

Millenium, 2(29)



DESENVOLVIMENTO DE UM PROCEDIMENTO ESTRUTURADO DE ACOLHIMENTO FAMILIAR EM CUIDADOS INTENSIVOS DE ADULTOS


DEVELOPMENT OF A STRUCTURED FAMILY RECEPTION PROCEDURE IN ADULT INTENSIVE CARE

DESARROLLO DE UN PROCEDIMIENTO ESTRUTURADO DE ACOGIDA FAMILIAR EN CUIDADOS INTENSIVOS DE ADULTOS

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RECEIVED: 04th January, 2026

REVIEWED: 12th March, 2026

ACCEPTED: 16th March, 2026

PUBLISHED: 27th March, 2026

DOI: <https://doi.org/10.29352/mill0229e.44825>

RESUMO

Introdução: O acolhimento da família em unidades de cuidados intensivos de adultos é uma prática essencial, mas frequentemente pouco estruturada, apesar das recomendações de cuidados centrados na família.

Objetivo: Desenvolver um procedimento estruturado de acolhimento familiar em cuidados intensivos de adultos e obter consenso de peritos quanto ao seu conteúdo.

Métodos: Estudo metodológico em duas fases. A Fase 1 incluiu um focus group com nove profissionais experientes em cuidados intensivos, visando explorar práticas e componentes do acolhimento. A Fase 2 recorreu à técnica e-Delphi, em duas rondas, com dez enfermeiros peritos, aplicando critérios de consenso predefinidos.

Resultados: Foram identificadas quatro áreas temáticas que sustentaram o procedimento proposto. Obteve-se consenso em 42 itens, organizados em três componentes: acolhimento pré-visita, comunicação pós-visita e disponibilização de informação escrita padronizada.

Conclusão: O estudo resultou num procedimento estruturado e consensual de acolhimento familiar em cuidados intensivos. Estudos futuros deverão avaliar a sua viabilidade e aplicação clínica.

Palavras-chave: enfermagem de cuidados críticos; relações profissional-família; humanização da assistência

ABSTRACT

Introduction: Family reception in adult intensive care units is a critical yet inconsistently structured practice, despite recommendations for family-centered care.

Objective: To develop a structured procedure for family reception in adult intensive care and achieve expert consensus on its content.

Methods: A two-phase methodological study was conducted. Phase 1 comprised a focus group with nine experienced intensive care professionals to explore current reception practices and key procedural components. Phase 2 used a two-round e-Delphi technique with ten expert critical care nurses to evaluate item relevance and clarity. Predefined consensus criteria were applied.

Results: Focus group analysis identified four thematic areas that informed the draft procedure. e-Delphi consensus was achieved for 42 items, organized into three components: a pre-visit reception moment, a post-visit communication moment, and provision of standardized written information.

Conclusion: This study produced a structured, expert-agreed family reception procedure for adult intensive care. Further studies should examine the feasibility, effectiveness, and family perspectives in clinical settings.

Keywords: critical care nursing; professional-family relations; humanization of assistance

RESUMEN

Introducción: La acogida de la familia en las unidades de cuidados intensivos de adultos es una práctica clave, pero se realiza de forma poco estructurada y variable, a pesar de las recomendaciones de atención centrada en la familia.

Objetivo: Desarrollar un procedimiento estructurado de acogida familiar en cuidados intensivos de adultos y alcanzar consenso experto sobre su contenido.

Métodos: Estudio metodológico en dos fases. La Fase 1 incluyó un grupo focal con nueve profesionales experimentados de cuidados intensivos para explorar prácticas y componentes esenciales de la acogida. La Fase 2 utilizó la técnica e-Delphi en dos rondas con diez enfermeros expertos, aplicando criterios de consenso predefinidos.

Resultados: El análisis identificó cuatro áreas temáticas que fundamentaron el procedimiento. Se alcanzó consenso en 42 ítems, organizados en tres componentes: acogida previa a la visita, comunicación posterior a la visita e información escrita estandarizada.

