Improving the quality of bereavement care experienced by family members who experience the death of a loved one in critical care.

Main Author: Fiona Walker
Co-authors: Stephanie Cronin, Juliana Zapatero, Laura Kemp, Nazir Lone, Janine Wilson on behalf of the Improving Bereavement after Critical Care Group*

Introduction

One in seven patients in UK intensive care units (ICUs) die (1). Critical illness onset may be sudden, unexpected and traumatic. In addition, transitions from life-sustaining treatment to end of life (EOL) care are often short; families struggle to understand and adjust to these events. Consequently, bereaved ICU families are at higher risk of 'complicated grief' (2,3). There is growing literature recommending components of bereavement pathways in ICU and collection of family correspondence details is crucial to facilitate follow-up (4). The ICU bereavement team in Royal Infirmary of Edinburgh (RIE) has a bereavement programme, but initial work identified that we are not consistently achieving these processes and therefore offering suboptimal support for bereaved families within ICU.

RIE bereavement care programme

- Memory making activities before death
- Collection of family correspondence before death
- Bereavement pack immediately after death
- Identification of family eligible for follow up
- 6-12 weeks after death - condolence card
- 3-6 months after death - bereavement survey

Aims

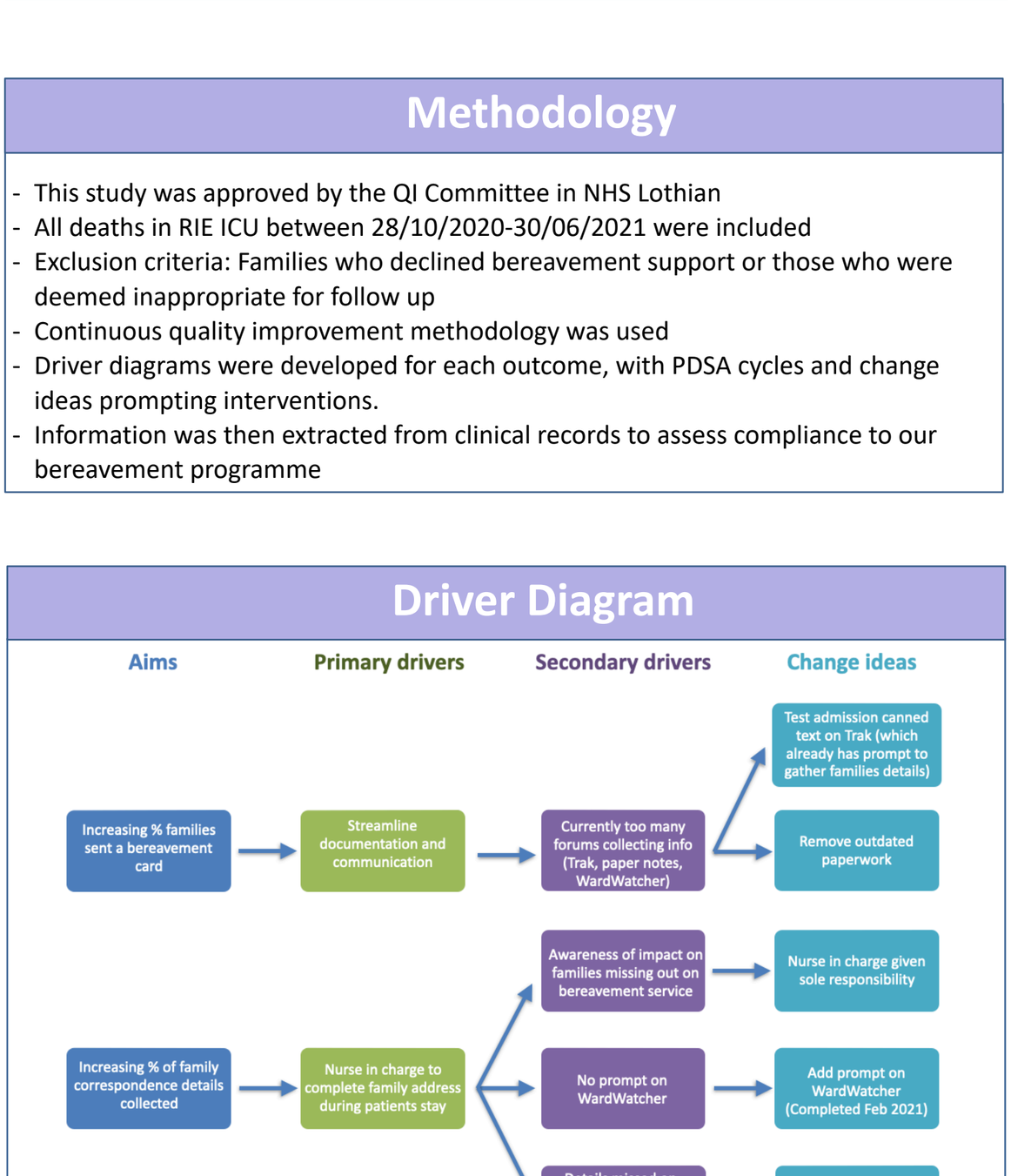
Our overall aim was to improve the compliance to our current bereavement programme in 9 months, by improving:

1. The collection of family correspondence details
2. Documentation of offering family memory making activities before death
3. The proportion of families sent a condolence card
4. The quality of care given, quantified from survey returns

