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From ICU to "I SEE YOU": Introducing the family member in COVID-ICU

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The death rates in Intensive Care Units (ICU) caused by COVID-19 were 37.3%,[1] creating traumatic outcomes in family members forced to detach from their relative, in their homes.[2]

Patient and Family Engagement in ICU has been defined as: "an active partnership between health professionals and patients and families working at every level of the healthcare system to improve health and the quality, safety, and delivery of healthcare."[3] Involving family members in a pandemic era in COVID-ICUs was a complex challenge, as a balance had to be struck between the five ethical principles of Family Centred Care's (FCC)[4] and the safety of visitors and patients[5] and thed increased burden of care of health professionals who worked in the COVID-ICUs[6] which were to contain the fear of family members[7] and support the family member to perform advanced activities such as donning/doffing of Personal Protective Equipment (PPE).[8]

According to a recent concept analysis, family involvement in high isolation in the ICU is a sensitive balance of several variables (education and information transfer; team collaboration; delegation of responsibility to the family; decision making; and protection of the family) that are determined by a triangular interaction between patient, family and nurse conditions.[9]

Following the ethical fundamentals of FCC[4] and the desire that emerged from family members in being close to their loved one hospitalized in COVID-ICUs,[10] a FCC Hospital for COVID-ICU project was introduced in Italy in January 2021. In fact, it has been highlighted in the literature how family members are the centre of care in ICU,[11] both in their active participation in ICU, their role in communication, sharing choices and making clinical decisions with health professionals,[12] as well as in the environmental role of bringing back daily figures in an alienating environment such as ICU 13. Results resulted in important outcomes such as reduction of depression, PTSD and anxiety stay in ICU and improvement quality of life of patients and family members.[13]

The restriction on ICU visitation policies harmed and fueled Post Intensive Care Syndrome-Family (PICS-F),[14] demolished years of research that conferred how important is the support of family members at the end of life and during intensive care,[15,16] an extremely important stage for grieving,[17,18] it has also been found to be critical in reducing long-term effects such as psychological, physical, cognitive, and social problems of family members subjected to traumatic separations due to hospitalization in ICUs[19]during the pandemic.[20] With a qualitative study,[21] the need of family members who have experienced separation and estrangement of their family member from home was analyzed, the results identified that fear, detachment, life on standby, family-related loneliness in the COVID-ICU and an unexpected event characterized the lived experience. In a second step, an instrument was developed to assess satisfaction with the training of family members on the donning/doffing of PPE, to reduce barriers due to lack of knowledge of the disease and lack of preparation for an extremely complex high isolation dressing, stating that the instrument was found to be reliable and valid for this procedure.[8] In the final instance, the lived experience of relatives who had contact with their relative with COVID in the ICU was investigated with a phenomenological study;[7] after a period of detachment from admission and showed that fear of contagion related to donning/doffing procedures, positive emotions related to first contact with the hospitalized relative, concern for the emotional state of the hospitalized relative, impact of the COVID-ICU and comparisons between imagination and reality regarding the severity of the disease, and recognition of and gratitude toward healthcare professionals char-

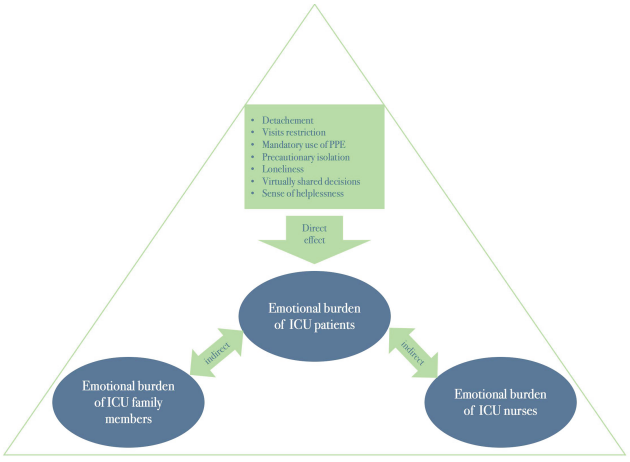

Figure 1. The triadic effects of policy on ICU visits.

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acterized the phenomenon of entry into the COVID-ICUs.

The project of integrating family members into high isolation ICUs was lengthy and gave nurses a way to reduce a devastating burden of loneliness of which the patient was the victim and nurses represented the unknown family members.

