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INFLUENCE OF COMMUNICATION ON THE NURSE-FAMILY RELATIONSHIP IN NA INTENSIVE CARE UNIT: SYSTEMATIC LITERATURE REVIEW

INFLUÊNCIA DA COMUNICAÇÃO NA RELAÇÃO ENFERMEIRO-FAMÍLIA EM CONTEXTO DE UNIDADE DE CUIDADOS INTENSIVOS: REVISÃO SISTEMÁTICA DA LITERATURA

INFLUENCIA DE LA COMUNICACIÓN EN LA RELACIÓN ENFERMEIRA-FAMILIA EN UNA UNIDAD DE CUIDADOS INTENSIVOS: REVISIÓN SISTEMÁTICA DE LA LITERATURA

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ABSTRACT

Background: Communication with the family in the context of an intensive care unit is crucial for the development of a nurse-family therapeutic relationship. The inclusion of the family in the provision of care to the person in a critical situation presents benefits for the user, as it allows a conscious and informed decision-making by the family and presents health gains.

Objective: To explore how communication influences the establishment of a nurse-family therapeutic relationship in an intensive care unit.

Methods: The methodology used was based on a systematic literature review, which included the development of the research question, research in scientific databases, analysis and interpretation of selected articles as well as the synthesis and presentation of the results obtained. For the selection of articles and formulation of the research question, the PI[C]OD methodology was used.

Results: Applied to the methodology, a final set of 10 studies was obtained, which support that family-centered care has benefits for patient safety, emphasizing the intervention of effective communication with family and family members. use of available technological resources in order to reduce the levels of anxiety and stress present in this health--disease transition phase.

Conclusion: Communication is an inherent competence in the practice of nursing care. The specific training area, norms and guidelines will allow the use of joint communication strategies of the upbringing families that in the protocol decision to a greater one of them for fundamental decision making.

Keywords: Breaking news; Communication; Family; Information; Intensive care unit; Nurse.

RESUMO

Enquadramento: A comunicação com a família em contexto de unidade de cuidados intensivos é crucial para o desenvolvimento de relação terapêutica enfermeiro-família. A inclusão da família na prestação de cuidados à pessoa em situação crítica apresenta benefícios para o utente, pois permite uma tomada de decisão consciente e fundamentada por parte da família e apresenta ganhos em saúde.

Objetivo: Explorar como a comunicação influencia o estabelecimento de relação terapêutica enfermeiro-família em unidade de cuidados intensivos.

Métodos: A metodologia utilizada alicerçou-se numa revisão sistemática da literatura, que incluiu o desenvolvimento da pergunta de investigação, a pesquisa em bases de dados científicos, a análise e a interpretação dos artigos selecionados bem como a síntese e apresentação dos resultados obtidos. Para a seleção de artigos e formulação da pergunta de investigação utilizou-se a metodologia PI[C]OD.

Resultados: Aplicada a metodologia, obteve-se um conjunto final de 10 estudos, os quais sustentam que o cuidado centrado na família apresenta benefícios para a segurança do doente, dando-se enfâse à intervenção de uma comunicação eficaz com os membros da família e da utilização dos recursos tecnológicos disponíveis, de modo a diminuir os níveis de ansiedade e *stress* presentes nesta fase de transição de saúde-doença.

Conclusão: A comunicação é uma competência inerente à prática de cuidados de enfermagem. A formação específica na área, bem como a criação de protocolos, normas e diretrizes permitiram o uso de estratégias comunicacionais eficazes junto das famílias levando a uma maior capacitação das mesmas para uma tomada de decisão fundamentada e obtenção de melhores resultados em saúde.

Descritores: Comunicação; Enfermeiro; Família; Informação; Más Notícias; Unidade de Cuidados Intensivos.

RESUMEN

Fundamento: La comunicación con la familia en el contexto de una unidad de cuidados intensivos es crucial para el desarrollo de una relación terapéutica enfermera-familia. La inclusión de la familia en la prestación del cuidado a la persona en situación crítica presenta beneficios para el usuario, ya que permite una toma de decisiones consciente e informada por parte de la familia y presenta beneficios para la salud.

