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Research paper

The impact of the intensive care unit family liaison nurse role on communication during the COVID-19 pandemic: A qualitative descriptive study of healthcare professionals' perspectives

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A B S T R A C T

Background: The COVID-19 pandemic has deeply impacted patient and family communication and patient- and family-centred care in the intensive care unit (ICU). A new role—the ICU Family Liaison Nurse (FLN)—was introduced in an Australian metropolitan hospital ICU to facilitate communication between patient and family and ICU healthcare professionals, although there is limited knowledge about the impact of this from the ICU healthcare professionals' perspectives.

Objective: The aim of this study was to explore the impact of the ICU FLN role on communication with patients and their family during the COVID-19 pandemic, from the ICU healthcare professionals' perspectives.

Methods: A qualitative descriptive study was conducted. Seven participants including ICU FLNs, ICU doctors, nurses, and social workers who worked with the ICU FLNs were interviewed. Thematic analysis was used to analyse the data.

Results: Two main themes related to the ICU FLN role were identified. First, the COVID-19 pandemic posed challenges to patient and family communication, but it also created opportunities to improve patient and family communication. Second, the ICU FLN role brought beneficial impacts to the ICU healthcare professionals' workflow and work experience, as well as patient and family communication. The ICU FLN role has potential benefits that extend beyond the pandemic.

Conclusion: We found that during the COVID-19 pandemic, the ICU FLN role was acceptable, beneficial, and appreciated from the ICU healthcare professionals' perspectives. Further research should continue the evaluation of the ICU FLN role during and post the pandemic.

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1. Introduction

The COVID-19 pandemic created an unprecedented global health crisis, placing a tremendous burden on intensive care unit (ICU) services and healthcare professionals (HCPs).¹ In Australia and internationally, ICUs have faced challenges in preparing surge workforce and resources, HCPs' upskilling and training, as well as infection control and prevention and staff protection.^{2–4} One

consequence is that overwhelmed ICU HCPs tend to prioritise patients' physical care needs over communication with patients' families and spend less time on addressing families' communication needs, resulting in a negative impact on patient- and family-centred care (PFCC).^{5,6}

COVID restrictions and personal protective equipment have also challenged the traditional communication methods and platforms. Similar to many places internationally, the Victoria government has implemented strict restrictions on hospital visitation since the pandemic started,⁷ resulting in negative impacts on the communication between ICU HCPs and patients' families and PFCC.⁸ Moreover, inconsistent communication, loss of nonverbal

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communication, language barriers, cultural differences, lack of communication skills, diluted workforce skill mix, and added COVID-19 stress may further amplify the challenges in effective communication between ICU HCPs and patients' families.^{9,10} Despite the above challenges, new technology and models of care have been explored and developed to optimise patient and family communication, such as videoconferencing and patient journaling.⁸

In light of this, a new role in Australia—the ICU Family Liaison Nurse (FLN)—was introduced in one Australian metropolitan hospital ICU. ICU FLNs exist elsewhere in the world, such as the U.S. and Switzerland, with the specific responsibility of enhancing communication between ICU HCPs and patients' families.^{11–16} Existing evidence indicates that ICU FLNs provide patients and families with communication support, emotional support, and decision-making support.^{11–16} Several studies demonstrate that this model of family care is associated with increased family satisfaction of communication with ICU HCPs and ICU care.^{11–14,16} The ICU HCPs also reported positive feedback on this model of care, such as better relationships with their patients and their families, feeling supported, less workload and work stress.^{11,12,14} As the ICU FLN role is new to the Australian context, the impact of this role in Australian ICUs on patient and family communication is unknown. Therefore, this study sought to examine ICU HCPs' perspectives on the impact of the ICU FLN role on communication with patients and families during the COVID-19 pandemic. The findings from this study may inform further development and implementation of ICU FLN practice in Australia to facilitate communication between ICU HCPs and patients and their families to promote PFCC.