Detachment, life on standby, restriction to visits, precautionary isolation, loneliness, sense of worthlessness, virtually shared decisions, end of life unsupported by family members, and mandatory use of PPE caused a direct emotional burden on the patient and an indirect emotional burden on family members and nurses creating a triangular emotional effect on the three protagonists of direct and indirect care in ICU. This policy path on visits has allowed people to desire contact with their loved one to see and touch them directly, even if with layers of protective tissues. It will be crucial for future studies to apply the data from these studies to centralize care in family members of relatives admitted to ICUs even in pandemic situations or those requiring preventive detachment (for diseases with high contagiousness), so as to confer humanization of care even in extreme situations. The pandemic era should not be a history book but a page of the present, following the principle of FCCs in ICUs, it is appropriate to guide care in a triadic direction so as to reduce the incidence of PICS and PICS-F and improve the nursing workload in ICUs (Figure 1).

References

1. Chandel A, Leazer S, Alcover KC, et al. Intensive care and organ support related mortality in patients with COVID-19: a systematic review and meta-analysis. Crit Care Explor 2023;5:e0876.
2. Amass T, Van Scoy LJ, Hua M, et al. Stress-related disorders of family members of patients admitted to the intensive care unit with COVID-19. JAMA Intern Med 2022;182:624-33.
3. Brown SM, Rozenblum R, Aboumatar H, et al. Defining patient and family engagement in the intensive care unit. Am J Respir Crit Care Med 2015;191:358-60.
4. Davidson JE, Aslakson RA, Long AC, et al. Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. Crit Care Med 2017;45:103-28.
5. Chanchalani G, Arora N, Nasa P, et al. Visiting and communication policy in intensive care units during COVID-19 pandemic: a cross-sectional survey from South Asia and the Middle East. Indian J Crit Care Med 2022;26:268-75.
6. Castano-Garcia M, Granero-Molina J, Fernandez-Ferez A, et al. "Who takes care of carers?": experiences of intensive care unit nurses in the acute phase of the COVID-19 pandemic. Healthcare (Basel) 2024;12:162.
7. Bartoli D, Trotta F, Pucciarelli G, et al. The lived experiences of family members who visit their relatives in Covid-19 intensive care unit for the first time: A phenomenological study. Heart Lung 2022;54:49-55.
8. Trotta F, Petrosino F, Pucciarelli G, et al. Reliability and validity of the training satisfaction questionnaire for family members (TSQ-FM) entering the ICU during an isolation disease outbreak. Heart Lung 2024;66:37-45.
9. Soleimani M, Fakhr-Movahedi A, Yarahmadi S. Family engagement in the care of infectious patients in intensive care units: A hybrid concept analysis. Nurs Open 2024;11:e2117.
10. Wendlandt B, Kime M, Carson S. The impact of family visitor restrictions on healthcare workers in the ICU during the COVID-19 pandemic. Intensive Crit Care Nurs 2022;68:103123.
11. Schwartz AC, Dunn SE, Simon HFM, et al. Making family-centered care for adults in the ICU a reality. Front Psychiatry 2022;13:837708.
12. Liu X, Humphris G, Luo A, et al. Family-clinician shared decision making in intensive care units: Cluster randomized trial in China. Patient Educ Couns 2022;105:1532-8.
13. Love Rhoads S, Trikalinos TA, Levy MM, Amass T. Intensive care based interventions to reduce family member stress disorders: a systematic review of the literature. J Crit Care Med (Targu Mures) 2022;8:145-55.
14. Vrettou CS, Mantziou V, Vassiliou AG, et al. Post-intensive care syndrome in survivors from critical illness including COVID-19 patients: a narrative review. Life (Basel) 2022;12.
15. Kentish-Barnes N, Meddick-Dyson S. A continuum of communication: family centred care at the end of life in the intensive care unit. Intensive Care Med 2023;49:444-6.
16. Galazzi A, Binda F, Gambazza S, et al. The end of life of patients with COVID-19 in intensive care unit and the stress level on their family members: A cross-sectional study. Nurs Crit Care 2023;28:133-40.
17. Fridh I, Forsberg A, Bergbom I. Family presence and environmental factors at the time of a patient's death in an ICU. Acta Anaesthesiol Scand 2007;51:395-401.
18. Pattison NA, White C, Lone NI. Bereavement in critical care: A narrative review and practice exploration of current provision of support services and future challenges. J Intensive Care Soc 2021;22:349-56.
19. Shirasaki K, Hifumi T, Nakanishi N, et al et al. Postintensive care syndrome family: A comprehensive review. Acute Med Surg 2024;11:e939.
20. Montauk TR, Kuhl EA. COVID-related family separation and trauma in the intensive care unit. Psychol Trauma 2020;12:S96-S7.
21. Bartoli D, Trotta F, Simeone S, et al. The lived experiences of family members of Covid-19 patients admitted to intensive care unit: A phenomenological study. Heart Lung 2021;50:926-32.

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