Objetivo: Explorar cómo la comunicación influye en el establecimiento de una relación terapéutica enfermera-familia en una unidad de cuidados intensivos.

Métodos: La metodología utilizada se basó en una revisión sistemática de la literatura, que incluyó el desarrollo de la pregunta de investigación, búsqueda en bases de datos científicas, análisis e interpretación de artículos seleccionados, así como la síntesis y presentación de los resultados obtenidos. Para la selección de artículos y formulación de la pregunta de investigación se utilizó la metodología PI[C]OD.

Resultados: Aplicada a la metodología se obtuvo un conjunto final de 10 estudios, que sustentan que el cuidado centrado en la familia tiene beneficios para la seguridad del paciente, enfatizando la intervención de comunicación efectiva con la familia y uso de los recursos tecnológicos disponibles con el fin de reducir los niveles de ansiedad y estrés presentes en esta fase de transición salud-enfermedad.

Conclusión: La comunicación es una competencia inherente a la práctica del cuidado de enfermería. Las capacitaciones específicas en el área, así como la creación de protocolos, normas y lineamientos, permitieron el uso de estrategias efectivas de comunicación con las familias, lo que llevó a un mayor empoderamiento de estas para tomar decisiones informadas y obtener mejores resultados en salud.
Palabras llave: Comunicación; Enfermera; Familia; Información; Más noticias; Unidad de Cuidados Intensivos.

INTRODUCTION

Health communication is essential for the quality of care provided and the safety of users and their families. In the context of hospitalization, communication is very important as it emerges explicitly and implicitly in the establishment of therapeutic relationships between nurses and the family. According to Meleis[1], human communication is "a process of behavior based on a system of exchanging symbols in which meaning is transmitted and interpreted among those who interact". It is expected that in the interaction with the family, which experiences a health-disease transition process with one of its members, nurses find strategies that facilitate communication with them.

Communication should be considered by the nursing team as a crucial and important moment of care, with an emphasis on listening and valuing the needs of the family of the person in a critical situation and with respect for cultural and religious differences. One of the purposes of communication is to assist the family to overcome the feelings of anxiety and anguish arising from this transition process.

The situation of serious illness affects not only the person in a critical situation, but also their family, negatively affecting their daily life. In this way, several authors confirm the idea that the admission of a patient to an intensive care unit (ICU) completely transforms the daily life of their relatives, since they do not have enough time to be adjusted to this new condition. Thus, nurses assume a fundamental role, so that these health professionals who, due to their continuous presence and demonstrated competences, can and should assess the family's situation as well as define a care plan that meets family's needs[2].

The nurse, the patient and the family experience the critical illness process independently; however, they are related to each other. It is based on these interactions in the context of clinical practice, as well as through the available resources, that the potential to inhibit or enhance family-centered care arises[3].

The importance attributed to communication in the nurse-family relationship is transversal, both from the nurse's perspective and from the perspective of the different family members. It can therefore be considered that communication is effective when it presents itself as a support for the relationship, as well as when it is seen as a strategy, responding to the need for information of the family of the person in a critical situation hospitalized in the ICU. This information must be carefully selected, and must be transmitted clearly and at the most opportune moment, since it is information of a sensitive nature[4,5].

According to Bueno *et al* (2018) quality communication requires training and collaborative effort on the part of the team. Adapting the information transmitted and the communication tools used to the questions and needs of the relatives of the person in a critical situation hospitalized in the ICU will not only improve their perception of the health care that the user is receiving, but will also help them to cope with this moment of uncertainty[6].

Communication with family members of critically ill patients often presents challenges due to time constraints, emotional changes on both sides, and varying levels of health literacy. While the information needs of family members are high, they also should not be burdened with irrelevant or overly complex information. High-quality dialogue with family members requires more than simply addressing the right topics. In addition to the content, the appropriate linguistic-interactive, psychosocial level and an adequate framing of the conversation are also necessary[7]. Another challenging aspect is the time allocated by health professionals in communicating information, which is often seen as excessive, leading to a high workload. On the other hand, the increasing availability of high-quality online resources and the widespread use of smartphones has the potential to reduce the burden on professionals and can be used as an enabling strategy[7].

Therefore, this literature review was carried out in order to identify and to describe the most up-to-date scientific knowledge on how communication influences the establishment of a nurse-family therapeutic relationship in an intensive care unit.