Conclusión: El estudio desarrolló un procedimiento estructurado y consensuado para la acogida familiar en cuidados intensivos. Se requieren estudios futuros que evalúen su viabilidad y aplicación clínica.

Palabras Clave: enfermería de cuidados críticos; relaciones profesional-familia; humanización de la atención

DOI: <https://doi.org/10.29352/mill0229e.44825>

INTRODUCTION

The intensive care unit (ICU) represents a paradoxical environment where life-saving technological advances converge with profound human vulnerability. While these units epitomize medical progress in critical care, they simultaneously create emotionally charged landscapes that can overwhelm families confronting their loved one's life-threatening condition (Fortunatti et al., 2021). The intersection of advanced medical intervention and family crisis demands a sophisticated understanding of how healthcare delivery extends beyond clinical protocols to encompass the relational and communicative dimensions of care (Azoulay et al., 2024; Fortunatti et al., 2022; Kesecioglu et al., 2024).

Contemporary critical care has witnessed a paradigm shift from purely biomedical approaches toward models that recognize families as integral partners in the therapeutic process. This evolution reflects growing evidence that family well-being directly influences patient outcomes and that the quality of professional-family interactions during critical illness can have lasting psychological implications (Azoulay et al., 2024; Naef et al., 2025; Wang et al., 2023). The initial encounter between healthcare professionals and families—often occurring at moments of acute distress—serves as a foundation that can either facilitate therapeutic partnership or exacerbate emotional burden (Koçyiğit Kavak & Demirci, 2025; Naldan et al., 2025).

The concept of family adopted in this study follows the definition proposed by the Society of Critical Care Medicine (SCCM), which states that family is defined by patients themselves or, when patients lack decision-making capacity, by their surrogates—encompassing individuals who provide support and with whom the patient maintains a significant relationship, regardless of biological or legal ties (Davidson & Zisook, 2017). This definition is consistent with the International Classification for Nursing Practice (ICNP), which conceptualises family as "a social unit or collective whole composed of people connected through blood, kinship, emotional or legal relationships, with the unit or whole being seen as a system, greater than the sum of its parts" (International Council of Nurses, 2019). Adopting an inclusive definition is particularly relevant in critical care, where the identification of a family representative is central to care coordination and communication.

Family-centred care (FCC) is understood as a healthcare approach that respects and responds to the individual needs and values of families, requiring structured interventions to mitigate the impact of critical illness crises and to prepare families for necessary decision-making (Davidson & Zisook, 2017). The SCCM guidelines formulate recommendations across five domains: family presence, family support, communication with families, the role of a specialised ICU team, and operational and environmental considerations (Davidson & Zisook, 2017). This framework is grounded in four core principles: respect and dignity, information sharing, participation in decision-making, and collaboration. These principles informed the conceptual orientation of the present study.

Despite widespread acknowledgment of family-centered care principles, the operationalization of these concepts remains inconsistent across critical care settings. The absence of standardized approaches to family reception creates variability that may compromise care quality and contribute to adverse psychological outcomes for both families and healthcare providers (Blok et al., 2025; Dong et al., 2025). This gap between theoretical understanding and practical implementation underscores the need for evidence-based procedures that can guide professionals in delivering compassionate, structured family support.

The present study addresses this imperative by developing and validating a comprehensive procedure for family reception in intensive care settings. Theoretically, the study is grounded in Meleis' Transitions Theory (Meleis, 2010), which frames critical illness as a disruptive transition requiring targeted nursing interventions, and in the SCCM guidelines for family-centered care in the ICU (Davidson & Zisook, 2017), which provide the practice-level framework for structuring family interactions. The concept of humanization of care further informs this work, emphasizing the preservation of dignity, empathy, and person-centered values within high-technology healthcare environments (Kvande et al., 2022). Through the integration of professional experience, scientific evidence, and expert consensus, this research aims to contribute to the standardization of family-centered practices while enhancing the visibility of nursing interventions in critical care contexts.

