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EDITORIAL

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Family-centered care during a pandemic: The hidden impact of restricting family visits

From the day the first case of COVID-19 was reported in Wuhan on November 17, 2019, to the declaration of a pandemic by the World Health Organization (WHO) on March 11, 2020 (WHO, 2020a), the world we are now living in has become vastly different. In the space of a few weeks, healthcare settings in many countries were overwhelmed by a COVID-19 surge (Grasselli, Pesenti, & Cecconi, 2020; Richardson et al., 2020), and a global public health emergency developed (Jackson et al., 2020). Reports of the healthcare response to the surge of COVID-19 cases in Italy (Grasselli et al., 2020) and the United States (Centers for Disease Control and Prevention, 2020) highlight the magnitude of the impact of COVID-19 on the healthcare system. Described as a tsunami of death (Jackson et al., 2020), the mortality associated with COVID-19 is unlike anything the current healthcare workforce has seen before.

In response, a suite of public health measures, such as restricting the free movement of people and limiting crowd sizes in the community, was implemented in an attempt to control the pandemic and minimize the risk of outbreaks (Parodi & Liu, 2020). In hospitals, infection prevention and control (IPC) measures have resulted in widespread use of personal protective equipment, isolation of patients with suspected or confirmed COVID-19, monitoring of staff and visitors for symptoms of COVID-19, and significant restrictions to visitors wanting to visit hospitalized patients (Bloomer & Bouchoucha, 2020; WHO, 2020b). A recent media report also describes how even when a patient was dying, visitors were banned (Hafner, 2020). While there is no doubt such restrictions are designed to minimize the spread of COVID-19 and protect those most vulnerable, they also present a significant and potentially long-lasting threat to the family unit (Hart, Turnbull, Oppenheim, & Courtright, 2020), particularly given that in times of disaster, it is known that the basic needs of humans to feel safe, connected, useful, and helpful are intensified (Howe, 2011).

A family-centered approach to care is an important feature of nursing care, grounded in recognition of the family as a social unit connected not just by blood (International Council of Nurses, 2012) and the mutually beneficial partnerships that form between family and clinicians (Grant & Johnson, 2019). During the COVID-19 pandemic, family-centered care is more, not less, important (Hart et al., 2020). The role of family members as part of the care team and finding ways for family involvement and collaboration are imperative, as are strategies that work to protect the integrity of the family unit despite IPC restrictions (Hart et al., 2020).

When a patient is dying, avoiding separation from their family is a priority (Hart et al., 2020). Dying is a time of intimacy and poignancy for family—one that is remembered in detail (Donnelly & Dickson, 2013). Family members of dying patients want to stay close (Slatyer, Pienaar, Williams, Proctor, & Hewitt, 2015), to keenly observe, to protect and provide comfort for the dying person (Donnelly & Battley, 2010), and to have an opportunity to say their farewells (Mossin & Landmark, 2011). When COVID-19 IPC measures mean family presence is not possible, opting for other strategies that address family members' need to be close to the dying person should be considered. Suggestions include the use of mobile phones and other electronic devises to enable video calls (Hart et al., 2020), or even encouraging families to visit from the other side of an external window (Wilson, 2020), may also provide some comfort. Even when innovative solutions are found to facilitate patients and their families connecting, albeit virtually, patients and their families may have only minutes to share final messages and say goodbye (Goldstein & Weiser, 2020). When circumstances mean that even virtual visits or connections are not possible, it may be up to nurses to share the patient's final moments (Natarajan, 2020).

Aside from these additional actions to support family presence, necessary because of COVID-19, other components of end-of-life care deemed most important for dying patients and families must continue. Effective communication, shared decision-making, and receiving expert care has been identified as highly important for dying patients and their families (Virdun, Luckett, Davidson, & Phillips, 2015). Receiving good physical care, which includes being kept clean and having symptoms managed, was also important (Virdun et al., 2015). Addressing the cultural and religious needs of patients and families before and after death and the provision of immediate grief and bereavement support for families are also essential (Raymond, Lee, & Bloomer, 2017) and exemplify the respectful and compassionate care for which nurses and other health professionals are known (Virdun et al., 2015).

Another aspect to consider is the potential impact that having to restrict family visits could have on nurses. The potential for compassion fatigue in nurses working in critical care and palliative care settings has been widely studied, identifying that stressful workplace situations were among factors increasing the likelihood of compassion fatigue (Alharbi, Jackson, & Usher, 2019). Evidence of the adverse impact of working on the COVID-19 frontline are starting to emerge (Alharbi, Jackson, & Usher, 2020), particularly in relation to the emotional toll of attempting to facilitate family connections to say goodbyes (Natarajan, 2020). Wu et al. (2020) surveyed frontline workers in China and, surprisingly, showed that nurses and medical

practitioners working on a ward dedicated to COVID-19 patients had a lower frequency of burnout than those working on their usual wards, suggesting that this may be due to feeling a deeper sense of personal achievement when seeing that the care provided had a positive impact on patients and the pandemic. Whether this sense of personal achievement remains when having to deny visits to a family member needs to be investigated along with other potential factors. While it may be too early in the COVID-19 pandemic to realize the potential impact of compassion fatigue and burnout on nurses, evidence collected following the severe acute respiratory syndrome (SARS) epidemic (Maunder et al., 2006) showed that healthcare workers who cared for patients with SARS had higher levels of burnout, psychological distress, and post-traumatic stress than other healthcare workers. From what we know about factors that may increase risks of compassion fatigue and burnout, having to limit visits for family members of critical ill and dying patients is likely to also have a negative impact on nurses by increasing their feelings of providing inadequate family-centered care.

Nurses have been at the forefront of the response to the COVID-19 pandemic and are facing extraordinary circumstances, where mortality is high, and patients have sometimes been dying alone. Restricting family visits, while a necessary measure to decrease the spread of COVID-19 to vulnerable patients and the community, is likely to have negative effects on families and nurses alike and these impacts need to be carefully considered. In an effort to promote patient and family needs and observe public health measures, a focus on the use of technology to improve communication and enhance patient and family connection may assist to avoid these negative consequences. Given that nurses are known for their ability to provide family-centered care, nurses should lead this work during the COVID-19 pandemic. Family visits could be facilitated by educating and supporting a designated family member in the correct use of PPE during a visit, thus ensuring a balance between IPC imperatives and family-centered care. Taking such an approach could not only enable nurses to stay compassionate in their care and advocate for patients and families but also assist in minimizing the potential negative psychological consequences for nurses and maintain shared decision-making.

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