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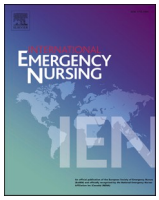

Editorial

# COVID-19, the family unfriendly virus: Is the family's experience of the ED relevant within the confines of a pandemic?

The COVID-19 pandemic spread quickly in 2020, leaving in its wake a trail of economic burden with large financial losses, psychological consequences, enforced changed patterns of social interaction and concomitant changes in healthcare delivery [1]. The pandemic has severely affected our working lives, with special note in the emergency care environment. In light of the aforementioned, one might ask about the relevance of such an editorial; why it might be important to focus on family engagement in the emergency department (ED)? Surely there are other more important matters during this time? Why indeed should this be considered a focal point of concern almost a year into the pandemic? Reading through the plethora of COVID-19 literature, there is an emergence of the adverse mental health impact of working as healthcare workers on the COVID-19 frontline, of note is the moral injury when exposed to emotional trauma for which we were not prepared, such as facilitating network connections to enable family goodbyes [2]. Indeed, it has been reported that COVID-19 may cause many psychological problems that could potentially be even more detrimental in the long run than the virus itself [3].

The family, consisting of self-defined members and described as: "two or more individuals who depend on one another for emotional, physical, and economic support" [4], is an important part of the healthcare team in the ED. A variety of reasons bring to the fore the importance of the family in the ED, inclusive of collaborating in the care and providing support to their ill or injured relative [5]. However, amidst the value the family offers, there is the possibility of them experiencing a myriad of psychological symptoms and disruptions in their family system [6], followed by changes in their needs for support due to the hospitalisation of their loved one [7].

An appraisal of the family's experience in the ED is important in informing changes in service delivery in the ED [8] to target crucial family nursing constructs, such as family proximity, communication, and support [9,10] and thus improve the ED experience for the family. Measurement tools, for example the Consumer Emergency Satisfaction Scale (CESS) [11] and the Critical Care Family Needs Inventory-Emergency Department Questionnaire (CCFNI-ED) [12], are available and hold relevance in measuring aspects of family satisfaction [13]. However, a dichotomy exists between the guiding principles to control the spread of COVID-19 and the constructs measured in some family engagement tools, which are important for ensuring positive and meaningful family experiences in the ED [9] such as proximity, communication, comfort, support, meaning, and participation [13]. Improved patient outcomes and family experiences of care require incorporating these constructs into the planning of care in the ED [8], however COVID-19 regulations require social isolation, limiting family interaction [5], thus restricting the appraisal process.

Consideration is usually given to keeping families as close to the patient as possible, and them being able to access the patient has been shown to positively assist the family's ability to cope with their fear and anxiety [9]. Further, families have been shown to benefit greatly from receiving clear, understandable, continuous, and consistent information, involving continuous updates from the ED staff [7,9] in particular, the nurse [9], having rated it as their highest need [10]. By contrast however, COVID-19 recommendations entail social distancing, which necessitates isolating the patient from their family [1]. Communication with the family, who is often prohibited from being in the ED, is thus a challenge, and if it occurs, it is restricted to interactions with "anonymous" staff whose identity is hidden behind a mask and a visor. This essential personal protective equipment namely; masks, goggles and visors, hide facial expressions which are important tools for displaying empathy [14]. Smiling, one of the easiest and most instinctual ways to connect with another person, becomes invisible and N95 respirators muffle voices, making it difficult to hear and frustrating to communicate effectively [14]. Meaningful communication contributes to a more positive experience [9]; however this becomes a challenge in the face of the novel virus fraught with more questions than answers [15], with limited opportunities to try and develop relationships which generate hopefulness.

The separation of the family from the patient inhibits the opportunity for family engagement and begs the question - what can/should nurses in the ED do when caught in between the dilemma of ensuring strict compliance to COVID-19 regulations while trying to meet the needs of patients' family members"? ED nurses can make use of other mechanisms to facilitate engagement and conversations between the patient and family members. An alternate to face-to-face communication is virtual collaboration through digital platforms such as video-conferencing using computers or mobile phones. The option of technology leaves the nurse working in the ED to decide on how to use the most accessible and appropriate digital communication technology for their context, in such a way that it promotes the art of caring [16].

Technology as a form of engagement is not without its dilemmas. The ethics of mobile phone use amongst clinicians has been widely explored [17], but remains an area for discussion in the arena of developing family relationships and measuring healthcare outcomes. Remote engagement has problems, for example how ethical is it to say "goodbye" to a family member through video-conferencing [3,10]? How do you engage virtually with family members in the face of digital divides, where they are not digitally literate, nor have the device or the data to do so? These restraints can limit families' engagement and challenges

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measuring their experience of the ED [5]. Even when these innovative solutions are found to facilitate patients and their families connecting [5], they may only have minutes to share final messages and say goodbye [16]. Alternatively, circumstances may arise when virtual visits or connections are not possible, and it may be up to ED nurses to share the patient's final moments [5]. Recounting or re-living multiple patients' final moments to numerous family members may have dire consequences for nurses whose psychological status has been traumatised consistently by loss.

It is envisaged that in months to come, in the aftermath of COVID-19, staff working in the ED might reflect on how the virus has shaped family engagement in this context. They will need to reflect on three aspects; i) whether they could execute any form of family engagement, ii) if so, how did they do this and iii) what was the family's experience? In these reflections, the questions posed by Anderson and Gehart [18] can be answered namely; "how can collaborative practice have relevance in this fast-changing world, what is the relevance, and who determines it?" [18]. During COVID-19, ED staff have an opportunity to respond to the need for relevance, examine novel, ethical and legal ways of involving families of patients in ED, and consider the quality of this experience. A crisis, as the saying goes, is a terrible thing to waste [19]. New knowledge, skills, and competencies developed during this pandemic might be geared towards developing novel strategies to further promote family engagement, and we all need to consciously think about how we could maximize the current momentum to affect positive change in the future.

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