The aim of this study was twofold: (1) to develop a structured procedure for the reception of families in adult intensive care units; and (2) to validate its content through expert consensus. This procedure intends to establish the initial family encounter as a foundation for meaningful engagement and partnership between healthcare professionals and relatives of critically ill patients. Specifically, the study sought to: (a) explore the perceptions and experiences of healthcare professionals regarding family reception; (b) identify thematic areas and categories to inform the construction of a structured procedure; and (c) validate the proposed procedure through expert consensus using the e-Delphi technique. The research question guiding this study was: *How can a structured procedure for the reception of families of critically ill patients in intensive care be developed and validated?*

1. BACKGROUND

The admission of a family member to an ICU precipitates a complex cascade of psychological, social, and physiological responses that extend far beyond the immediate medical crisis. Families experience what can be characterized as a state of "suspended reality," where familiar patterns of daily life are disrupted by the urgency of critical illness and the alien environment of intensive care technology. This disruption manifests across multiple domains: cognitive processing becomes impaired under stress, emotional regulation systems are overwhelmed, and decision-making capacity may be compromised at precisely the moment

DOI: <https://doi.org/10.29352/mill0229e.44825>

when crucial choices must be made (van Beusekom et al., 2016; Marques & Souza, 2010). Research has documented the emergence of Post-Intensive Care Syndrome—Family (PICS-F), a constellation of psychological symptoms including anxiety, depression, sleep disturbances, and post-traumatic stress responses that may persist long after hospital discharge (He et al., 2024; Smith et al., 2025). These findings highlight the critical importance of early interventions that can mitigate psychological distress and promote adaptive coping mechanisms during the acute phase of ICU admission (Davidson et al., 2017).

The quality of initial communication between healthcare professionals and families has been identified as a pivotal factor in shaping the entire ICU experience. Effective communication serves multiple therapeutic functions: it provides essential information for decision-making, reduces uncertainty and anxiety, establishes trust relationships, and empowers families to participate meaningfully in care processes (Kentish-Barnes et al., 2021; Wang et al., 2023). However, communication in ICU settings faces unique challenges. The complexity of medical information, time constraints, emotional intensity, and the technical environment all contribute to communication difficulties. Furthermore, families' capacity to process information is often compromised by stress, making traditional approaches to information delivery potentially ineffective (Fortunatti et al., 2021, 2022).

The theoretical foundation for structured family reception can be anchored in Afaf Meleis' Transitions Theory, which conceptualizes critical illness as a transition process affecting not only patients but entire family systems (Meleis, 2010). Transitions are characterized by periods of instability and vulnerability that require targeted professional interventions to facilitate healthy adaptation. From this perspective, family reception becomes a therapeutic intervention designed to support successful transition navigation (Dijkstra et al., 2025). Complementing this framework is the concept of humanization of care, which emphasizes the preservation of dignity, empathy, and person-centered values within high-technology healthcare environments. Humanization requires intentional design of procedures and interactions that acknowledge the emotional and relational dimensions of care alongside technical competencies (Kvande et al., 2022).

In Portugal, as in many healthcare systems globally, standardized protocols for family reception in ICU settings remain underdeveloped. Practice variations among professionals and institutions create inconsistencies that may compromise care continuity and quality (Camões et al., 2022). This situation reflects broader international challenges in translating family-centered care principles into systematic, actionable procedures (Davidson et al., 2017). The development of evidence-based guidelines for family reception represents a critical step toward addressing these inconsistencies. Such procedures must be grounded in both scientific evidence and contextual realities of clinical practice, ensuring they are not only theoretically sound but also practically feasible within existing organizational structures.

