

The development of a family liaison team to improve communication between intensive care unit patients and their families during the COVID-19 pandemic

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ABSTRACT

A family liaison team was developed to improve communication between intensive care unit patients and their families during the COVID-19 pandemic.

THE PROBLEM

High quality family centred care is an integral part of how sick patients are managed in modern healthcare systems, and remains imperative in times of crisis.¹ However in the 2020 COVID-19 pandemic the necessity of isolation and social distancing prevented families accessing the support they usually would when a relative is in the intensive care unit (ICU). During the pandemic, families were not allowed to visit the ICU so they could not speak to doctors and nurses in the usual way. This exacerbated the family's worries and feelings of fear about their loved ones.

The COVID-19 pandemic required major changes to the way ICU was run, to allow a fourfold increase in capacity. This included the redeployment of staff from other areas and huge clinical pressures on all staff. These teams were not able to prioritise communication with families due to clinical pressures. The ICU had received several complaints regarding this and were open to ideas to resolve these issues.

AIMS

Our hospital is a large teaching hospital with an established infectious disease unit and as such had a large and early surge of patients with COVID-19. Our project aimed to use a group of paediatricians with pre-existing transferable skills to develop and embed a

communication strategy within the ICU for the duration of the COVID-19 surge. Paediatricians are used to communicating regularly with patients, and their families. Paediatricians also work in multidisciplinary teams and are used to communicating with other teams.

In our sector, inpatient children's services were relocated to Great Ormond Street Hospital, leaving local paediatricians and doctors in postgraduate training in a position to help in this role.

As families were not receiving a daily update from the ICU, our aim was for all families to be updated at least once daily, and for all families to be offered the option of using video links to speak to their relatives should they chose to do so.

MAKING A CASE FOR CHANGE

Initially a small team went to speak to the ICU matrons in order to put forward our idea of what we could offer. Once we had their approval and understood the clinical need, a larger team of acute and community paediatricians along with child psychiatrists was coordinated.

Support contacts were developed with psychological services to provide help for staff and families, anticipating that the role was likely to be stressful.

IMPROVEMENTS

Plan, Do, Study, Act (PDSA) cycle 1

Three paediatricians immersed themselves into three different clinical subsections of the ICU.

The paediatricians attended the morning ward round and were then able to telephone families to give clinical updates.

Some families required very clinically detailed information while others needed



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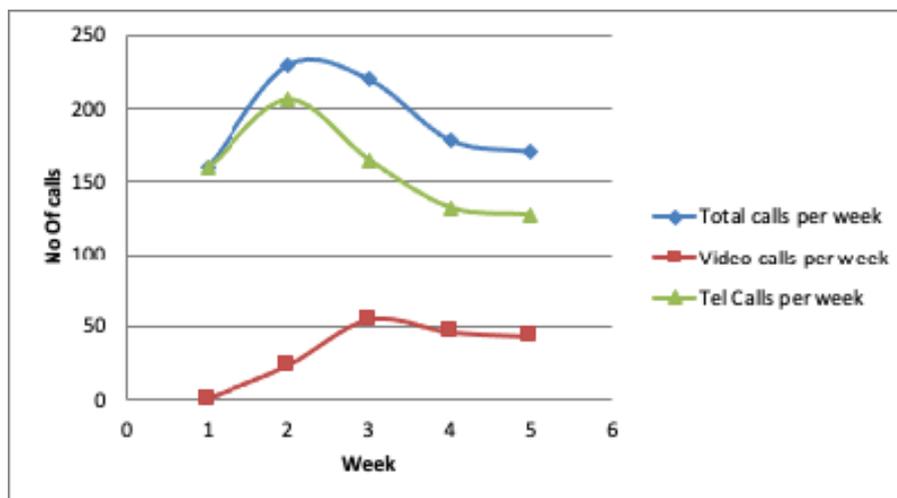


Figure 1 Number of calls made per week.

a more holistic discussion. Difficulties for the team included a lack of understanding about a new disease and unfamiliarity in looking after adult patients. Communication with families while wearing full personal protective equipment was challenging. The team undertook a daily debrief. The numbers of phone calls per week was recorded (figure 1).

PDSA cycle 2

Four to five paediatricians attended daily, in blocks of at least 3 days in a row, which allowed for continuity and comprehensive cover of the ICU patients. A proforma was designed in order to standardise what information was helpful to record on the ward round based on common recurring questions. This facilitated smoother phone calls to families. As relationships developed, families expressed an increasing desire to see their relatives.

PDSA cycle 3

As families were largely not able to visit the hospital, we offered the use of video links in a select group of families, for example, those who were able to download an app at home. A trial of this virtual visit was conducted in one patient per clinical area. Patient feedback was recorded.

PDSA cycle 4

The use of video links was expanded in order to provide this to all families who wanted it. Medical students and nursing support buddies were trained in order to ensure all those who requested a video call could do so. This helped the use of video calls to become embedded. The numbers of video consultations conducted per week were also recorded (figure 1).

Records were kept as part of a daily communication sheet within the ICU notes, detailing what had been said and to whom. Qualitative feedback was gathered

from staff and families. Twenty of 22 families reported that the quality of the feedback had improved.

LEARNING AND NEXT STEPS

The project was successful due to a combination of clinical need, the feeling of ‘all being in it together’ and building joint resilience when faced with working in unfamiliar environments. Relationships were built between staff who would never usually have worked together at all and these will remain lasting collaborations.

Keeping the clinical ICU team small at the start of the project enabled us to develop proformas and anticipate components of successful phone calls and standardise them accordingly. The subsequent upskilling of our colleagues was then more focused so that ultimately the service was predictable, reliable and did not have excessive variation.

Medical students had been an underused group and their help was invaluable in setting up and facilitating video calls to families. They had superior technology skills to many of the paediatricians and we were able to schedule shift timings so that calls could be undertaken at a wider range of times in the day.

The future plan is unclear at present due to the uncertainty about the longer-term impact of COVID-19. In our hospital the ICU surge has started to subside, and paediatrics has become busier again. However the importance of regular calls, video links and holistic thinking about families has been spotlighted within the teams. As we withdraw, we anticipate regular communication will remain a priority. Medical students continue to help provide this service. If there is a further surge, we remain available to assist our ICU colleagues in order to aid family liaison. Processes are now established in order for other clinical teams to provide this service to families if needed.

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