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The Implications of the COVID-19 Pandemic for Bereavement Practice and Support in PICU

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Dear Editor,

The COVID-19 pandemic has given healthcare workers reason to reflect on many aspects of caring for people at the end of life. That reflection extends to looking at the impact of the pandemic restrictions on how holistic family-centred care is delivered [1]. With mounting pressure of health service demand and resource constraints, it is challenging to find time and space to explore the implications for bereavement practice.

In the Paediatric Intensive Care Unit (PICU) we conducted a retrospective review of bereavement supports offered to bereaved families over two 3-month periods, November 1st, 2019 to January 31st, 2020 and April 1st, 2020 - June 30th, 2020. This study was carried out as part of a broader quality improvement project conducted over a period of 12 months. We identified seven domains of practice that are offered to families when a child is at the end of their life in PICU. These include open family visiting, religious or pastoral care services on PICU, co-sleeping, photography, memory-making and follow-up bereavement visits. Not all families avail of all or any supports. On admission, families are routinely referred to our social work team and psychology service. In the period November 2019 – January 2020, more that 90% of families availed of 3 or more supports offered on PICU at the end of their child's life. The study identified key areas for improvement including documentation and communication with community health services.

With the arrival of the pandemic, it became obvious that social and medical restrictions would have an impact on how families could be cared for in a children's hospital and intensive care unit during this difficult time [2].

When we compare the two time periods, there is a difference between the ranges of bereavement supports that could be extended to families during the pandemic. Specifically, due to government mandated restrictions we have not been able to provide open visiting to extended family, external photographers and follow-up bereavement visits.

Some bereavement meetings have taken place off-site, and clinical staff have remained in contact with families by telephone and email, to answer questions and offer emotional support. More widespread use of technology to facilitate video calls for family communication has been explored in adult ICU. This may have less applicability to PICU due to the young age and developmental stages of our patients.

Our audit was designed to describe multidisciplinary bereavement supports in PICU. The landscape of caring for infants and children at the end of life changed in an unforeseen manner during the audit period. As a result, there are consequences of this shift in practice which we have not measured. They include family follow-up and feedback, staff feedback, retention and morale. There are early studies published which indicate that staff experienced moral distress and anxiety during the first 6 months of 2020 [3,4].

As change is forced upon staff dedicated to dignified end of life care, the challenge is to create new ways of delivering compassionate bereavement care to families experiencing loss during the pandemic and after.

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