

POSITION STATEMENT



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ACCCN and ACIPC POSITION STATEMENT ON FACILITATING NEXT-OF-KIN PRESENCE FOR PATIENTS DYING FROM COVID-19 IN THE ICU (UPDATED 2021)

ACKNOWLEDGEMENTS

Position statement development group

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FOREWORD

The COVID-19 pandemic is challenging health care systems worldwide; none more so than critical and intensive care settings. Significant attention has been placed on the capacity of Australian ICUs to respond to a COVID-19 surge, particularly in relation to beds, ventilators, staffing and personal protective equipment. In light of the unparalleled increase in deaths in ICUs associated with COVID-19 seen internationally, this Position Statement has been produced to guide critical care nurses in facilitating next-of-kin presence for patients dying from COVID-19 in the ICU.

INTRODUCTION

The Australian College of Critical Care Nurses Limited (ACCCN) is the peak national professional nursing association representing critical care nurses in Australia. The Australasian College for Infection Prevention and Control (ACIPC) is the peak body for Infection Prevention and Control professionals in the Australasian region.

BACKGROUND

End-of-life care is a fundamental component of critical care nursing, with almost one quarter of patients admitted to the ICU dying.¹ Death in the ICU is seldom unexpected, and most occurs as a result of withdrawal of futile interventions.^{2, 3} Yet critical care nurses may face multiple challenges associated with end-of-life care on a daily basis.³ These challenges include coordinating communication between the treating team and next-of-kin⁴ and ensuring communication is culturally-sensitive.⁵ Critical care nurses are also known for their role in preparing next-of-kin and families for treatment withdrawal,^{6, 7} creating space and privacy,⁴ and focusing on what is important to the patient, next-of-kin and family before and after death.^{8, 9}

The Coronavirus Pandemic (COVID-19) is impacting ICUs worldwide. Sixteen percent of patients in Lombardy, Italy¹⁰ and 24% of patients in New York, USA diagnosed with COVID-19 required an ICU admission.¹¹ Government and community measures to contain and minimise the spread of COVID-19 in Australia¹² 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 health care workers.^{13, 14} The World Health Organization also recommends that visitors should not be allowed to visit suspected or confirmed COVID-19, unless strictly necessary.¹⁵ 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.¹⁶ Family members want to be present, to observe, comfort and protect the dying person.¹⁷ Hence dying is not only what the patient experiences, but also what the family experiences, with the death experience remembered in detail.¹⁸ 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.¹⁹

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The Australian College of Critical Care Nurses (ACCCN) and the Australasian College of Infection Prevention and Control (ACIPC) endorse practices aimed at facilitating family visitation in critical care, where resources (such as PPE) and staffing permit.

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 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 minutes after any Aerosol Generating Procedure (AGP).
- 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 to 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 not do.
- VII. Next-of-kin should be instructed to wipe over valuables and wash hands for at least 20 seconds. With the assistance of the ICU staff member, next-of-kin should be assisted to don PPE (gown, goggles, gloves and N95/P2 mask, with the mask fit-checked).^{20, 21} The next-of-kin should be instructed not to remove or touch the front of their mask at any time during the visit.
- 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, 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 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.

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