METHODOLOGY

Review aim

To explore how communication influences the establishment of a nurse-family therapeutic relationship in an intensive care unit.

Research protocol

The present study consists of a systematic literature review and free research. This type of review combines the strengths of the critical review with the comprehensive research process. It addresses broad issues to produce a better synthesis of evidence and brings together available knowledge on a thematic area[8].

The review began with the construction of the following research question: What is the influence of communication with the family of the person in a critical situation, in the nurse-family therapeutic relationship?

Given the research question developed, the inclusion criteria were identified, following the PICOD methodology (participants, intervention, context, results and design) (Table 1↗).

After defining the research question and a brief free search on the EBSCO and Google Scholar platforms, the research protocol presented below was defined.

The research of the studies was centered between 2018 and 2021, on the EBSCO platform, with selection of the business databases Source Complete, CINAHL Plus with Full Text, ERIC, Library, Information Science & Technology Abstracts, MedicLatina, MEDLINE with Full Text, Psychology and Behavioral Sciences Collection, Regional Business News, SPORTDiscus with Full Text. The intersection between the descriptors of the Boolean operator was used, resulting in the following Boolean equation: communication AND intensive care unit AND family AND nurse.

A free search was also carried out in order to include the most recent studies and with greater scientific evidence in the present review, for which a new search was carried out on the Google Scholar platform with the keywords: communication, intensive care unit, family, nurse, information, breaking news.

As search delimiters, articles in full text (full text) and written in English and Portuguese were defined. The selected inclusion criteria are: age group over 18 years-old and studies whose object of study were the communication strategies used in the nurse-family relationship in an intensive care unit. Exclusion criteria are: pediatric age, studies without relevance to nursing practice, articles that did not provide the full text and articles that were prepared in the context of the COVID-19 pandemic.

24 articles were selected through reading the title and abstract, which were read in full, and 10 articles were included in this review. These articles were examined by two independent reviewers and applied to the Joanna Briggs Institute rating grids. Studies were classified according to their level of evidence using the tables proposed by the Joanna Briggs Institute[9].

The entire study selection process was outlined according to the PRISMA model (Preferred Reporting Items for Systematic Review and Meta-Analyses)[10], schematically represented in Figure 1↗.

Assessment of the methodological quality of studies using the JBI evaluation grids (Table 2↗).

Extraction of results/Synthesis of data

After analyzing the articles, a table↗ was created to extract the results, including the identification of the authors of the studies, year of publication, objective of the study and the synthesis of the main data and emerging results in each of them.

RESULTS

The qualitative study developed by Mendes (2018) found that the experience lived by the family in the knowledge of the critical illness situation is considered the inaugural moment that triggers all the following events. It is recognized that the information transmitted to family members, with regard to content, form and person who transmits, influences this same experience. It is considered that nurses thus assume a central role in responding to the real and potential needs of family members both individually and collectively[18].

The nurse, the patient and the family experience the critical illness process in a unique way, however, they establish relationships with each other throughout this process. Thus, this triad, the professional practice environment and the resources available for family-centered care, have the potential to act as barriers or facilitators for the family's involvement in the planning of care for the person in a critical situation. As recommended in the structure of care centered on the person hospitalized in the ICU as well as on their family, communication and high-quality information transmitted to them are essential for the satisfaction and integration of the family in the care process[3,21].

According to Mendes (2020), uncertainty and the unforeseen are the basis for defining communication as a strategy, however these two concepts can also limit the possibility of communicating. Uncertainty and the unforeseen experienced in the health-critical illness transition process interfere in the communication processes, becoming one of the main responsible for the loss of its effectiveness. Ambiguity, doubt and misinformation or incorrect information influence uncertainty, leading to its growth or permanence[17].

From the study carried out by Mendes (2020), three essential themes emerge: (i) the antecedents of uncertainty: condition inherent to the subject; (ii) the uncertainty appreciation process: capabilities and opportunities and (iii) the way of dealing with uncertainty: coping strategies. These themes allow us to understand that uncertainty does not arise in isolation from the subject, the experience or the context in which it occurs[17]. Health professionals, namely nurses, are fundamental in mediating this transition, as they positively or negatively influence the communication processes initiated by both. It is important, however, to clarify that nurses who work daily with families in this health-disease transition, based on the theoretical frameworks of Mishel (1981) and Meleis (2000), cited by Mendes (2020), developed the concept of coping and adaptation, which allowed understanding the real needs of the family as well as implementing nursing interventions that facilitated this experience[17].