The convergence of these factors—documented family psychological vulnerability, evidence for communication as therapeutic intervention, theoretical frameworks supporting structured approaches, and practical gaps in current practice—creates a compelling rationale for developing validated procedures to guide family reception in ICU settings. This study responds to this imperative by employing a rigorous methodological approach that combines qualitative exploration of professional experience with structured expert consensus validation. The resulting procedure aims to contribute not only to improved family outcomes but also to enhanced professional satisfaction and institutional quality of care. By making visible the often-invisible relational work of nursing in critical care settings, this research reinforces the essential role of nursing interventions in promoting holistic, family-centered care.

2. METHODS

This is a methodological study, combining a qualitative exploratory phase with a structured consensus validation phase. The first phase involved a focus group to explore the perceptions of ICU nurses and physicians regarding the reception of families of critically ill patients. The second phase employed an electronic Delphi (e-Delphi) technique to validate a proposed procedure through expert consensus (Creswell & Creswell, 2018; Nasa et al., 2021). This combination of methods was chosen to ensure that the final procedure was both theoretically grounded and contextually relevant, aligning professional experience with current evidence and expert judgement.

2.1 Setting and sample

The study was conducted in two phases within the context of intensive care in Portugal.

Phase 1 – Focus Group: The qualitative exploration involved a group of intensive care professionals. Twelve professionals were invited, and nine ultimately participated (five nurses and four physicians). Three invited professionals were unable to attend due to unforeseen health-related constraints. The final sample size of nine participants was considered adequate based on established recommendations for focus group research, which suggest groups of four to twelve members (Krueger & Casey, 2015) or three to ten members (Hernández Sampieri et al., 2006), ensuring sufficient diversity of perspectives while allowing all participants to contribute meaningfully. Inclusion criteria were: (i) holding a management role within the ICU; (ii) a minimum of 10 years of professional experience in nursing or medicine; (iii) at least five years of critical care experience; (iv) serving as shift coordinator; and (v) holding a clinical specialty. In the Portuguese ICU context, the shift coordinator is a clinical leadership role assigned on a

DOI: <https://doi.org/10.29352/mill0229e.44825>

rotational basis, primarily involving team organization, resource management, and multidisciplinary communication during each shift, rather than a permanent management appointment. These criteria were non-cumulative to ensure sample heterogeneity (Krueger & Casey, 2015). Participants' demographic profile included 30% male and 70% female, predominantly aged 35–45 years, with most having ≥ 15 years of professional experience and 80% having more than five years of ICU experience.

Phase 2 – e-Delphi Technique: The validation phase was conducted with a purposive sample of expert nurses recruited from different institutions to maximize diversity. Experts were selected through snowball sampling, whereby initial participants recommended other professionals meeting the inclusion criteria (Barrett & Heale, 2020). Inclusion criteria were: (i) at least five years of professional experience in critical care; (ii) at least ten years of overall professional experience; and (iii) holding a nursing specialty qualification. Eleven experts from seven public hospitals in Northern Portugal were invited; ten responded in Round 1, yielding a 90.9% response rate. A panel of ten or more experts is recommended to ensure robust results in Delphi studies (Barrett & Heale, 2020), while panels exceeding thirty members carry increased attrition risk (Giannarou & Zervas, 2014). Given that the procedure is primarily operationalized by nursing professionals, expert validation focused on nurses with extensive critical care experience.

2.2 Data collection tools and methods

Phase 1 – Focus Group: Data were collected through a semi-structured focus group discussion lasting approximately 2 hours and 45 minutes. The session was held in a private meeting room within the ICU, selected to ensure confidentiality, comfort, and visual contact among all participants. A semi-structured topic guide was developed based on a preliminary review of the literature on family-centered care in ICU settings, following established guidelines for focus group interviewing (Krueger & Casey, 2015). The guide comprised open-ended questions progressing from general to specific topics, covering themes such as first contact with families, information sharing, emotional responses, practice gaps, and suggestions for improvement. The session began with an introductory ice-breaker question to facilitate group interaction (Krueger & Casey, 2015). The discussion was audio-recorded with participants' prior consent. The session was moderated by the first author (A.S.) and observed by the supervisor (M.A.P.), who took field notes. This configuration was chosen to ensure comprehensive data capture while minimizing researcher influence on group dynamics (Krueger & Casey, 2015). Verbatim transcription was performed by the first author (A.S.) and subsequently verified for accuracy against the audio recording by another author (M.A.P.).