2. Methods

2.1. Design, setting, participants, and procedures for recruitment

This study used a qualitative descriptive methodology. Qualitative description provides a detailed description of a phenomenon where little is known.¹⁷ It aligns with the interpretivist paradigm, which is generally used to understand individuals' perspectives and their interpretation of a phenomenon.^{17,18} As little is known about the ICU FLN role in Australia in facilitating and supporting patient and family communication, this study sought to explore this new role from the perspectives of ICU FLNs and other ICU HCPs. The study setting was a large public metropolitan hospital ICU in Australia. This hospital increased its capacity by more than 50% to accommodate the increase in patients due to the COVID-19 pandemic, and it treated the sickest and most complex COVID-19 cases in the city.

A purposive sampling technique was used to recruit participants. The key inclusion criterion was that participants needed to be either acting as or working with the ICU FLNs. Purposive sampling allows the researcher to identify participants that are able to provide relevant, rich, and in-depth information related to the topic of interest.¹⁸ Due to time limitations, recruitment and data collection had to occur during the period from March to April 2021. A total of seven HCPs agreed to participate during this time. Recruitment was achieved by flyer dissemination around the unit and email invitations to all staff members who worked at the unit. Ethical approval was obtained from the participating hospital's Low Risk Hospital Research Ethics Committee (Project number: 794/20).

2.2. Data collection & data analysis

Semistructured interviews were conducted with participants via videoconferencing using the Zoom platform or via telephone

from March to April 2021. Each of the seven interviews took approximately 30 minutes. An interview schedule was informed by the relevant literature and the research aim and was used to guide questions, but participants were encouraged to discuss any aspect of their experience of working with the ICU FLN (See Appendix A). Data were thematically analysed, following the 6-phase guide summarised by Braun and Clarke.^{19,20} The first author transcribed all interview records, developed codes through inductive reasoning, and analysed and combined the codes to generate themes. Coding and analysis was iterative with the data and memos. Two of the other researchers coded two transcripts and met with the first author to discuss codes and emerging themes. Analysis and development of themes was reviewed at several meetings. Pseudonyms were used to ensure participants' anonymity. An audit trail and a code-recording strategy were used to establish dependability and confirmability. In addition, the reflexivity is maintained by acknowledging that some of the authors had existing relationships with the participants; however, they were not involved in any interviews and the voluntary and confidential participation was emphasised. The first author also maintained a reflexive journal to increase transparency and decrease the researcher's influence. Because the first author is an ICU nurse in a different hospital and also looked after COVID-19 patients during the pandemic, it is important that the first author is reflexive and is aware of how her own experiences, beliefs, and assumptions may influence the study process constantly.

3. Results

Seven participants were recruited for this study: two ICU FLNs, an ICU doctor, two ICU nurses, and two ICU social workers. Both ICU FLNs were highly experienced ICU registered nurses with postgraduate critical care qualifications, and one was involved in setting up the ICU FLN role. The ICU doctor was a senior ICU consultant who was also involved in setting up the ICU FLN role. Both ICU nurses were registered nurses with postgraduate critical care qualifications, and one was employed as a nurse in charge during the COVID-19 pandemic. Both ICU social workers were senior social workers with extensive knowledge and experience.

This study found two main themes that represented the participants' perceptions of the impact of the ICU FLN role on patient and family communication during the COVID-19 pandemic: (i) Impacts of COVID-19 pandemic on communication in ICU and (ii) Beneficial impacts of the ICU FLN role.

3.1. Impacts of COVID-19 pandemic on communication in the ICU

All seven participants referred to the communication with patients and families as challenging during the COVID-19 pandemic. According to participants, the 'no-visitor' policy had a major negative impact on the communication with patient families during the COVID-19 pandemic.

The reduced visiting at the bedside is probably one of the key losses of opportunities for communication (ID 4).

The only method by which ICU HCPs could update patients' families was via telephone calls or telehealth. Participants reported that communication with patients' families via telephone calls was especially challenging because they were unable to be certain of the person's identity. Therefore, it was difficult to know how much information to disclose, while maintaining the patients' confidentiality.

... to be very careful with what we say on the phone and keep what we say on the phone very minimal (ID 4).

In addition, communication skills were also identified as a challenge for some ICU HCPs, as highlighted by some participants:

So it was a skill development around de-escalation techniques and communication techniques (ID 4).

