COVID-ICU and FAMILIES

A survey to describe

Family visitation policies, facilities, communication and support

variations within and between countries in the setting of the COVID-19 pandemic.

Protocol

V 1.1

Dated 27/11/2020

Protocol

Objectives:

To describe

- Current visiting policies and how they have changed since the COVID-19 pandemic
- Support offered to families, including virtual visiting and communication strategies.

Rationale

The ongoing COVID-19 pandemic has caused a disruption of communication, services and support for relatives of ICU patients (1). Since the very beginning of the pandemic (2), and in periods of high community transmission, visits to critically ill patients have been strictly limited or stopped altogether to minimize the risk of COVID-19 transmission and to conserve limited PPE supplie

Prior to December 2019, family centred critical care, which includes unrestricted, open visiting, had been increasingly recognised as an integral and important component of the management of ICU patients.

Society guidelines acknowledge the importance and impact such restrictions may have on relatives of ICU patients, especially around the time of death. This includes establishing local guidelines, including frequent structured communication and the use of technology to palliate the inability to provide with the usual interactions and information (3-5).

The aims of this survey are to describe the organisation of information and visiting for relatives of ICU patients and the services available to support them in the current pandemic times.

Methods

Survey Design

We will use a custom-designed survey using the survey-monkey online platform. It will be tested by management committee members and by clinicians with relevant experience not in the management committee for flow, content and administration. Iterative adaptation will be performed based on tester feedback.

The survey will be designed to be short and not take more than 20 minutes to complete. It will investigate 5 core domains

1. Institutional demographics. Description of the hospital and the ICU. Local pandemic status. Identification of the ICU to avoid duplicates – Only country information will be kept for analysis, the other variables will be deleted prior to importing in the statistical software
2. Visiting Policies, including visiting hours and management near the end of life; ~~use of PPE by visitors~~ and the use of technology and virtual visiting
3. Use of technology to facilitate virtual visiting by relatives of icu patients
4. art 3 communication with relatives of ICU patients.

Anonymity and data management processes

Data will be collected via survey monkey and exported to an excel document. Data will be checked for duplicates by sorting by country, town, hospital name and ICU names if available.

If duplicate entries are found, they will be checked for completion. If any completion discrepancies, the most complete entry will be kept.

In case where several complete entries are available for the same ICU, they will be sorted according to the role of the respondent (Medical director, Nurse unit manager or nursing director, Medical senior role, Nursing senior role, Medical other, Nursing other, Administrative role, Other). The entry with the ranking that comes first in this list will be kept.

Once duplicates removed, the following data fields will be deleted: role, town, name of hospital, name of ICU. Data will then be saved as the master data file for the study and transferred to the statistical software for analysis.

Descriptive statistics will be provided for reporting and publication.

Survey population

ICUs worldwide– we define ICU as an inpatient service with capacity to provide invasive mechanical ventilation. One response per ICU will be sought. Sample size will be defined as a convenience sample from the ICUs that respond. Response rate will be by design unknown.

Survey dissemination

We will disseminate the survey through all means available to the management committee including the following:

1. European Society of Intensive Care Medicine mailing list
2. Partner scientific societies mailing lists
3. Personal networks of management committee members
4. Social media (Twitter accounts of management committee members)

We will also ask respondents to forward the survey to their contacts for snowball sampling.

Endorsement has been being sought from:

European Society of Intensive Care Medicine (ESICM)

Ethical considerations

Exemption from full ethical review and approval as a quality assurance activity will be sought from the Human Research Ethics Committee, Royal Brisbane and Women's Hospital, Brisbane, Australia

Organizing committee

Alexis Tabah	Redcliffe ICU, Metro North Hospital and Health Service, The University of Queensland, Brisbane, Australia	alexis@tabah.org
Jan de Waele	Ghent University Hospital, Ghent, Belgium.	Jan.DeWaele@UGent.be
Kevin Laupland	Department of Intensive Care Services, Royal Brisbane and Women's Hospital, Queensland University of Technology, Brisbane, Queensland, Australia	Kevin.laupland@qut.edu.au
Francois Barbier	Médecine Intensive - Réanimation Hôpital de la Source - CHR Orléans Orléans, France	barbierfrancois.chro@gmail.com
Maurizio Cecconi	Head of Department Anaesthesia and Intensive Care Units. Humanitas Research Hospital. Milan, Italy. Professor of Anaesthesia and Intensive Care Humanitas University. President Elect ESICM	maurizio.cecconi@hunimed.eu
Marlies Ostermann	Critical Care & Nephrology at Guy's & St. Thomas' Foundation Trust, London.	marlies.ostermann@gstt.nhs.uk
Laurą galarza	Department of Intensive Care, Hospital General Universitario de Castellon, Castellon de la Plana, Spain.	lauragalarzabarrachina@gmail.com
Julie Benbenishty	Intensive Care Trauma, Hadassah Medical Center, Jerusalem, Israel.	JULIE@hadassah.org.il
Regis Goulart Rosa	Intensive Care Unit, Hospital Moinhos de Vento, Porto Alegre, Rio Grande do Sul, Brazil	regis.rosa@hmv.org.br
Kirsten Fiest	Department of Critical Care Medicine, University of Calgary & Alberta Health Services, Department of Community Health Sciences & O'Brien Institute of Public Health, University of Calgary, Department of Psychiatry & Hotchkiss Brain Institute, University of Calgary, Calgary, Canada	kmfiest@ucalgary.ca
Muhammed Elhadi	Faculty of Medicine, University of Tripoli, Tripoli, Libya.	muhammed.elhadi.uot@gmail.com
Mariangela Pellegrini	Centrala intensivvårdsavdelning 70G (CIVA), Department of Critical Care Medicine AnOpIVA, Akademiska sjukhuset, Uppsala, SWEDEN. Hedenstierna Laboratory, Department of Surgical Science, Uppsala University, Uppsala, SWEDEN.	mariangela.pel@gmail.com
Elie Azoulay	Médecine Intensive et Réanimation, Groupe FAMIREA, Hôpital Saint-Louis, Université de Paris, Paris, France.	elie.azoulay@aphp.fr
Guy Francois	Division of Scientific Affairs-Research, European Society of Intensive Care Medicine, Brussels, Belgium	guy.francois@esicm.org
Takeshi Unoki	Professor at Adult Health Nursing (Critical Care Nursing), School of Nursing, Sapporo City University Sapporo, Japan	iwhyh1029@gmail.com
Andrea Cortegiani	Department of Surgical, Oncological and Oral Sciences. University of Palermo, Italy University Hospital Policlinico Paolo Giaccone	andrea.cortegiani@unipa.it

References

1. Azoulay É, Curtis JR, Kentish-Barnes N. Ten reasons for focusing on the care we provide for family members of critically ill patients with COVID-19. Intensive Care Medicine. 2020.
2. Liao X, Wang B, Kang Y. Novel coronavirus infection during the 2019–2020 epidemic: preparing intensive care units—the experience in Sichuan Province, China. Intensive care medicine. 2020;46(2):357-60.
3. Vergano M, Bertolini G, Giannini A, Gristina GR, Livigni S, Mistraletti G, et al. Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian perspective during the COVID-19 epidemic. Springer; 2020.
4. Australian and New Zealand Intensive Care Society (2020) ANZICS COVID-19 Guidelines. Melbourne: ANZICS.
5. Aziz S, Arabi YM, Alhazzani W, Evans L, Citerio G, Fischkoff K, et al. Managing ICU surge during the COVID-19 crisis: rapid guidelines. Intensive care medicine. 2020;46(7):1303-25.