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.

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Current Insights in Intensive & Critical Care Nursing

How the COVID-19 pandemic has reaffirmed the priorities for end-of-life care in critical care: Looking to the future

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In April 2020, Pattison's editorial in *Intensive and Critical Care Nursing* described the COVID-19 pandemic as an unprecedented and unfolding global situation necessitating rapid change in critical care, including end-of-life care (Pattison, 2020). In the midst of rapid critical care unit expansion, stockpiling of resources, forecasting staffing and alternate models of care, the mortality rate of patients presenting with COVID-19 demanded urgency in the development and upscaling of systems to support end-of-life care (Pattison, 2020). Now two years on, it is timely to revisit what is important at the end of life for patients, families and nurses, now and into the future.

Whilst end-of-life care is just as important as curative care, end-of-life decision-making is complex and challenging (Riegel et al., 2021). An international comparison of end-of-life decision-making practices from ETHICUS-I conducted in 1999 and ETHICUS-II conducted in 2015 provided some interesting data about nurse involvement in end-of-life decision-making (Benbenishty et al., 2022). While findings from the latter study demonstrated greater agreement between doctors and nurses in end-of-life decision-making, nurses were consulted on end-of-life decisions in only 64.4% of cases (Benbenishty et al., 2022). Hence, the unique and important contribution of nurses to end-of-life decision-making and care is urgently warranted.

Family-centred care is core to critical care nursing. A systematic review that sought to describe clinical practice interventions to support family-centred care in critical care during the COVID-19 pandemic identified family support and engagement, and systems to facilitate communication with families as key to family-centred care (Fernández-Martínez et al., 2022); a finding consistent with another systematic review that examined how family members of dying patients are supported during infectious disease outbreaks, including COVID-19 (Bloomer and Walshe, 2021). Common to both reviews was the importance of building connectedness through the sharing of information (Bloomer and Walshe, 2021; Fernández-Martínez et al., 2022), particularly at the end of life (Bloomer and Walshe, 2021). Information about the patient's condition and care are essential to family coping (Bloomer and Walshe, 2021), so long as communication is delivered with cultural sensitivity, in accordance with the norms, customs and practices of the patient and their family (Brooks et al., 2019). Facilitating communication between the patient and family is also critical to humanisation in which the patient is recognised and respected as a person (Fernández-Martínez et al., 2022), attenuating the negative impacts of separation (Bloomer and Walshe, 2021).

Just as important as communication, supporting family presence at the bedside for a dying patient was previously part of routine end-of-life care in critical care. Due to COVID-19 however, in many critical care settings, visitor access was restricted to mitigate transmission risks. Whilst the rationale as an infection prevention and control measure may be mostly understood, keeping families away from dying patients opposes cultural norms and prevents families from fulfilling their desired caring role, and contributes to family suffering and distress at the end of life (Bloomer and Walshe, 2021). A survey designed to explore how family visitor restrictions during the COVID-19 pandemic impacted ICU clinicians in the USA identified that whilst clinicians spent more time using telephone and web-based applications to facilitate communication and a connection between patients, families and clinicians, clinicians also reported negative impacts on end-of-life care, associated with decreased comprehension and greater emotional distress for family members (Wendlandt et al., 2022). Whilst facilitating family presence at the bedside must remain a priority, at the very least, the lessons learnt during COVID-19 demonstrate how the value of virtual visiting should not be overlooked in situations where families may be unable to visit due to distance, time or other factors.

The impact on clinicians, and more specifically on critical care nurses when providing end-of-life care must also be considered. Nurses are typically known for their roles as information brokers and as an important source of emotional support for family members as they process information and attempt to contribute to end-of-life decisions (Benbenishty et al., 2022). Yet cultural differences can potentiate confusion and conflict (Brooks et al., 2019), likely amplified when

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Table 1
Evidence-based people-focused priorities in the provision of end-of-life care.

Patients and Families	Support and maintain the patient-family bond	• Facilitate in-person visits for family, where local guidelines and resources allow (Bloomer and Bouchoucha, 2021) • Connect patients and family through virtual visiting (telephone or web-based applications) (Bloomer and Walshe, 2021; Fernández-Martínez et al., 2022) • Seek to understand and respect patient and family wishes before and after patient death (Bloomer and Walshe, 2021) • Provide information about infection prevention and control restrictions and alternate ways to connect with the patient, even when dying (Bloomer and Walshe, 2021; Fernández-Martínez et al., 2022) • Ask family about how to meet their specific needs linked to aspects of their culture (Brooks et al., 2019)
	Prioritise regular communication and updates for family	• When communicating via telephone or web-based applications, allow extra time to explain key information, confirm family understanding and time for questions (Wendlandt et al., 2022) • Act as an information and communication broker between family and members of the patient's larger healthcare team (Fernández-Martínez et al., 2022) • Seek support from a professional translator to ensure effective and accurate communication with family members (Brooks et al., 2019)
Nurses	Challenge assumptions that may create barriers for the provision of end-of-life care	• Promote the importance of end-of-life care as a core feature of critical care (Riegel et al., 2021) • Consider own culture, including values and beliefs and how this may lead to assumptions in the provision of end-of-life care (Brooks et al., 2019) • Advocate for the patient and family by participating in end-of-life discussions and decision-making (Benbenishty et al., 2022; Fernández-Martínez et al., 2022) • Maximise opportunities to emphasise the unique and important contribution of nurses to end-of-life care planning and decision-making (Benbenishty et al., 2022)
	Prioritise self-care	• Seek support from others to evaluate and reconcile emotions and potential conflicts about care (Imbulana et al., 2021; Riegel et al., 2021; Taylor et al., 2020) • Prioritise self-care by asking for accepting help, taking regular breaks, and reflecting on own emotions and wellbeing (Taylor et al., 2020)

visitor restrictions are in place. Family visitor restrictions were also challenging for nurses, bearing the responsibility of holding the dying person's hand in place of a family member (Wendlandt et al., 2022). A Norwegian study exploring critical care nurses' experiences of withdrawal of life-sustaining treatments highlighted that disagreements in decision-making, concerns about overtreatment and prolonging patient suffering were a source of distress for nurses (Taylor et al., 2020). When presiding over the withdrawal process, nurses reported feeling alone, isolated and emotionally affected, and distressed when attempting to comfort families (Taylor et al., 2020). Moral distress, a complex phenomenon linked to personal stress, workload and concerns over individual patients or the unit can also result in harmful effects for nurses (Imbulana et al., 2021). Strategies to minimise moral distress include using reflective practice to challenge underlying moral judgments, building moral courage through empowerment, and cultivating moral resilience by maintaining a strong sense of self and purpose in times of challenge (Imbulana et al., 2021).

In recognition that COVID-19 has created new challenges in caring for patients and families at the end of life, practice recommendations are available to support nurses in facilitating family visitation in critical care within infection prevention and control parameters (Bloomer and Bouchoucha, 2021). But this is just one part of end-of-life care. Whilst the challenge of COVID-19 remains, critical care nurses should demonstrate their expert leadership in the provision of end-of-life care by drawing upon the lessons learnt and the research evidence (Table 1), to lead the way forward beyond COVID-19, where the focus is on what is important to patients, families and clinicians. After all, people are at the core of what critical care nurses do.

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