According to Hetland *et al* (2019) the establishment of trusting relationships, frequent communication between nurses and the family, a professional practice environment that supports their involvement in care delivery and decision-making, as well as resources available for family involvement, are strategies that facilitate the establishment of a nurse--family therapeutic relationship[3].

The purpose of family involvement is to integrate the family in the provision of care, as well as in the elaboration of care plans. In this way, nurses should actively seek together with the family for members who can participate, prioritizing the preferences and needs of users[21].

According to Kalocsai *et al* (2018), the roles played by nurses and doctors promote the therapeutic relationship in three dimensions: communication, integration and collaboration. The family members who participated in this study identified these roles as fundamental in the construction of therapeutic relationships, also describing that nurses actively contributed to the promotion of communication when compared to other health professionals[14].

Family members also revealed that informal interactions with nurses facilitated the development of therapeutic relationships, contrary to what happened with other health professionals. Participants point to doctors as the agents of transmission of clinical information, however, it is nurses who facilitate their understanding, providing emotional support through clear, accurate and empathic communication. Participants in this study not only found that nurses treated their family members respectfully, but also played an important role in managing the suffering experienced by families[14].

The result of the study developed by Frivold *et al* (2021), showed that family members were involved and treated as active partners in communication processes, namely dialogues, discussions and decision-making, developing a relationship of trust with nurses[21].

Families intend to play a more active role in the care of patients hospitalized in the ICU, so nurses play a vital role in the transformation of family-centered care, due to their continuous presence in the ICU and in the constant interaction with the family. Family involvement in a shared decision-making approach has demonstrated mutual benefits[5,22].

Yoo *et al* (2020) revealed that ICU nurses struggle daily to achieve a balance between their workload and the time spent communicating with patients and their families. Effective communication seems to be related to a higher level of job satisfaction and lower levels of psychological burden, also promoting positive responses in the family. The nurses participating in the study in question described communication as one of the most challenging but essential aspects in the ICU. At the same time, they developed active listening skills and empathy, in the daily therapeutic relationship established with the families[16].

A qualitative study developed by Hetland *et al* (2019), states that the workload associated with the care provided to critically ill patients, as well as the lack of internal policies, protocols and guidelines, sometimes makes it difficult for the family to be involved in the provision of care. However, the same author argues that the establishment of therapeutic relationships and communication with family members presents positive responses in the quality of care provided, as well as in the environment of professional practice, so strategies must be defined in order to overcome this obstacle[3].

In the study developed by Jo *et al* (2019), the quality of communication regarding the process of serious illness and imminent death, as well as respect for their spiritual and religious beliefs, were described by family members as being very low compared to professionals of nursing. The authors argue, even though nurses, as they are the health professionals closest to patients and their families, can encourage the doctor to communicate with the family, thus providing comfort and emotional support to family members while they process the information received[11].

For Ganz *et al* (2019), the quality of communication is associated with high levels of stress in family members of people hospitalized in ICU, these levels were not associated with the personal characteristics of the members or the perceptions of the current medical status of the users. Most components of patient-centered communication were negatively correlated with stress levels, with significant correlations emerging in therapeutic relationship building, participation in care management, and emotional support. Study participants also found that effective communication correlates with lower levels of stress[12].

Mistraletti *et al* (2019), developed a project called "Intensive 2.0", understood as an opportunity to spread humanization in intensive care. Its purpose is to propose a cultural change, with the objective of creating a therapeutic alliance with family members in order to promote the adequacy of care to users, transmission of correct information, well-being of family members and health professionals. The introduction of tools such as: website, leaflets and posters, allow the family members to elucidate what the ICU is, how it is structured, and what happens to the user in this unit, etc., which will certainly help to understand better. the care provided. On the other hand, a better understanding is related to a decrease in anxiety and depression, as well as the development of post-traumatic stress syndrome, helping different family members to manage their feelings during this transition[19].

