Guidelines for Nurses Regarding the Significant Involvement of Relatives in the Care of In Patients

Purpose

The purpose of these guidelines is to provide guidance to nursing staff regarding the significant involvement of relatives in the care of in-patients. The overarching principle is that the type and scope of involvement must be agreed by the qualified nurse and the relative(s) in advance of any care being given. This document can also be shared freely with patients, relatives and other carers, in view of its nature.

Guidance

For the sake of convenience, the term “relatives” is used throughout this guidance to refer to “next of kin” but may also include “significant others” who are not related to the patient through family lines or marriage but for whom “significant involvement” (defined below) with the care of the patient is appropriate. The degree to which a patient’s relatives wish to be involved in the care of the patient varies, and is influenced by many factors, including the patient’s condition, the relatives’ prior experience of caring for the patient, their expectations and standards, and any number of intrinsic personal factors. Some relatives may have professional qualifications and experience. However, it should never be assumed that any relative will necessarily want to be involved in the care of their relative, whatever their background may be. To have “significant involvement”, in these guidelines, means to undertake “hands on” tasks, normally on a regular rather than a “one-off” basis, and includes activities such as feeding the patient or assisting them to drink, assisting them with personal hygiene needs, taking them to the toilet or helping them use a commode or urine bottle, dressing, undressing or changing them, or becoming involved in mobilisation or repositioning. Likewise, having “significant involvement” may also include monitoring and/or recording food or fluid intake, or reporting information to nursing staff.

Clearly, there are situations when relatives are only too keen to become involved in tasks such as those described above, and this should be facilitated when it is safe and appropriate to do so. The following considerations must however be observed:

a. any involvement of the relatives in the care of the patient should be explicitly discussed, negotiated and agreed with the relative(s) concerned by a qualified nurse, preferably the patient’s named nurse – no relative must feel coerced into this role, and specific care must be taken to avoid this impression at times of staffing difficulty, where relatives may feel obliged to assist;

b. a record should be kept in the nursing notes of the degree of involvement which has been agreed, and if the notes contain no such record, no assumptions must be made about involving the relatives in the patient’s care;

c. the relatives may, in some circumstances contribute to some of the patient’s records, but only those to which the patient themselves could contribute if they were able. This means that they could record oral fluid intake, for example, (if this was is the interests of the patient, and the qualified nurse felt they were competent to do so) but should not make entries in the nursing notes or any other record which requires professional or technical knowledge; clearly, all patients and relatives are encouraged to use the communication sheet at the foot of each bed, in appropriate circumstances.

d. the safety of the relatives and the patient must be the highest concern, and any task delegated to the relative(s) must be well within their sphere of competence;

e. whether or not relative(s) are “significantly involved” in the care of the patient, it is essential that, subject to the agreement of the patient, the relatives are kept informed of the nursing plan of care and the patient’s response to it. Information giving for a specific patient is primarily the responsibility of the named nurse;
f. similarly, whether or not the relative(s) are “significantly involved” in the care of the patient, it is essential that conversations and agreements between the nursing staff and the relatives are recorded along with all significant care events, including advice regarding changes in the elements of the care plan in which the relative(s) may be involved (e.g. a change from thickened to normal fluids, the implementation of a “nil by mouth” regime);

g. specific care needs to be taken when the relative is a qualified nurse employed by the Trust. This does not debar them from significant involvement in the care of the relative, but all staff should be conscious of the potential for conflict of interest, or of placing junior staff in a difficult professional position. To avoid difficulty, the type and scope of involvement must be agreed between the qualified nurse with responsibility for the patient and the relative(s), in advance of any care being given, in every case;

h. extreme care needs to be exercised in relation to any patient who has a need for manual handling or positioning. It would not normally be expected that such roles would not be taken on by relatives in the hospital setting. However, such situations may provide an opportunity for education of the relatives in relation to safe manual handling practices to be utilised after discharge but this needs to be careful planned and managed, deploying appropriate expert assistance;

i. similarly, staff should seek to utilise opportunities to work with relatives as a means of ensuring they have received appropriate information about discharge drugs, dietary requirements, and so on.

These guidelines are operative with immediate effect, and will be subject to review every 2 years, or in the event that new policy, guidance or legal precedent requires them to be changed.

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