Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Australian Critical Care 34 (2021) 132–134

Contents lists available at ScienceDirect

Australian Critical Care

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

Discussion paper

Australian College of Critical Care Nurses and Australasian College for Infection Prevention and Control position statement on facilitating next-of-kin presence for patients dying from coronavirus disease 2019 (COVID-19) in the intensive care unit

Melissa J. Bloomer, PhD, MN(Hons), MPET, MNP, Crit. Care Cert., BN, RN PhD [a, b, c, d, *]
Stéphane Bouchoucha, PhD, MSc (PH), Grad. Cert. IPC, BSc (Hons), RN PhD [a, b, c, e]

[a] School of Nursing and Midwifery, Deakin University, 1 Gheringhap Street, Geelong, Victoria, 3220, Australia
[b] Centre for Quality and Patient Safety Research, Deakin University, 1 Gheringhap Street, Geelong, Victoria, 3220, Australia
[c] Institute for Health Transformation, Deakin University, 1 Gheringhap Street, Geelong, Victoria, 3220, Australia
[d] Research Advisory Panel, Australian College of Critical Care Nurses, Surrey Hills, Victoria, 3127, Australia
[e] Australasian College for Infection Prevention and Control, 228 Liverpool Street, Hobart, Tasmania, 7000, Australia

ARTICLE INFORMATION

Article history:
Received 13 May 2020
Received in revised form
6 July 2020
Accepted 10 July 2020

Keywords:
Coronavirus
COVID-19
Critical care
End-of-life care
Family-centred nursing
Infection prevention and control

ABSTRACT

The coronavirus disease 2019 (COVID-19) pandemic is challenging healthcare systems worldwide, none more so than critical and intensive care settings. Significant attention has been paid to the capacity of Australian intensive care unit (ICUs) to respond to a COVID-19 surge, particularly in relation to beds, ventilators, staffing, personal protective equipment, and unparalleled increase in deaths in ICUs associated with COVID-19 seen internationally. While death is not uncommon in critical care, the international experience demonstrates that restrictions to family presence at the end of life result in significant distress for families and clinicians. As a result, the Australian College of Critical Care Nurses and the Australasian College for Infection Prevention and Control supported the development of a position statement to provide critical care nurses with specific guidance and recommendations for practice for this emerging priority area. Where possible, position statements are founded on high-quality evidence. However, the short time period since the first recognition of a cluster of pneumonia-like cases in China in January, 2020, meant that an integrative approach was required to expedite timely development of this position statement in preparation for a COVID-19 surge in Australia. This position statement is intended to provide practical guidance to critical care nurses in facilitating next-of-kin presence for patients dying from COVID-19 in the ICU.

1. Introduction

The corona virus disease 2019 (COVID-19) pandemic) is challenging healthcare systems worldwide,[1] none more so than critical and intensive care settings.[2,3] Described as an extraordinary public health emergency,[4] the first line of defence against COVID-19 is to establish stringent infection prevention and control measures to control the spread and minimise transmission.[5] Whilst the case fatality rate for COVID-19 is not high, given the scale of the COVID-19 pandemic, the actual number of deaths is considerable,[6] with critical care settings a key part of the healthcare response globally.[1] Significant news and social media attention has highlighted the distress caused to families and clinicians when a COVID-19–positive patient dies and infection prevention and control measures prohibit or limit family presence.[7–9]

In response, the Australian College of Critical Care Nurses Limited (ACCCN), which is a national professional nursing association representing critical care nurses in Australia,[10] and the Australasian College for Infection Prevention and Control (ACIPC), a key professional body for Infection Prevention and Control professionals in the Australasian region,[11] supported the development of this position statement to provide specific guidance and practice

* Corresponding author. Building W, Deakin University, 223 Burwood Highway, Burwood, Victoria, 3125, Australia.
E-mail address: m.bloomer@deakin.edu.au (M.J. Bloomer).

https://doi.org/10.1016/j.aucc.2020.07.002
1036-7314/

recommendations for critical care nurses in the facilitation of family presence at the end of life in the intensive care unit (ICU).

In accordance with ACCCN and ACIPC objectives to provide timely guidance for critical care clinicians during the course of the COVID-19 pandemic, the aim was to develop a position statement that reflected the most relevant evidence and information related to end-of-life care and family visitation in Australian critical care practice settings. Using an approach similar to that used for rapid reviews, where the outcome is intended to provide a tailored, targeted synthesis of research that addresses a specific issue arising in the real world,[12] two researchers with backgrounds in critical care and demonstrated expertise in end-of-life care (M.J.B) and infection prevention and control (S.B.) undertook a search for evidence related to family visitation, family presence at the end of life, and end-of-life care in critical care. Where possible, Australian research evidence was selected to ensure relevance to Australian critical care settings. Given the unprecedented nature of the COVID-19 pandemic and consequent lack of time for high-quality research to be undertaken and published, national and international guidelines, current opinion pieces, and media reports related to COVID-19 were also used to inform this position statement. The position statement was reviewed and approved by the Boards of the ACCCN and ACIPC.