Family involvement presupposes a relationship based on mutual respect and trust between family members and the multidisciplinary team. A relationship of trust can be built on the basis of an inclusive dialogue and the transmission of information. In order to alleviate the anxiety or stress associated with this process, it may be beneficial to provide written or video-based information to aid their perception and assimilation. The use of handouts and journaling can help to reduce the anxiety and stress experienced by the family, as well as video-based information can support existing formats and, at the same time, can help families with lower levels of literacy. The use of technologies associated with the facilitating strategies used by nurses, such as communication, emotional support and active listening, suggest a superior benefit for the patient and his family[21,23].

A study developed by Pecanac & King (2018), where group interviews were carried out with nurses, doctors and family members, revealed that nurses were invited to attend less than half of the family meetings, contributing little to them. They were rarely invited to participate in the conversation, except to address logistical issues. When selected to speak, nurses often answered yes or no. Faced with these restrictions, the nurses intervened in the meeting with short and simple interactions, where they provided clarification and/or an updated assessment of the patient's condition. Despite all the restrictions and the brief intervention by the nurses in the meetings with the family, it can be concluded in the study that the information provided by them, although short and simple, was well understood and received by the family members[13].

Naef *et al* (2020), based on the family's experience and with the intervention of the family nurse in the ICU, developed a research study, through which they found that family members and health professionals described the intervention to support the family as an adequate, acceptable and complementary service to the care provided by doctors and nurses. Even if they are not present, whenever the family visits the ICU, the family nurse

can be contacted, either by phone and/or e-mail, leading to positive feedback from family members, as they receive all in the mornings, a phone call from the nurse responsible for the relative to inform the patient's clinical condition. Families thus experienced emotional, practical, useful and significant support. Examples of nursing interventions received by families include offering presence, active listening, therapeutic dialogue, provision of information, training, referral to additional services, among others. For the participants, the family nurse was a liaison person who facilitated the interaction between the user, the family and the ICU team[15].

In another study developed by Withe *et al* (2012), it is described how the inclusion of a nurse specialist in family support in the ICU team, benefits in overcoming cognitive, emotional, psychological and communicational barriers that threaten the quality of decision-making that is usually present in the ICU[24].

Silva and Casarini (2019) developed a qualitative study that allowed the creation of a guiding question guide for communication with families in ICU. The authors observed that this script contributed to a better organization, planning and identification of the information to be transmitted, based on the need that family members have to learn about the state of the patient hospitalized in the ICU. Such learning seems to constitute a process, which begins with the knowledge of the reasons for transfer to the ICU and the characteristics of this unit, to later evolve to a progressively more improved knowledge about the disease process, treatment and prognosis[20].

In the study developed by Wilson *et al* (2015), several topics were identified by the family members who were the subject of clarification in the dialogue with health professionals, namely diagnosis, treatment, prognosis, clinical status, visiting hours, comfort and family participation. Professionals responsible for communicating with families benefit from prior knowledge about their concerns and needs, thus allowing a better provision of family-centered care[25].

CONCLUSION

Family-centered care has been a concern for nurses worldwide, gaining prominence in the most recent scientific evidence. The provision of excellent care involves the humanization of care in the ICU and, for this to occur, the inclusion of the family in the provision of care becomes fundamental.

Communication plays an important role in the establishment of therapeutic nurse-family relationships, with regard to the person in a critical situation hospitalized in the ICU. Nurses have verbal and non-verbal communication skills such as therapeutic dialogue, active listening, therapeutic touch, coping, empowerment, empathy, among others, which influence the establishment of this relationship with the family.

The family of the person in a critical situation hospitalized in the ICU should be considered the focus of care, in this way the data collection carried out with this person will allow the elaboration of a care plan focused on the real needs of its members, which will therefore lead to the their training for informed decision making and the management of feelings in the face of the health-disease transition process.

Specific training in the area of communication as well as the existence of protocols, norms and guidelines will allow for a more effective and safe nursing intervention with families and the consequent provision of care centered on the same.

