Editorial

Nursing shortages and patient safety problems in hospital care: is clinical monitoring by families part of the solution?

I am currently in the USA,* where I have been struck by the frequency of the message – especially in advice to health care consumers – that hospital patients should, if possible, have a family member with them to be vigilant about their condition and the care they are given in order to keep them safe from health care errors. The strength of the recommendations and the kinds of vigilance recommended vary, but the following examples should serve to illustrate what I am talking about:

> [If] you're going into the hospital,…your most important first step is selecting someone you trust to be your health care advocate…The most important attribute for your health care advocate is the willingness and ability to *speak up* – to ask questions when things happen that you don't understand and to insist that people take the necessary measures to protect you from harm…
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> If you're not able to arrange for a health care advocate, don't despair. You can still take steps to ensure a safer hospital stay … You don't need someone constantly looking over your caregivers' shoulders. There are certain critical periods…when errors are most likely to occur. Get help for these times, and you're well on the way to a safe hospital stay.[1]
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> …Ask [a trusted family member or friend] to stay with you, even overnight, when you are hospitalised. You will be able to rest more comfortably and your advocate can help to make sure you get the right medications and treatments…If you do not recognize a medication, verify that it is for you. Ask about oral medication before swallowing, and read the bags of intravenous (IV) fluids. If you're not well enough to do this, ask your advocate to do this.[2]
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> If you are in hospital, ask your nurse how many patients she has to care for on a given day. The more patients she or he has, the more cautious we urge you to be about ensuring that the right medicines are being given and the right follow up care is taking place…
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> If at all possible, there should be a family member, a friend, or if that's not possible and if your resources allow, a private nurse, with you 24/7 during any hospital stay…
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> Most nurses will gladly assist a patient, but it helps to have someone to get the nurses attention and get what the patient needs.[3]
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> If you know someone is going to be in hospital, try to be there "24/7". Family members repeatedly say how important it is to be present in the hospital as much as possible and to watch everything that is done to the patient…
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> A physician who was undergoing treatment for cancer describes how she witnessed numerous errors in her care…She says "…I have told everyone I know who is going into the hospital to get a private duty nurse."[4]

These messages and the concerns that underpin them have major implications for health services and for patients and family members.

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Even if the recommendations are currently not widespread outside the USA (or universally endorsed within it), it is important that their origins are understood and responses to them carefully considered.

The advice that family members should engage in what I will call 'clinical monitoring' (checking of a hospitalized patient's health status and of professionally delivered tests and treatments) has been prompted by concerns about shortages of trained nurses in direct care roles in hospitals and the high rates of harm to patients caused by errors in health care provision.

Neither of these problems is confined to the USA, and policy makers worldwide have been considering various strategies to address them. If we focus on low nurse–patient ratios in hospitals, which may be among the factors contributing to health care errors and poor outcomes,[5–7] we can note, for example, that policy responses have included efforts to improve the retention of qualified and experienced nurses in direct patient care positions, to entice qualified nurses back from non-nursing positions, to recruit nurses from international sources, to train more new nurses, to stipulate minimum safe staffing levels for particular patient care situations, to redefine and reallocate nursing roles, to promote more effective team and interdisciplinary working, and to ensure that working arrangements in hospitals promote optimal use of nursing skills for crucial patient care roles.

Strategies to reduce the harm associated with health care errors include creating systems and cultures that encourage health care providers to report and learn from errors and 'near misses', improving the accuracy of communication between health care providers, designing treatment delivery systems that make certain types of error impossible to commit, and building in multiple checks to ensure that (correctly) planned interventions get to the right patients in a timely manner.

The American Institute of Medicine recently published a report reviewing potential changes in nurses' working environments that might increase patient safety.[8] This report started to consider the role of families in the promotion of patient safety, although it did not focus on this *per se*. It suggested that families should be told when nurse staffing levels are low enough to constitute a threat to patient safety and that 'family members may want to attend to patients for longer periods' in such circumstances (p. 237). While stressing the necessity of professional nursing knowledge and skills for functions such as monitoring patient health status, performing therapeutic treatments and integrating care to avoid health care gaps (all of which were deemed important for patient safety), it also noted that patients and family members 'can provide additional monitoring assistance' (p. 262) and help ensure that information crucial to patient care is not lost as a result of handovers between nursing staff (p. 263).