Furthermore, participants felt that communication via telephone limited their ability to offer adequate emotional support to patients' families. This was an additional challenge for ICU HCPs because the families were already stressed about visitor restrictions in the ICU, and therefore, the inability to support those families amplified the challenges to communication in the ICU and the ICU HCPs' stress levels.

It definitely added an extra stress to their day, losing that natural communication that you know, from when families just visited (ID 1).

Despite the challenges to communication in the ICU due to the COVID-19 pandemic, participants reported some positive aspects:

I'd say it was a severe change, but not necessarily a bad one in terms of communication (ID 6).

All seven participants felt that telehealth was a great help and played a major role in facilitating patient and family communication. It was relatively easy and less time-consuming to organise a telehealth meeting than an in-person meeting. Telehealth enabled families to see their loved ones' face and what is going on in the ICU, which was important especially during the lockdown. They reported that communication was more regular and organised during the pandemic with the use of telehealth; a booking system was implemented to schedule calls and meetings with family members, healthcare providers, and interpreters.

I think communication became more deliberated with families and more scheduled, and potentially more regular, particularly with our medical staff (ID 6).

3.2. Beneficial impacts of the ICU FLN role

Participants described positive changes to their practice due to the implementation of the ICU FLN role. The ICU FLN's responsibilities included the initial contact with the family and then regular follow-ups, providing them with necessary information about the ICU and establishing who would be the main contact for the patient. The ICU FLN role had a positive influence on the HCPs practice because it enhanced collaboration among the interdisciplinary team.

... (The ICU FLNs) fostered collaborative work, which made all of us still meeting the needs of all patients and families (ID 2).

The ICU FLNs met with the nurse manager, clinical nurse coordinators, ICU lead social worker, and medical consultants regularly, to discuss patient families' situations. The ICU FLNs reported patient families' needs and concerns back to the medical, nursing, and social work teams.

Additionally, participants appreciated that the ICU FLNs were able to determine family dynamics quickly and prioritise their referrals.

If there was a particular patient to highlight, they would often call in the morning, or I felt strongly that I would like them to contact the family of a particular patient on the day zero or the day one and prioritise them, then they were very receptive to that (ID 6).

The ICU FLNs would also assist in utilising telehealth at the bedside and organising family meetings. Most of the participants felt that even though this role was implemented suddenly, it evolved quickly over time in the ICU and the FLNs got along well with the ICU team.

The ICU HCPs felt supported by the ICU FLNs in several ways: It helped their workload and contributed to efficient workflow. This enabled nurses to focus on the direct physical care of the patient. One participant felt relieved and less stressed with the ICU FLN around at work because she knew that patients' families were being contacted, updated, and looked after.

Now we have this role and just specifically for talking with the family and updating them, that kind of like a big relief for me. Yeah, not having to worry too much (ID 3).

The ICU HCPs also described the ICU FLNs as a bridge to facilitate communication between ICU HCPs and patients' families.

They were kind of connecting the dots; So the link, I think, in creating the team with the bedside nurse, the ANUM (Associate Nurse Unit Manager) and the FLN, the FLN actually the key in that, because they would call the bedside and they also called ANUMs (ID 6).

The ICU FLNs empowered patients' families and prompted open and effective communication. The ICU HCPs thought it was extremely beneficial for patients' families to have that open communication, therapeutic listening, and regular point of contact. Participants felt that patients' families were reassured with the calm and clear communication they received from the ICU FLNs.

I think that families feel very reassured by the level of communication offered and provided by the family liaison nurse in the ICU setting (ID 5).

Having the ICU FLNs make regular contacts with patients' families was helpful to ensure a consistency in communication and a continuous process of ICU care and save a lot of potential miscommunication.

The role has been beneficial in providing consistent messages to families (ID 6).

All participants expressed that the ICU FLN role should remain in the ICU after the pandemic. They highlighted a number of areas that would benefit from having the ICU FLNs post pandemic, including patient discharge support, patients and their families' post-ICU experience follow-up, staff education on patient and family communication, participation in future research, and future development on The National Safety and Quality Health Service Standards: partnering with consumers standards.

- Maybe the role would also include patient transition out of ICU, going to the wards, or going to other hospitals (ID 2).

