Covid 19- “Broken Hearts”

Communicating with families of patients in intensive care during a pandemic

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Aim

To communicate and support families of patients in ICU during a pandemic”.

Introduction

Communicating with families of patients within the ICU setting requires sensitivity, clarity, compassion and needs to be timely and consistent. This is supported by Briggs (2017) who highlights that communication needs to be clear, accurate and jargon free. Consistency is important. Contradictory or inconsistent information particularly about prognosis leads to dissatisfaction. Families reported being given different information by different physicians treating the same patient (Briggs, 2017).

This was never more evident than at the height of the Covid- 19 pandemic, when ICU teams were working at full capacity, nurses were re-deployed from other clinical areas to support and family visiting was restricted and allowed only when patients were at end of life. Additionally, ICU professionals attempting to communicate by phone with distressed family members while wearing full PPE, while clinically monitoring patients, was without doubt, the biggest challenge teams have ever endured in clinical practice.

In the study by Boulton et al (2021), they demonstrated how teams responded to the challenges by creating communication teams within their units and highlighted the creative and innovative practice, which was so urgently put in place by many hospital ICU teams. The importance of taking pressure off the frontline teams, ensuring skilled compassionate communication updates for families was evident in the very early stages of the pandemic.

This work describes the new development of a family liaison support service initiated by the supportive and palliative care team in two specialist cardio thoracic hospitals and the impact the service had for families and health care professionals.

Methods

The palliative care team recruited 39 volunteers to support the service, including nurses, chaplains and allied health care professionals. The service ran from early January 2021 until the end of March 2021.

Members of the service worked on a seven-day week rota, contacting families as soon as possible once their relatives were admitted to the hospital. The family received a letter explaining the service, together with general information regarding ICU. Families were offered daily calls, this take up varied in agreement with the families being supported, some requiring calls less frequently. For families requiring additional support, the team referred to the appropriate services, like the hospital’s welfare advisor, psychology and chaplaincy services, as well as referral to community colleagues if required and consent was given.

The palliative care co-ordinator monitored messages and photographs sent from families in a secure email address, these were printed, laminated and taken to the bedside. To help families feel connected with their loved ones, a matching pair of hearts, made by volunteers in the community, including a poem, were offered, one placed with the patient, the other posted to the family. Matching knitted teddies were sent if there were children in the family. On completion of the service, questionnaires were sent from a secure link (managed by the patient and public engagement (PPE) service) using email addresses shared by the families for correspondence. The survey had a covering note explaining why it was being sent with one reminder email following this. The replies were anonymous unless the respondent wanted to add their details for future PPE involvement.

For this work a literature search was undertaken examining communication challenges with families of patients in ICU, six databases were explored.

Eight research articles were included identifying the importance of skilled and consistent information in the ICU setting.

Research from a variety of countries, including the UK were included.

Results

Number of families contacted: 156
Number of family liaison calls: 813
Number of family that did not answer: 31
Referrals to chaplaincy: 17
Referrals to welfare service: 35
Medical updates requested and arranged: 114
Facilitated videocalls: 389
Teddies sent to families: 27
Matching hearts: 98
Family visits arranged: 37
Support letters written to enable foreign travel: 3

Feedback from families was positive 21 responses in total;

- 81% were satisfied or very satisfied with the level of information on admission
- 47% found the video’s useful (some were unaware of the videos)
- 80% felt queries were efficiently and effectively handled
- 91% spoken to with dignity and respect
- 91% given adequate information from FL team
- 82% Always or usually received emotional support
- 91% were very satisfied or satisfied with the service

Information that was most helpful; 90% the daily update 36.5% emotional support, 36.5% having information to share with family.

Frontline staff reported a huge decline in calls, relieving the pressure and allowing the focus to remain on clinical work. The research examined was clear in the necessity for skilled, consistent and regular communication with families from healthcare professionals with the adequate training and knowledge to provide this communication. The importance of communication with family in the first few days of admission was also identifiable.

Discussion

It is evident from the research that families of patients in ICU require timely, consistent, clear and skilled communication. The study by Naef et al (2020) examining the effectiveness of a nurse led support service in ICU, clearly demonstrated an increase in family satisfaction, particularly with regards to understanding clinical decisions and at end of life. However, the distress levels and psychological wellbeing of family members at this time appeared unaltered. Chuang et al (2020) explored if ethnicity of family members impacted the quality of communication received by families and while there was no evidence of this, what was evident was the reluctance by clinicians to engage in early prognostication and end of life discussions, focusing on treatment and active interventions only. They suggest the necessity for early family meetings within the first 72 hours of admission to ICU and clear communication regarding likely prognostication.

Despite this recommendation, while caring for patients with a virus with an unknown disease trajectory, this was not always achievable or safe. Therefore, many of these difficult conversations were had by phone by the ICU physicians. In the follow up survey, what appeared to help families were the follow up calls made by the liaison service to reiterate what had been previously discussed and the empathy and listening ear offered by the team.

In the short few months this service was operating, what was evident in the ICU setting was the huge reduction in calls to the unit. When medical updates or videocalls with their loved one were requested by family members, the family liaison service ensured this was achieved in a timely fashion. Families appeared to appreciate the continuity and support they received from the service. The feedback appeared positive, clearly demonstrating, despite the fear and distress they were experiencing, consistent and skilled communication was beneficial. Some of the feedback from families;

“I can’t say thank you enough there was a time I didn’t think it was going to be possible but thankfully it won’t be long and he will be home -and that is down to all of you.
Also want to thank all the staff in the family support all of you have been amazing from the calls to the hearts so we can feel close to my son.
Thank you Thank you Thank you”.

“We appreciate all the work you are all doing to get him well and back to his feet. God bless you all and thank you”.

“ The hearts and teddies were so thoughtful and provided such comfort .We can never thank you enough or express our thanks in simple words”.

The team mainly consisted of palliative care nurses and senior staff in other disciplines, therefore, the communication skills were at an advanced level, this may have impacted the level of satisfaction from the families being supported in this service. Anderson et al (2016) advises that training and education in communication is crucial for ICU professionals. Adams et al (2015) highlights that while ICU nurses clearly identify the importance of communication with families, they discuss the importance of formal training to improve the failings in communication. In the Boulton et al (2021) study feedback was not positive when communication teams were made up of administration staff.

It has been noted that the provision of this service also appears to have improved the working relationships and inclusion of palliative care services within the ICU setting. The palliative care team continue to support families, working alongside the ICU teams in the delivery of supportive care to families. Mercadante et al (2018) highlights that improved communication and early intervention of palliative care services within the ICU setting improved care for patients with a poor prognosis. Cook and Rocker (2014) also support the coexistence of palliative care and intensive care highlighting “palliative care in ICU has come of age”.

Conclusions

Expert, consistent and skilled communication with families of seriously ill patients is required in all clinical areas, most significantly within the ICU setting. The pandemic has highlighted if ever before the urgent requirement for this best practice. The family liaison/ support service demonstrated the importance of continuity and expert communication skills when dealing with distressed families. The survey results were positive, clearly demonstrating the impact of this service.

The implications for clinical practice suggest appropriate communication training for health care professionals within the ICU setting. Additionally, the early intervention of palliative care services and effective communication and teamworking within ICU suggests improved patient and family care.

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