Phase 2 – e-Delphi Technique: Data collection was conducted through two electronic rounds using the Google Forms platform. Experts were contacted via email and provided with a link to the questionnaire along with an alphanumeric code to ensure anonymity. The draft family reception procedure, derived from focus group findings and a literature review, was structured into six sections: initial reception, information to provide to families, oral information to convey, information for the first moment (pre-visit), information for the second moment (post-visit), and written information for the leaflet. Experts were asked to evaluate each item using a five-point Likert scale (1 = totally disagree to 5 = totally agree). At the end of each section, an open-ended field was provided for qualitative comments and suggestions.

Round 1 was distributed between 22 March and 5 April, allowing a two-week response period consistent with recommendations (Scarpato et al., 2012). Round 2 was distributed between 2 May and 16 May, accompanied by the statistical results from Round 1 to support informed re-evaluation. Based on expert feedback from Round 1, items with low or moderate consensus were reformulated or excluded, and new items were added where suggested. All ten experts responded in both rounds (Round 1: 90.9% response rate from 11 invitations; Round 2: 100% response rate).

2.3 Data analysis

Phase 1 – Focus Group: Data were analyzed using thematic content analysis following Bardin's framework (Bardin, 2011). The analysis involved multiple readings of the verbatim transcript, followed by a coding process in which units of analysis were identified and grouped into categories and subcategories based on shared characteristics. A data reduction matrix was constructed to organize the emergent thematic structure. Coding was performed by the first author (A.S.) and reviewed iteratively by the study supervisor (M.A.P.). Analytical decisions were discussed until agreement was reached, and the coherence of the thematic structure was verified through peer debriefing. Data saturation was considered achieved as no new themes emerged during the final stage of analysis.

Phase 2 – e-Delphi Technique: Quantitative data from the e-Delphi rounds were analyzed using descriptive statistics in Microsoft Excel. For each item, medians (Md) and interquartile ranges (IQR) were calculated. Consensus criteria were defined a priori following Capelas et al. (2018), who propose four levels of consensus based on the percentage of agreement (sum of responses 4 and 5), Md, and IQR: very high consensus (agreement $\geq 80\%$, Md = 5, IQR = 0), high consensus (agreement $\geq 80\%$, Md ≥ 4 , IQR ≤ 1), moderate consensus (agreement 60–79%, Md ≤ 4 , IQR ≤ 1), and low consensus (agreement $< 60\%$, Md = 4, IQR > 1). Only items achieving very high or high consensus were retained in the final procedure. Qualitative comments from Round 1 were analyzed to

DOI: <https://doi.org/10.29352/mill0229e.44825>

inform item reformulation between rounds. Item reformulation was conducted by A.S. and reviewed by M.A.P. before redistribution in Round 2.

2.4 Ethical and Institutional Approvals

This study received ethical approval from the Ethics Committee of [omitted for blind peer review]. The research was conducted in accordance with the principles of the Declaration of Helsinki and the General Data Protection Regulation (GDPR). Only healthcare professionals participated, and all provided written informed consent prior to data collection. Confidentiality and anonymity were guaranteed, and no personal identifiers were retained in transcripts or reports.

3. RESULTS

This section presents the findings of the two sequential phases of the study: (1) the qualitative data from the focus group, which informed the construction of the family reception procedure, and (2) the results of the e-Delphi process used to validate that procedure through expert consensus.

3.1 Phase 1 – Focus Group

The content analysis of the focus group transcript resulted in the identification of four thematic areas: Information to Provide, Reception Structure, Facilitating Elements, and Hindering Elements. These were further organized into twenty categories and multiple subcategories, as presented in Table 1.