Nursing shortages, the use of error-prone practices and legitimate public concern about these are unlikely to be eliminated in the near future. Policy makers do need to consider whether health care providers might be more likely to maintain the confidence of their service users and develop effective working relationships with family members to promote positive patient care outcomes if they are explicit about the difficulties they face in service provision, explain to family members how they can help ensure the quality and safety of care and support them in providing that help.

However, the suggestion that families could or should contribute to the clinical monitoring of hospital patients might also precipitate a loss of confidence or trust in hospital services, which could have numerous negative consequences. In addition, it raises all sorts of practical and ethical questions. For example, are family members and health professionals able and willing to accept such roles? How should skills professional time be allocated between patients with different degrees of family support available to them? Who is morally and legally responsible, in what circumstances, for the outcomes of hospital care?

I outline here some of the issues that will need careful consideration as policy makers, health care providers and consumer advocates decide whether family involvement in the clinical monitoring of hospitalized patients is something

to be avoided at all costs, or something they should support in some form, either as a 'bonus' when it occurs, as something to be encouraged where possible, or as a necessity to safeguard patients against the deficiencies of stretched and imperfect hospital systems.

The lack of evidence

As far as I am aware, there have been no evaluations of the introduction of policies or practices that aim to encourage and support family involvement in the clinical monitoring of hospital patients for safety improvement purposes. Empirical evidence about the acceptability, feasibility and effects of such interventions is therefore lacking. As evidence does start to emerge, care will need to be taken about interpreting the findings of surveys of attitudes and practical initiatives carried out in particular clinical and social settings and applying them to other contexts.

The expectations and attitudes of families and health professionals

Family members and friends already play various supportive roles for hospitalized patients. Almost universally, they provide companionship, emotional support, entertainment and a connection back to the patients' usual communities. In some countries they provide meals, and where public resources for health care are in chronic short supply, they may routinely be asked by doctors to procure the medical and surgical consumables needed for treatment.[9] Local norms about these kinds of family contribution tend to be well established, and the expectations of health care providers and service users are usually compatible.

Family members are also often vigilant about patients' conditions and treatments when they visit them in hospital. There are numerous anecdotal examples of family members being the first to notice that something was going wrong and bringing it to the attention of medical or nursing staff. However, most people still think that good clinical monitoring requires professional knowledge and skills, and that responsibility for it rests with professional health care providers. I suspect that few family members think that they should be relied upon to monitor a patient's condition and treatment in hospital.

Health professionals are likely to have varying opinions about the roles that patients and family members can and should play in clinical monitoring. It is quite possible that many will see it as a challenge to their professional expertise and commitment, and also that many will see it as contrary to the best interests of the patient and family – especially if the proposal is for a round-the-clock family presence. Even health professionals who are committed to family centred care may be sceptical that greater family involvement in clinical monitoring is likely to make a substantial positive impact on patient safety.

Professional 'buy-in' will be important in any attempt to implement family involvement in clinical monitoring in hospital contexts, because family members will usually be dependent on professional nursing and medical staff to confirm the significance of any problems they perceive, to understand their nature and cause, and to implement an appropriate 'rescue'.

The concept of clinical monitoring of patients in hospital by families has the potential to generate serious role tensions for health professionals and families. Any attempt to introduce it formally or routinely would need extremely careful management.

Families' capacity to contribute

Some patients would find it difficult to muster family members or others to accompany, monitor and advocate for them during hospital stays. Geographic dispersion, work commitments, personal illness or disability among other family members and multiple caring responsibilities mean that some families do not have the capacity to provide full-time vigilance at a hospital which may be some distance from home and few workplace or welfare benefits would currently facilitate this. Even when family members can be present for hospitalized patients, they are likely to vary in terms of their ability to take on clinical monitoring roles.

