “This is certainly a team effort—and I’m glad to be a part of it!”

One question we posed was prompted by the results of a recent study that suggest that critical care nurses are reluctant to “let go” of their ties to patients’ families. A common response was “Who said that, and do they really know all we have to do!” (during end of life cases). Another offered, “It’s not ‘letting go’—it’s doing the job I’m supposed to be doing [patient care].” When the protocol was used, critical care nurses were confident that the spiritual, emotional, and informational needs of patients’ families were being sufficiently addressed and/or monitored by the chaplain.

As one nurse observed, “The chaplains are essential to ‘hold hands’ [of patients’ families and nursing staff] and a key ingredient they add is the level of trust they create.” In addition, having the chaplain in this role allowed the nurses to focus on the multiple and diverse clinical tasks that characterize end-of-life cases.

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Also relevant is the context in which these comments were made. Within our hospital, and consistent with national trends, retention and turnover of nursing staff are critical issues. However, in sharp contrast to other areas of nursing, relatively low turnover (5% in critical care compared with 15% hospital-wide mean) and high retention characterize our critical care nursing staff. The majority of the nurses in the study reported 15 or more years in nursing; almost 90% had been working in their current unit for 5 to 10 years. Turnover is the exception, and openings are promptly filled when they occur, often by candidates recruited by current staff members. Survey data provide further support for these observations. With the highest and most positive ranking, the critical care nurses working under the FCC protocol showed strong commitment to their work unit (6.58), to their profession (6.65), and to their hospital (5.05).

In short, our efforts at implementing a protocol with one set of outcomes in mind succeeded. Use of the protocol not only improved the outcomes of organ donation but also resulted in an unintended and positive consequence: a less stressful critical care environment. What can we learn from our findings? And how can we use these lessons to improve other aspects of the critical care work environment?

Lessons Learned, Roads Yet Untraveled

Our experience with the FCC protocol indicates that providing clear goals, stated guidelines, and specific performance expectations—of individuals and professional teams—in a critical care environment is
associated with the perception of reduced stress among at least one group of caregivers, the critical care nurses. Although we have not as yet systemically studied other members of the multidisciplinary team (ie, chaplains, medical staff, OPO coordinators, respiratory therapists), informal conversation suggests similar findings. In addition to the previously identified impact, the FCC protocol led to improved team training, established quality care standards for care of patients with devastating neurological conditions, and a committee organized to evaluate and monitor the donation process.

The lessons learned from use of the FCC protocol lend themselves to other end-of-life situations. High-intensity trauma cases and cases of terminal weaning or withdrawal of life support share similarities with potential organ donation cases. Each situation demands well-coordinated efforts by diverse professionals and the need for psychosocial support and effective communication with patients’ families. Also, efforts to deal with each situation can be supported by protocols that specify responsibilities of each member of the healthcare team. In these cases, effective medical resolution might be accompanied by an improved work environment for the professionals involved. Perhaps it’s time to also consider the emotional health of the care providers.

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