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LETTER

Introducing an external team for ICU family communication during the pandemic: not without risks

Carmen Lopez Soto and Victoria Metaxa*

Dear Editor,

Aiming to lessen the devastating effects of patient/family separation during the coronavirus disease 2019 (COVID-19) pandemic, the medical professional bodies in the United Kingdom (UK) published guidance on different modes of maintaining communication [1]. Our intensive care unit (ICU) created a family liaison team (FLT) which operated between April–June 2020 and January–April 2021, matching the two surges of the UK pandemic. The FLT setup was described in detail elsewhere [2, 3]. In summary, the team consisted of 40 redeployed, non-ICU healthcare professionals; 92% were medical with 74% in a consultant grade. The FLT were mainly tasked with facilitating communication between families and the ICU team (medical updates, video calls, visitation support). They received relevant medical information twice a day: after morning handover and post ward round.

We surveyed both the ICU and FLT team focusing on their collaboration during the two surges, using the Interprofessional Collaboration Scale (ICS) [4]. Family satisfaction was only measured during the first surge and was presented elsewhere [2].

We received 24/39 (61.5%) and 26/39 (66.7%) responses from the FLT, and 25/147 (17%) and 67/147 (45.6%) from ICU staff for the first and second wave, respectively. 73% of the families received at least one phone call during the second wave, up from 39.5% in the first one (p value = 0.004). The comparative results of the ICS questionnaire are presented in Table 1. The low initial scores in the FLT ICS on understanding responsibilities were significantly improved between the two waves, as the roles of the FLT became clearer for the members of the ICU team, and interactions and teamwork improved.

Both teams reported that communication around treatment plans was adequate, and both felt respected and heard by each other (Table 1). However, comments from the critical care team suggested that the updates given by the FLT regarding a patient's clinical picture and trajectory, and the message the ICU physicians frequently differed. The discrepancy between the transmitted information may reflect the non-ICU background of the redeployed staff, a difficulty in understanding critical illness and/or a reluctance to break bad news.

There are several limitations. We report the experience of a single centre and the survey responses from the ICU team were limited, restricting the generalisability of our results. Furthermore, the survey design of the study precludes strong cause–effect conclusions. Last, we didn't study the impact of the information provision discrepancy on family satisfaction or as a cause of conflict in both surges. Nonetheless, satisfaction with medical updates was rated very high in the first wave, despite the identified communication difficulties [2].

The new liaison team successfully enabled communication with families through the very difficult isolation periods. The clarification of roles and responsibilities improved the cooperation between the two teams between the surges. However, the ICU team expressed concerns around the FLT's ability to accurately convey the poor clinical condition and worsening trajectory of some patients. Similar concerns have been reported before [5] and caution is warranted when new communication models are adopted in ICU, especially when visiting is also restricted and end-of-life information is being conveyed.

*Correspondence: victoria.metaxa@nhs.net
Department of Critical Care, King's College Hospital NHS Foundation Trust, London SE5 9RS, UK

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Table 1 Differences in responses from the Interprofessional Collaboration Scale

Domain	FLT 1st wave ($n=24$)	FLT 2nd wave ($n=26$)		ICU 1st wave ($n=25$)	ICU 2nd wave ($n=66$)	
	Mean (95%CI)	Mean (95%CI)	*p* value	Mean (95%CI)	Mean (95%CI)	*p* value
There was good understanding between teams about their respective responsibilities	4 (0.33)	5 (0.26)	0.02*	4 (0.79)	4 (0.79)	0.44
Each team was usually willing to take into account the convenience of each other, when planning their schedule	4 (0.79)	4 (0.46)	0.81	4 (0.81)	4 (0.33)	0.54
I feel patient treatment/ care were not adequately discussed between the teams	2 (0.43)	2 (0.41)	0.74	2 (0.52)	2 (0.29)	0.2
Teams were willing to discuss issues arising with each other	5 (0.3)	5 (0.44)	0.93	5 (0.8)	4 (0.34)	0.6
Each team didn't usually ask for the other´s views regarding communication with family	2 (0.62)	2 (0.48)	0.94	2 (0.52)	2 (0.25)	0.86
Important information was always communicated between teams	4 (0.37)	4 (0.32)	0.69	4 (0.75)	4 (0.34)	0.79
I felt welcomed and respected by the other team	5 (0.37)	5 (0.25)	0.92	4 (0.78)	4 (0.34)	0.65

p-values calculated by Mann–Whitney *U* test. Statistically significant difference $p<0.05$

FLT Family Liaison Team, *ICU* intensive care unit, *CI* confidence interval

5 = strongly agree; 4 = agree; 3 = neither agree nor disagree; 2 = disagree; 1 = strongly disagree

Declarations

Conflicts of interest

On behalf of both authors, the corresponding author states that there is no conflict of interest.

Publisher's Note

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