Participants highlighted the absence of a formal, standardized protocol to guide family reception in the ICU, resulting in inconsistent practices, increased emotional burden for staff, and communication processes often shaped by individual judgment rather than institutional guidance. The reception moment was described as emotionally demanding and logistically fragile, frequently occurring under time constraints and in inadequate spaces.

Table 1 - Thematic areas, categories, and subcategories identified in the focus group

Thematic Area	Category	Subcategory
Information to Provide	Mode of Transmission	Uniform; Complete; Up-to-date; Realistic; Adequate
	Type of Oral Information	Clinical Situation; Prognostic Forecast; Unit Dynamics; Logistical Questions
	Type of Written Information	Reference Nurse; Unit Manager; Unit Contact; Personal Belongings; Unit Functioning
Reception Structure	Dedicated Physical Space	
	Multidisciplinary Team	
	Two Separate Moments	
	Visit Scheduling	
	Leaflet Creation	
Facilitating Elements	Identification of Family Representative	
	Team Motivation	
	Scheduled Reception	
	Team Training	
	Shift Handover Involvement	
	ISBAR use	
Hindering Elements	Time Availability	
	Lack of Physical Space	
	Absence of Leaflet	
	Time Constraints	
	Unpredictability	
	Team Size	

Note: Thematic areas, categories, and subcategories were derived through inductive content analysis following Bardin's framework. The structure reflects the participants' shared experiences and interpretations concerning the reception of families in the ICU.

Four key thematic areas were identified:

- Information to provide – Families should receive uniform, updated, realistic information tailored to their emotional state and literacy level. Oral information should cover clinical status, prognosis when appropriate, and unit logistics, while written materials (e.g., a leaflet) were seen as essential to reinforce understanding. As one participant observed: “(...) *there are many technical terms, and people receive all the information but do not understand it (...)*” (Participant 8).
- Reception structure – Professionals recommended a clear, structured process, ideally starting in a dedicated space and involving both physicians and nurses. Dividing reception into two moments (pre-visit and post-visit) was considered beneficial: “*There’s a lot to explain. If we do it all at once, it’s too much. Two moments would help*” (Participant 5).

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- Facilitating elements – Motivation, team training, scheduled reception times, structured communication tools (e.g., ISBAR), and integration into shift handovers were identified as enablers. As one nurse remarked: *“If we had a set time, with someone responsible and trained, it would make a huge difference”* (Participant 2).
 - Hindering elements – Barriers included lack of physical space, absence of institutional guidelines or materials, time constraints, unpredictable clinical dynamics, and limited staffing. As a participant explained: *“Sometimes we give terrible news in the hallway. There’s nowhere to sit down, nowhere to breathe”* (Participant 3).
- These findings provided the empirical foundation for drafting the structured family reception procedure, which was later validated through the e-Delphi panel.

3.2 Phase 2 – e-Delphi Technique

The proposed family reception procedure was validated through a two-round e-Delphi panel with ten expert nurses. Forty-two items were evaluated in the first round: 26 (62%) reached very high consensus, 11 reached high consensus, 3 reached moderate consensus, and 2 reached low consensus, requiring reformulation. Items strongly endorsed included conducting a reception in a private, calm space, joint participation of physician and nurse, and provision of honest and complete information. Items with low consensus, such as identifying the reference nurse in the leaflet and discussing prognosis at first contact, were revised or excluded. In the second round, 14 items were reassessed or added based on expert suggestions. Ten achieved consensus, including the provision of psychological support, availability of religious/spiritual assistance, and phased information sharing about unit routines. Four items, such as visitation by multiple relatives and inclusion of prognostic forecasts, did not reach consensus and were excluded.