It is concluded that the studies included in this systematic literature review answer the initial question presented, insofar as communication positively and/or negatively influences the establishment of a nurse-family therapeutic relationship in the ICU. The establishment of an effective therapeutic relationship with the family allows its inclusion in the planning of care for the person in a critical situation hospitalized in the ICU, which will not only allow informed decision-making by the family, but also bring significant health gains for the patient.

It is also important to reinforce the idea that further studies should be carried out in this area, in order to define effective communication strategies for the promotion of a nurse--family therapeutic relationship that can lead to changes in behavior and consequent increase in better results.

Authors' contributions

JR: Study coordination, study design, data collection, storage and analysis, review and discussion of results.
IB: Study design, data analysis, review and discussion of results.
PV: Study design, data analysis, review and discussion of results.
All authors read and agreed with the published version of the manuscript.

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Table 1 – PICOD Chart.

P	Population (Participants/Structures)	Who was analyzed?	Family of person in critical situation
I	Intervention (Care/Process relation)	What was done?	Nursing intervention Communication
C	Context	Comparisons among results	Intensive care unit
O	Results (Intermediate and final)	What were the results or effects?	Influence of communication in the establishment of a nurse-family therapeutic relationship
D	Study Design	How is it?	Systematic review of literature and research

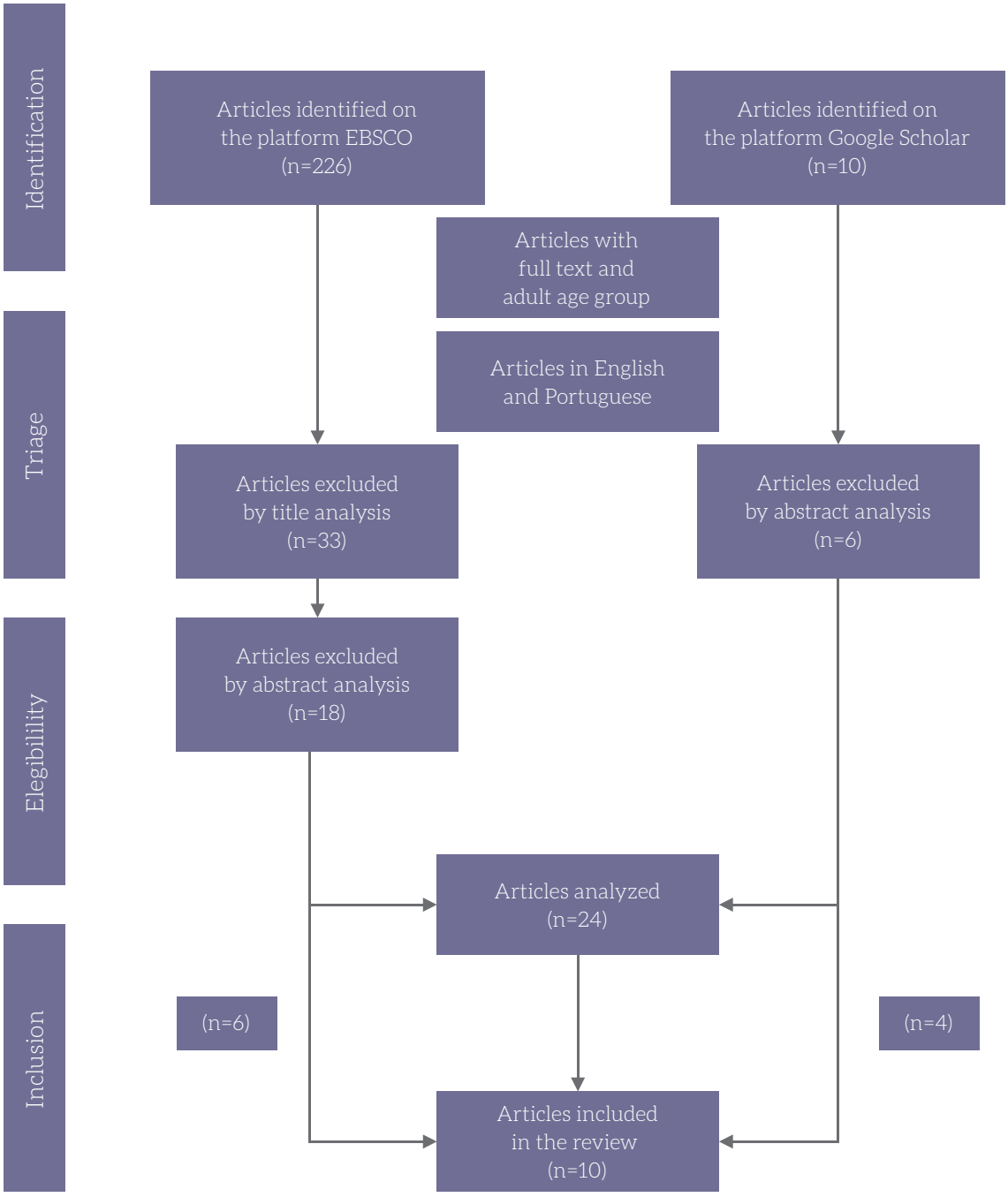

Figure 1 – Diagram adapted from PRISMA Statement representative of the research process[10].

Table 2 – Summary of the level and quality of evidence of articles selected according to JBI and results of critical evaluation of included studies according to the JBI Critical Evaluation Checklist.

References/Evidence Level	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Result
Jo *et al* (2019)[11] Observational study – descriptive study (IV – B)	Y	Y	Y	Y	N.A.	N.A.	Y	Y						75%
Ganz *et al* (2019)[12] Observational study – descriptive study (IV – B)	Y	Y	Y	Y	N.A.	N.A.	Y	Y						75%
Pecanac & King (2019)[13] Observational study – descriptive study (IV – B)	Y	Y	Y	Y	N.A.	N.A.	Y	Y						75%
Kalocsai *et al* (2018)[14] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%
Naef *et al* (2020)[15] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%