- I would also like to see it expand to family follow up ... I think it has the potential for really good data gathering for patients and families post ICU experience (ID 6).

- Certainly, there's certainly room in this role for some education around family communication and setting up communication plans ... Further down the line, the role has been utilised for recruitment for studies ... In terms of benefits of the role going forward ... doing some further work around national standard two (ID 4).

Some participants pointed out that issues with funding may present challenges to keep the ICU FLN role. They were also concerned about the ICU FLNs' future capacity as there are only two ICU FLNs working in this ICU with a capacity for 40 patients. In addition, one participant mentioned that there was a need to measure and capture the real impact of the ICU FLN role so that its benefits could be made visible to all.

So the hospital will be very keen to cut something like this unless we can show that it works and can measure the impact ... The impact of the FLN is almost hard to measure (ID 7).

4. Discussion

This descriptive study explored the ICU HCPs' experiences with the ICU FLN—a newly implemented role to enhance patient and family communication during the COVID-19 pandemic in an Australian ICU. The development of the ICU FLN role is in urgent need of addressing patients' and families' unmet needs for effective communication, while at the time supporting the bedside nurses during the pandemic. The findings of this study suggest that the ICU FLN supported ICU HCPs' workflow and their communication with patient and family during the pandemic. Our study also suggests the future role of the ICU FLN is multidimensional including, but not limited to, facilitating patient and family communication, providing education, participating in more research, and following up the patient and family post ICU experiences.

Our study is consistent with results from similar studies with interventions that were designed to improve communication between ICU HCPs and patients' families.^{11–14,16} Even though our study differs in that we examined the ICU FLN's impact under the COVID-19 pandemic, such care models have been found to have a beneficial effect on patient and family communication with ICU HCPs. The ICU FLNs acted as a link between ICU HCPs and patients' families. They listened to patient families' concerns and needs with empathy. During this stressful time, the ICU FLNs were able to develop strong relationships with patients' families. They ensured the consistency and accuracy of patient and family communication with ICU HCPs,^{11,14} under a difficult situation where hospital open visitation had been interrupted.

Our findings that describe the ICU FLN role are consistent with the core concepts of PFCC, in which HCPs and patients' families should communicate openly and share timely and accurate information.²¹ The ICU FLNs provide communication support to patients' families and advocate for patients and their families. They support ICU HCPs to ensure a PFCC approach throughout the patients' ICU admission is achieved.²² Furthermore, the findings from our study are supported by position statements from our peak national professional body for critical care nursing, the Australian College of Critical Care Nurses, that outline the importance of principles of PFCC in ICU when partnering with families in critical care²² and planning workforce for intensive care nursing.²³ Participants in our study worked in an ICU that promotes a philosophy and culture of PFCC. The ICU FLN role was able to optimise communication with families by adapting digital technology communication aids to promote family participation and optimise effective patient and family communication during the pandemic.²²

Our results were comparable to those of three previous studies which also investigated the ICU HCPs' perceptions of similar care models.^{11,13,14} The FLN service is perceived as an additional support to the ICU HCPs in their work, reducing their workload and alleviating their stress.^{11,13,14} Study findings revealed that having the ICU FLN provide a regular point of contact and report it back to the ICU team made it easier for the ICU HCPs to have a better understanding of family situations and their needs. ICU HCPs felt that they were able to better engage with families and build better relationships. ICU HCPs reported that ICU FLNs also freed up more time for the bedside nurses to focus on direct patient care activities. In contrast, a study conducted by Moore et al.¹⁶ found no significant changes in nurses and doctors' (n = 175) perceptions of quality of communication after implementing the ICU FLN role. Possible explanations for the divergence of findings are that the two studies have different backgrounds, study methods, and samples. Additionally, our study context is situated in a pandemic and it is likely this had a significant impact on the ICU HCPs perceptions.

Another issue highlighted by our findings is that telehealth technology has been adapted well and expanded rapidly in ICU. Telehealth provided a pathway to link ICU HCPs and ICU patients with their families. Our findings are similar to those of many studies that evaluated the use of telehealth during the COVID-19 pandemic.^{24–26} However, there is a lack of literature on the impact of telehealth on patient and family communication in ICU during the COVID-19 pandemic. Future research is required to support, develop, and improve the telehealth *utilisation* with patients and their families in ICU.