The final validated procedure comprises three components: (1) a pre-visit moment in a private environment, with disclosure of the patient’s condition and identification of a family representative; (2) a post-visit moment with multidisciplinary communication, clarification of routines and logistics, scheduling of visits, and space for questions; and (3) written information via a standardized leaflet covering visiting rules, contact details, support resources, and unit policies.

This 42-item procedure is feasible, adaptable, and provides a structured, humanized approach to family reception in intensive care, supporting its transferability to other ICUs.

4. DISCUSSION

This study demonstrates that structured family reception is not merely an organizational tool, but a cornerstone intervention for enabling authentic engagement and partnership between families and professionals in intensive care. The combination of qualitative focus group data and structured e-Delphi consensus enabled the development of a contextually grounded, professionally validated intervention oriented towards humanizing and systematizing nursing care in critical settings.

The initial family contact was consistently described as a moment of high symbolic and emotional intensity. Without formal institutional guidance, this encounter varies according to the professional on duty, admission circumstances, and availability of space and time, potentially compromising care quality and increasing family uncertainty. The consensus obtained regarding the need for a dedicated, private physical space outside the clinical area aligns with recommendations by Davidson et al. (2017), who emphasize the importance of the environment in facilitating compassionate communication (Archer & Meyer, 2021; Julia et al., 2024).

The multidisciplinary nature of reception emerged as a key element, validated unanimously by experts, because it symbolizes shared responsibility and fosters the conditions for partnership and co-construction of care decisions. Joint physician-nurse participation enriches informational content and symbolizes professional cohesion and institutional commitment. This reinforces that family reception should be viewed as a structured, shared clinical intervention rather than an individual or informal act, supporting findings by Davidson et al. (2017) regarding shared leadership in communication processes during clinical severity.

Critical aspects related to information management, such as content, timing, and language, were identified. Focus group participants expressed concern about information overload and families’ capacity to retain information under emotional shock. The e-Delphi panel confirmed the need for clear, honest information adapted to family literacy levels. High consensus supported dividing reception into two moments: pre-visit preparation and post-visit detailed discussion, aligning with recommendations for phased, collaborative communication (Julia et al., 2024; Reifarth et al., 2023).

Notably, providing information in a gradual, progressive manner did not achieve consensus, potentially reflecting operational constraints where time pressure and emotional intensity demand direct communication. Similarly, discussing prognostic forecasts during initial reception was excluded, suggesting professional caution about premature disclosure of uncertain outcomes, aligning with ethical concerns about truth-telling and family readiness (Mendes, 2018; Reifarth et al., 2023).

Written informational support through standardized leaflets was strongly validated, supported by literature as tools that reinforce understanding, reduce anxiety, and serve as an ongoing reference. However, identifying the reference nurse in leaflets did not reach consensus, possibly due to concerns about role definition, shift dynamics, and continuity feasibility. Conversely, including unit manager information was accepted alongside visitation rules, hygiene procedures, and communication channels.

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The unanimous validation of psychological and spiritual support availability reflects growing awareness of psychosocial dimensions in critical illness and the importance of providing families with means to cope with suffering and anticipatory grief. These support services play central roles in preventing long-term psychological sequelae, including anxiety, depression, and post-traumatic stress (Dijkstra et al., 2025; Smith et al., 2025).

The study also revealed structural and organizational challenges that may hinder partnership, including inadequate physical infrastructure, workload constraints, and limited training in family engagement. Addressing these barriers is essential to transform structured reception into a sustainable practice of partnership in intensive care.

4.1 Limitations

This study presents several limitations that warrant consideration. The focus group was conducted in a single ICU, potentially limiting generalizability to other healthcare systems with different organizational cultures or family-centered care practices. The expert panel, while comprising experienced professionals from different institutions, was exclusively composed of nurses, excluding physicians, psychologists, and, importantly, patient and family representatives who are the intended beneficiaries. This mono-professional approach may have introduced bias and overlooked important stakeholder perspectives.