Yoo *et al* (2020)[16] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%
Mendes (2020)[17] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%
Mendes (2018)[18] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%
Mistraletti *et al* (2019)[19] Experimental Study (I-C)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
Silva & Casarini (2019)[20] Qualitative Study (III)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				100%

Subtitle: Y – *Yes*; N – *No*; U – *Unclear*; N.A. – *Not Applicable*.

Table 3 – Summary table for extracting data from the quantitative and qualitative evidence of the selected studies.

Author of the study	Study objective	Participants	Results	Period
Jo *et al* (2019)[11]	To analyze the association between health professional-family communication and the development of symptoms of anxiety, depression and stress.	71 Family members.	• Families of ICU users were moderately satisfied with the quality of communication with health professionals; • Several family members reported that doctors and nurses did not focus on several key points for the quality of communication, namely, informing about the possibility of imminent death, asking about spirituality and religious beliefs; • Regarding nurses, family members revealed that levels of depression are associated with the quality of communication.	December 2015 and April 2016.
Ganz *et al* (2019)[12]	To describe the association between family-centered communication and levels of stress experienced by the family during ICU admission.	130 Family members.	• The quality of communication is associated with levels of stress in family members; • Family members' stress levels decreased as the quality of communication increased; • Most components of communication were negatively correlated with stress levels, with significant correlations for relationship building, participation in care planning, and emotional support.	N. A.
Pecanac & King (2019)[13]	To explore nurse-family communication during and after family meetings.	36 Family meetings.	• Nurses attended less than half of the family meetings and, when present, made few contributions. They were rarely invited to participate in the conversation, except to address logistical issues. When selected to speak, nurses used to answer yes or no; • Most of these interactions were short and simple and provided clarification, reassurance, or an up-to-date assessment of the client's current status.	January 2015 and December 2015.

Table 3 – Summary table for extracting data from the quantitative and qualitative evidence of the selected studies.