4.1. Implications

This study highlighted the value of having the ICU FLN in the ICU to support patient and family communication. It would be beneficial if the ICU FLN could provide ongoing education and training to ICU staff on patient and family communication. It is also important to educate and raise the conscious awareness of the ICU FLN role among ICU HCPs so they can better understand and work with the ICU FLNs.

To address the challenges in funding and resources when future implementing the ICU FLN role, more research is needed to investigate the ICU FLN role, from both HCPs', patients', and their families' perspectives. The results of a cost–benefit analysis could be used to inform the financial resources required to implement the role on an ongoing basis. However, this information must be weighed up against the qualitative evidence that supports the feasibility of the ICU FLN role. If there is more evidence available to support this role, it would be worth implementing the ICU FLN role to other ICUs and potentially a similar role to other general wards.

4.2. Strengths and limitations

To our knowledge, this is the first study to investigate the ICU FLN role and its impact on patient and family communication in an Australian ICU and during a pandemic. Therefore, our study is novel and would have increasing relevance if the ICU FLN is implemented widely in ICUs across Australia. Second, this qualitative study collected data from a range of different HCPs which offered a variety of perspectives.

There are several limitations. The study team experienced challenges in recruiting participants in the short time period, from early March to mid-April. We recruited only one ICU doctor as many of those who worked last year with the ICU FLNs under the COVID-19 restrictions had left the unit after their rotation. In this study, a small sample size of seven participants was interviewed once over a period of 5 weeks and ICU doctors were underrepresented in the

sample. Hence, it is possible that some perspectives about the ICU FLN role were not captured. This study was conducted in one Australian ICU, which limits the transferability of the results to other ICUs. In addition, some of the participants were involved in developing and promoting the ICU FLN role. This likely resulted in more positive viewpoints being highlighted and an underrepresentation of any negative viewpoints. Furthermore, the scope of this study was restricted to HCPs. Hence, patients and their families' voices were not explored, which is another limitation when evaluating the patient and family communication and PFCC. Future research is needed to include patients and families and more HCPs from other disciplines, to report the full range of experience with the ICU FLN role.

Moreover, many studies that investigated such ICU family liaison role have employed ICU nurses for the role,^{11–14,16} including our study, except one study where a nurse and a social worker were appointed.¹⁵ The fact that we did not explore why such role would best fit within a nurse's scope of practice limits the understanding of the scope of this role and its impact. However, apart from the care ethics and a good understanding of both HCPs' and patients and families' experiences in the ICU in nursing, some studies also highlighted that such role was required to interpret and explain medical information to patients and families.^{11,12,14,16} Those qualities and requirements make the ICU nurses well suited for this role. Future research to explore the ICU family liaison role run by someone from other disciplines would also be beneficial.

5. Conclusion

The COVID-19 pandemic has significantly impacted communication between patients, family, and PFCC in ICU. The ICU FLN was introduced in one Australian metropolitan ICU to facilitate patient and family communication during this stressful time. This study found that the ICU FLN role was valuable in supporting communication between patients' families and ICU HCPs during the COVID-19 pandemic and has the potential to facilitate patient and family communication and improve PFCC in ICU when the pandemic is over. Further research is required to better understand the impact of the ICU FLN on patient and family communication from the perspectives of patients' and their families and more ICU HCPs.

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CRedit authorship contribution statement

RC – Conceptualisation, Methodology, Formal analysis, Investigation, Resources, Data Curation, Writing – Original draft, Writing – Reviewing & Editing, Visualisation, Project administration

MT – Conceptualisation, Methodology, Validation, Formal analysis, Investigation, Resources, Writing – Reviewing & Editing, Visualisation, Supervision, Project administration

JRW – Conceptualisation, Methodology, Writing – Reviewing & Editing

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PW – Conceptualisation, Methodology, Validation, Formal analysis, Investigation, Resources, Writing – Reviewing & Editing, Visualisation, Supervision, Project administration

All authors have revised the article critically for important intellectual content and have provided the approval for the final version to be submitted.

Conflict of interest

None.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.aucc.2022.09.004>.

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