The e-Delphi methodology relied on professional judgment rather than empirical evidence of effectiveness, with consensus reflecting opinion about what should work rather than demonstrated impact on family outcomes. The absence of pilot testing represents a critical gap—without real-world implementation data, the practical feasibility, resource requirements, and actual impact on family satisfaction or anxiety levels remain unknown. Additionally, the study did not assess organizational barriers to implementation or potential unintended consequences that structured protocols might introduce.

4.2 Recommendations or Implications for Practice and/or Further Research

This research addresses a critical gap in family-centered care implementation by providing a structured, evidence-based approach to family reception in critical care settings. The validated procedure offers immediate practical value for ICUs seeking to standardize family interactions while maintaining clinical excellence and humanizing care environments. For clinical practice, the two-moment reception model provides an innovative framework that balances immediate emotional support with comprehensive information provision, potentially reducing family anxiety and improving decision-making capacity. The multidisciplinary approach reinforces interprofessional collaboration while validating nurses' essential role in family-centered interventions. The emphasis on dedicated physical space and standardized materials has important implications for institutional policies, infrastructure planning, and staff training programs.

From a research perspective, this work establishes a foundation for future studies examining long-term outcomes of structured family interventions and provides a methodological model for developing evidence-informed procedures in critical care contexts. Priority research areas include family-inclusive validation studies that directly engage patients and families to assess the procedure's acceptability and effectiveness, addressing the critical limitation of mono-professional consensus. Pilot implementation studies measuring family satisfaction, anxiety reduction, and PICS-F prevention are essential, alongside economic evaluations assessing cost-effectiveness and organizational factors affecting adoption. Digital health innovations such as interactive family platforms and mobile communication tools represent additional opportunities for enhancing procedure delivery across diverse healthcare settings. These research directions aim to transform the developed procedure into a comprehensive, family-centered intervention with demonstrated effectiveness in humanizing critical care.

CONCLUSION

This study addressed a critical yet frequently overlooked dimension of intensive care nursing: the structured reception of the family of the critically ill patient, reframing it as the first step in establishing engagement, partnership, and shared decision-making in intensive care. By combining the experiential knowledge of frontline professionals with expert consensus, it was possible to develop and validate a practical, evidence-informed procedure that responds to the emotional, communicational, and informational needs of families during one of the most vulnerable moments of the care trajectory.

The results confirm that family reception is a key component of family-centered, ethical, and humanized care, integrating principles of clear communication, emotional support, and interdisciplinary collaboration. The procedure's formalization enhances nursing intervention visibility and promotes consistency across different shifts and professionals. Although developed within a specific institutional context, it may serve as a transferable model for other critical care settings. Future studies should pilot the procedure in real-world conditions, assessing its impact on family outcomes and organizational culture while expanding validation to include other professional groups and patient representatives. Structuring family reception in intensive care reflects a necessary commitment to dignity and empathy, while also providing a replicable pathway for operationalizing international principles of family engagement and partnership in critical care practice.

DOI: <https://doi.org/10.29352/mill0229e.44825>

ACKNOWLEDGEMENTS

The authors thank the intensive care professionals who generously shared their experiences, and the expert panel for their valuable contributions during the e-Delphi process. We also acknowledge the support of the [omitted for blind peer review] and the [omitted for blind peer review].

AUTHORS' CONTRIBUTION

Conceptualization, A.S.; data curation, A.S., J.A., S.M., J.O. and M.A.P.; formal analysis, A.S., J.A., S.M., J.O. and M.A.P.; investigation, A.S., J.A., S.M., J.O. and M.A.P.; methodology, A.S., J.A., S.M., J.O. and M.A.P.; project administration, A.S.; resources, A.S., J.A., S.M., J.O. and M.A.P.; supervision, M.A.P.; validation, A.S., J.A., S.M., J.O. and M.A.P.; visualization, A.S., J.A., S.M., J.O. and M.A.P.; writing – original draft, A.S. and J.A.; writing – review & editing, A.S., J.A., S.M., J.O. and M.A.P.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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