2. Background

End-of-life care is a fundamental component of critical care nursing, with almost one quarter of patients admitted to the ICU dying.[13] Death in the ICU is seldom unexpected, and most occurs as a result of withdrawal of futile interventions.[14,15] Yet critical care nurses may face multiple challenges associated with end-of-life care on a daily basis.[15] These challenges include coordinating communication between the treating team and next of kin[16] and ensuring communication is culturally sensitive.[17] Critical care nurses are also known for their role in preparing next of kin and families for treatment withdrawal,[18,19] creating space and privacy,[16] and focusing on what is important to the patient, next of kin, and family before and after death.[20,21]

The COVID-19 pandemic is impacting ICUs worldwide. Sixteen percent of patients in Lombardy, Italy,[2] and 24% of patients in New York, USA, diagnosed with COVID-19 required an ICU admission.[1] Government and community measures to contain and minimise the spread of COVID-19 in Australia[22] have resulted in a significantly smaller impact in Australian critical care settings.

Where possible, isolation and/or cohorting of COVID-19–positive patients and the use of personal protective equipment (PPE) is essential for all healthcare workers.[23,24] The World Health Organization also recommends that visitors should not be allowed to visit suspected or confirmed patients with COVID-19, unless strictly necessary.[25] In response, hospitals have restricted visitation, resulting in some COVID-19–positive patients dying in critical care, separated from their next of kin and significant others, herein referred to as family.

When a patient is dying, there is clear evidence of family vulnerability.[26] Family members want to be present, observe, comfort, and protect the dying person.[27] Hence, dying is not only what the patient experiences but also what the family experiences, with the death experience remembered in detail.[28] For critical care nurses, having courage to be creative in addressing end-of-life challenges, rather than adopting a purely risk-averse approach, such as that created by COVID-19, can assist in creating solutions that address barriers to end-of-life care provision.[29]

3. Position statement

The ACCCN and the ACIPC endorse practices aimed at facilitating family visitation in critical care, where resources (such as PPE) and staffing permit.

4. Recommended practice

i. Family visitation should ideally be limited to one person, nominated as next of kin. The person should be deemed fit and well, not self-isolating due to COVID-19 exposure, and not currently COVID-19 positive.
ii. Any limitations to the duration of the visit should be explained.
iii. Where possible, the dying person should be located in a single room within the ICU[5] to ensure maximal privacy for the family and limit exposure to other patients.
iv. The visit should be scheduled at a mutually convenient time, ensuring the ICU leadership are aware of the visit, and so an ICU staff member is available to assist. The visit should be scheduled a minimum of at least 30 min after any aerosol-generating procedure.[30]
v. Next of kin must be able to drive directly to and from the hospital to limit potential exposure to others, to dress in single-layer clothing that is suitable to hot machine wash, remove jewellery, and minimise valuables (e.g., suggest phone and car keys only).
vi. On arrival, next of kin should be prepared for what they will see on entering the critical care unit, what they may do, and what they may not do.
vii. Next of kin should be instructed to wipe over valuables and wash hands for at least 20 s. With the assistance of the ICU staff member, next of kin should be assisted to don PPE (gown, surgical mask, goggles, and gloves).[25] The next of kin should be instructed not to remove or touch the front of their mask at any time during the visit.[25] If death is imminent, and a visit within 30 min of an aerosol-generating procedure is imperative, the next of kin must wear an N95 mask (instead of a surgical mask).[31]
viii. Where feasible, the next of kin should be provided with time alone with the dying person, with instruction on how to use the call bell to seek staff assistance.
ix. At the cessation of the visit, the ICU staff member should assist the next of kin to doff all PPE,[25] ensuring it is disposed of properly. The next of kin should be instructed to wash their hands, leave the unit, and head directly home.
x. Upon return home, the visitor should be instructed to wash their clothing in a hot machine wash.
xi. When necessary, immediate emotional support[32,33] can be provided by the ICU staff member appointed to support the visitor. The visitor should also be provided with details of support services available to them such as the social worker, pastoral care, or counselling service available through the health service or local community services.

CRediT authorship contribution statement

Melissa J. Bloomer: Conceptualisation, Methodology, Writing - original draft, Writing - review & editing. **Stéphane Bouchoucha:** Conceptualisation, Methodology, Writing - original draft, Writing - review & editing.

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