The capacity to contribute is likely to be unequally distributed across social groups. Communities with relatively little social capital might find it particularly difficult to contribute to the clinical monitoring of hospitalized patients. If the hospitals that serve these communities are also particularly prone to struggle to recruit medical and nursing staff, and/or to implement costly strategies to reduce health care errors, attempts to shift some of the responsibility for improving patient safety onto families might leave these communities further disadvantaged when it comes to accessing high quality hospital care.

Accommodating families: hospital facilities and policies

Many hospitals – even among those that are generally considered well resourced – lack the facilities to accommodate family members round the clock, although maternity services and children's hospitals often try to do so. Family space is increasingly being designed into new facilities (in response to both staff work flow and patient preference considerations), but it is likely to be a while before this is the norm for hospitals.

Many hospitals still have policies that restrict 'visiting' times and require family members to leave patients' bedsides while health professionals are discussing care plans, carrying out tests, administering treatments or handing over between shifts. Both kinds of policy are likely to restrict family members' ability to carry out continual and informed clinical monitoring.

Education and other support for family participation

For family members to make effective contributions to clinical monitoring, they need to be able to recognize important indicators of a patient's health status, to judge what constitutes a potentially important deterioration, and to identify deviations from agreed treatment plans. The knowledge and skills required to do this well are usually acquired by years of clinical training, although the checking of medications offered against medications prescribed is relatively simple and, as many post-discharge instructions imply, most people can be taught relatively quickly to look for a limited number of specific signs that might indicate problems in people with particular conditions who have had particular treatments.

The role of patient and family education in hospitals has traditionally been assigned to nurses, many of whom already quite regularly give advice about what I am calling clinical monitoring. However, patient and family education tends to be one of the tasks that nurses skip or truncate when pressed for time.[10] If clinical monitoring by families was to be formally encouraged, education for family members would probably be less optional for nurses, and might need to be more rigorous and time-consuming. It is not clear whether the time and costs needed to prepare families to help in this way would be outweighed by the benefits.

Innovative practices that aim to promote family centred care and/or quality improvement may also tend to facilitate family contributions to clinical monitoring. For example, inviting family members to be present during interdisciplinary 'rounds' in which communication is directed to the patient and family[11, 12] may help them to understand salient features of the patient's condition and to identify deviations from agreed plans. It may also help to create a sense of partnership between health care providers and family members. However, while these innovations could support family involvement in clinical monitoring, that was not their primary intent.

Responsibility

The promulgation of messages telling families what they can do to help preserve the safety of hospitalized members tends to encourage families to feel and be seen as bearing some of the responsibility for the safety of care given to particular individuals. The psychological, ethical and medico-legal ramifications of this are substantial, and need careful consideration.

If hospital services encourage family members to monitor patients, they oblige themselves to respond effectively when those family members alert them to problems.

Sadly, in some cases when family members have expressed concerns about errors they have perceived in patient care or deterioration in a patient's condition, health professionals have not taken their concerns seriously, and/or have been unavailable or unable to effect a rescue.[4] Not surprisingly, these families have felt doubly let down by their health care providers. If family members are actively encouraged to engage in clinical monitoring type activities and then not adequately responded to, their frustration, grief and anger might justifiably be further compounded.

Concluding remarks

Policy makers and health care providers in many countries have made commitments to work with patients and families to improve the quality of care. However, few have seriously addressed the concept of family involvement in the clinical monitoring of hospitalised patients.

In the context of nursing shortages, high rates of health care error, and public concern about both, American patients are being advised by some sources that in order to protect their safety, their family members should engage in clinical monitoring activities while they are in hospital.

Policy makers and health care providers need to think carefully – and support research to inform their thinking about – how to respond to family members who wish to engage in clinical monitoring of hospitalised patients, whether and how they should more routinely encourage and support such monitoring, and how else they might address the concerns that have led some to perceive it as necessary.

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