Methodology

- This study was approved by the QI Committee in NHS Lothian
- All deaths in RIE ICU between 28/10/2020-30/06/2021 were included
- Exclusion criteria: Families who declined bereavement support or those who were deemed inappropriate for follow up
- Continuous quality improvement methodology was used
- Driver diagrams were developed for each outcome, with PDSA cycles and change ideas prompting interventions.
- Information was then extracted from clinical records to assess compliance to our bereavement programme

Driver Diagram



Results

- After exclusion criteria, 167 patents were included in the primary analysis
- **Aim 1:** Family correspondence collection on WardWatcher increased from 15.7% in October 2020 to 53% in June 2021 (Figure 1).
- **Aim 2:** There has been a consistent increase in memory making documentation, from 32% in October 2020 to 64% in June 2021 (Figure 1).
- **Aim 3:** Subsequent to increased family correspondence collection, the proportion of condolence cards sent increased from 59% in October 2020 to 75% in April 2021 (Figure 1).

Figure 1

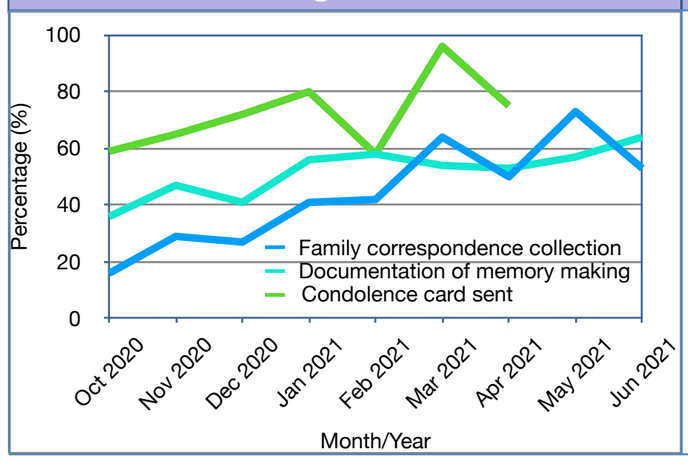
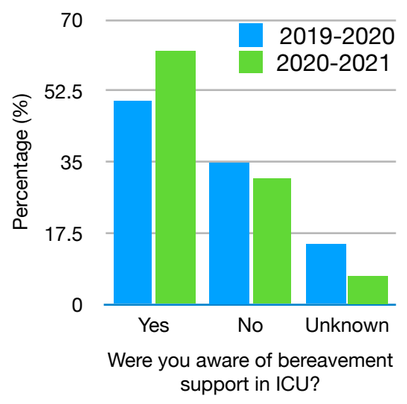


Figure 2



- **Aim 4:** Received questionnaire indicated families were better informed of the bereavement support available to them between August 2020-July 2021 than the previous year (Figure 2). Questionnaire responses answering 'yes, definitely' when asked if families received enough support, improved from 77% to 89% between August 2020-July 2021.

Questionnaire Feedback

"The final touch of offering us a lock of my fathers hair and a handprint was the loveliest of gestures"

"I found (the service) immensely supportive and took the opportunity to meet with a Dr. This was a most helpful, supportive and informative meeting that went a long way to helping me understand"

"I was made aware of the bereavement support and was grateful for the follow-up card"

Conclusion

We have a huge impact on how a family experiences the death of their loved one, with only one opportunity to get it right. The impact of the first wave of COVID-19 pandemic highlighted the challenges in providing good end of life and bereavement care in ICUs.

This project was ongoing during the second wave of the pandemic; face-to-face correspondence and information sharing regarding bereavement support was likely limited. However, our interventions led to increased compliance with the current bereavement programme in RIE ICU.

- Increased correspondence collection resulted in more families receiving a condolence card which highlights support available
- Education of staff has meant more families are being offered memory making opportunities
- Preliminary data from questionnaire responses suggest improvements in both the support given and awareness of support available for bereaved families

Moving forward, we aim to extend our project to become a multi-centre bereavement QI project, and provide ongoing high standards of bereavement care.

Acknowledgements

Funding - Scottish Partnership for Palliative Care. Improving Bereavement after Critical Care Group: Janine Wilson (lead), Susan Somerville, Michelle McCool, Fiona Walker, Stephanie Cronin, Sarah Gossner, Louise Bell, Joanne McPeake, Vivian Cummings, Kirsty Boyd, Natalie Pattison, Emma Carduff, Caroline Pretty, Nazir Lone, Jane Whitehorn

References

1. 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. Journal of the Intensive Care Society. June 2020. doi:10.1177/1751143720928898
2. Berry M, Brink E, and Metaxa V. Time for change? A national audit on bereavement care in intensive care units. J Intensive Care Soc 2017; 18: 11–16.
3. Azoulay E, Chaize M, Kentish-Barnes N. Involvement of ICU families in decisions: fine-tuning the partnership. Ann Intensive Care. 2014 Nov 30;4:37. doi: 10.1186/s13613-014-0037-5.
4. Erikson A, McAdam J. Bereavement Care in the Adult Intensive Care Unit: Directions for Practice. Crit Care Nurs Clin North Am. 2020;32(2):281-294. doi:10.1016/j.cnc.2020.02.009