Author of the study	Study objective	Participants	Results	Period
Kalocsai *et al* (2018)[14]	To explore the perspectives of family members on barriers and facilitators and for establishing therapeutic relationships with doctors and nurses in the ICU.	36 Family members.	• Physicians provided clinical information, while nurses facilitated understanding of this information and provided emotional support through frequent, reliable, clear, and empathetic communication; • Family members recognized nurses and doctors as valuable sources of information about the patient's condition and care; • Families recognized the communication with doctors with a focus on end-of-life issues, but saw the nurses as an expression of empathy during the patients' stay in the ICU; • Family members appreciated how the nurses treated patients respectfully, but also how they dealt with the family's suffering.	October 2014 and February 2015.
Naef *et al* (2020)[15]	To explore the experience of family and healthcare professionals with a family support intervention led by an ICU family nurse.	38 Participants (50% family members, 45% nurses and 5% doctors).	• The family nurse was a liaison person who facilitated the interaction between the user, the family and the ICU team, providing advice and support whenever necessary; • Families experienced emotional support as helpful and meaningful. Examples of family nurse interventions include offering presence, active listening, therapeutic dialogue, providing information, training, and referring to additional services; • The role of a family nurse in the ICU is acceptable to both families and the multidisciplinary team.	February 2019 and July 2019.

Table 3 – Summary table for extracting data from the quantitative and qualitative evidence of the selected studies.

Author of the study	Study objective	Participants	Results	Period
Yoo *et al* (2020)[16]	To explore the experiences related to the communication of ICU nurses, users and their families.	16 Nurses with intensive care training.	• Greater job satisfaction for ICU nurses is associated with better communication. Therapeutic communication effectively lessened the psychological burden and promoted positive responses; • Participants learned that communication is a challenging but essential aspect. Nurses must establish a relationship with the patient and their families, otherwise they will not understand their needs; • Participants developed empathy and active listening skills when talking to patients and their families, over time, the quality of care and non-verbal communication skills such as therapeutic gaze and touch improve.	July 20, 2019 and September 30, 2019.
Mendes (2018)[18]	To understand the impact of critical illness news on the experience lived by family members in an ICU.	21 Family members.	• Three essential themes were identified: the unexpected; the harbinger of death; the impact on taking care of oneself. • The unexpected: Participants demonstrate that the news of a critical illness compromised their daily lives, leaving them weaker, fragile and vulnerable; • The harbinger of death: The situation of critical illness appears related to the concept of finitude. Timely, clear and accurate information has taken on an important meaning in the family's experience; • The impact on taking care of oneself: Dealing with a family member's critical illness situation becomes distressing and retracts the initiative to take care of oneself; • The family seeks to receive information but also comfort to know how to manage feelings and make decisions; • Nurses must see the family as the focus of care, understand their needs and fears as well as assist in problem solving and decision making.	N.A.

Table 3 – Summary table for extracting data from the quantitative and qualitative evidence of the selected studies.

Author of the study	Study objective	Participants	Results	Period
Mendes (2020)[17]	To understand, based on Mishel's Theory of Uncertainty in Disease and Meleis' Theory of Transitions, the way in which uncertainty in the disease and the unforeseen mediate the nurse-family communication process.	21 Family members.	• Uncertainty in critical illness and the unforeseen mediate communication processes and are responsible for their effectiveness or ineffectiveness; • Continuous and adequate communication with the nurse is assumed as a facilitating factor in the health-disease transition; • Ambiguity, doubt, lack of information or inconsistent information lead to increased uncertainty; • Nurses positively or negatively influence communication processes initiated by both family members and nurses. When accurate and clear information enables the person to be prepared, allowing them to deal with uncertainty and create adaptation strategies.	N.A.
Mistraletti *et al* (2019)[19]	Introduction of tools in the communication process between the UCI team and family members and the educational support dedicated to the UCI team.	2100 Family members.	• The Intensive 2.0 Project proposes the creation of a therapeutic alliance with family members to promote care, the transmission of correct information, well-being of family members and health professionals; • The introduction of tools such as a website, leaflets and posters, which explain to family members what the ICU is, how it is structured and what happens to the patient in this unit, will help to better understand the care provided as well as the prognosis. A correct understanding of medical treatments decreases the prevalence of anxiety, depression and post-traumatic stress symptoms.	January 2018 and December 2020.
Silva & Casarini (2019)[20]	To develop a guide for communication in the ICU based on doubts identified with family members and professionals.	10 Health profesionals 11 Family members.	• Creation of a script that intends to respond to the information requested by family members during hospitalization in the ICU, which contributes to the organization, planning and identification of information to be transmitted, favoring the construction of knowledge about the patient; • From this script emerge several groups related to the structure and functioning of the ICU, with the communication mechanisms and the clinical evolution of the users.	November 2013 to July 2014.