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Collegian 27 (2020) 248–249

Contents lists available at ScienceDirect

Collegian

journal homepage: www.elsevier.com/locate/coll

Editorial: COVID-19 and what it means for end-of-life care in ICU: Balancing the priorities

The COVID-19 pandemic is challenging health care systems worldwide, described as an unparalleled and extraordinary public health emergency (Jackson et al., 2020). Australian measures designed to contain and minimise the spread and impact of COVID-19 have been relatively successful compared to other countries (Chin et al., 2020). Yet, heightened vigilance and hospital-wide preparations for a COVID-19 surge are ongoing. A recent Australian survey identified that there is capacity to increase the number of Intensive Care Unit (ICU) beds and ventilators by 191% and 121% respectively (Phua et al., 2020). ICU preparedness is a key part of Australia's response, given that as many as 16% of patients in Lombardy, Italy (Grasselli et al., 2020) and 24% of patients in New York, USA diagnosed with COVID-19 required an ICU admission (Centers for Disease Control and Prevention [CDC], 2020). But there is more to an ICU admission than beds and ventilators. ICU clinicians must adapt, evolve and develop new ways to meet the needs of the critically ill and the greater community.

International debate about who should receive ICU care, and when to withhold or withdraw life-sustaining treatments during the pandemic is ongoing. Morbidity and mortality from COVID-19 is substantially higher in older patients (Curtis et al., 2020) and those with pre-existing chronic illness (CDC, 2020). Hence, how to balance the intensity of care a person may need, with a person's values, wishes and preferences is a topic of global discussion (Curtis et al., 2020).

The issue of ethical rationing has also emerged in response to shortages of essential resources such as personal protective equipment (PPE) (Binkley & Kemp, 2020). The World Health Organization (WHO) has provided recommendations for a public health response to limit the transmission of COVID-19, protect patients and healthcare workers and combat PPE shortages in healthcare facilities (WHO, 2020). These recommendations include the restricted access for family members of patients with confirmed or suspected COVID-19 (WHO, 2020). As much as the need for infection prevention and control measures may be broadly understood, the consequences of restricted access for families are likely greatest when a patient is dying.

Internationally, COVID-19 has resulted in a 'tsunami' of death (Jackson et al., 2020). Of those admitted to the ICU for COVID-19, in excess of 60% of patients requiring mechanical ventilation died (Intensive Care National Audit & Research Centre, 2020; Yang et al., In Press). ICU nurses play a key role in managing end-of-life care. This not only includes ongoing clinical care for the dying patient, but caring for and supporting families; likely founded on the notion that nurses do not view families as visitors, but rather, nurses see patients are part of a family unit, caring for the whole. Nurses facilitate regular communication with the treating team (Brooks et al., 2017) and advocate for family needs and priorities (Ranse et al., 2016; Riegel et al., 2019). ICU nurses also spend time preparing families for imminent death (Bloomer et al., 2017), acknowledging family members' vulnerability (Mossin & Landmark, 2011) and providing immediate bereavement support (Raymond et al., 2017). Creating space and privacy for families to hold vigil (Brooks et al., 2017; Slatyer et al., 2015) and spend time with the dying person is also facilitated by ICU nurses. This is because even when death cannot be prevented, family members like to stay close, keenly observe, comfort and protect the dying person (Donnelly & Battley, 2010) and say their farewells (Mossin & Landmark, 2011). When these actions are possible, family presence at death becomes a time of intimacy, vulnerability and poignancy, a special moment remembered in detail (Donnelly & Dickson, 2013). Yet, multiple stories, circulated via the media and social media networks in recent times, describe how many patients (in ICUs and elsewhere) have died alone, without family and significant others by their side.

Just because this has been the experience elsewhere, the same experience does not have to occur in Australia. ICU nurses must have courage to be creative in addressing end-of-life challenges rather than adopting a purely risk-averse approach (Ranse & Coombs, 2019), such as that created by COVID-19. To support ICU nurses in this, the Australian College of Critical Care Nurses and the Australasian College of Infection Prevention and Control have collaborated to produce a position statement (Bloomer & Bouchoucha, 2020), which outlines how family presence for COVID-19 positive patients dying in the ICU can be facilitated, where adequate resources, including PPE and staffing permit. Even if family presence is not possible, a video or telephone call to enable the family to hold 'virtual vigil', provide comfort and say their goodbyes, is possible and already successfully used in many other care settings. Balancing the priorities for family presence, duty of care for ICU patients which extends to family, and upholding the strictest of infection prevention and control measures, is possible. We can rely on our ICU nursing workforce to make this happen.

https://doi.org/10.1016/j.colegn.2020.05.007
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Melissa J. Bloomer[a,b,c,d,*]
[a] *School of Nursing and Midwifery, Deakin University, Geelong, Australia*
[b] *Centre for Quality and Patient Safety Research, Deakin University, Australia*
[c] *Institute for Health Transformation, Deakin University, Australia*
[d] *Research Advisory Panel, Australian College of Critical Care Nurses, Australia*

Stephane Bouchoucha[a,b,c,d]
[a] *School of Nursing and Midwifery, Deakin University, Geelong, Australia*
[b] *Centre for Quality and Patient Safety Research, Deakin University, Australia*
[c] *Institute for Health Transformation, Deakin University, Australia*
[d] *Australasian College for Infection Prevention and Control, Australia*

* Corresponding author.