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Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

By

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Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

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ABSTRACT

A paradigm shift in the Canadian healthcare system has transitioned the patient and family from care recipients to integral and valued members of the multidisciplinary team. Implementation of family-centered care within the context of the adult Intensive Care Unit (ICU) remains slow to adopt in Canada despite evidence that open visitation and family presence offer many benefits to improve the delivery of quality care, and satisfaction with the overall patient experience. The COVID-19 pandemic has further complicated the ability of the healthcare team to effectively include patients and families into their daily multidisciplinary rounds. Restricted visitation policies, infection control and social distancing concerns, physician variability, and a healthcare staffing crisis are among a few barriers to practice that hinder the ability to reintegrate families into a process that was once successful pre-pandemic.

This qualitative study uses a phenomenological approach guided by the philosophical underpinnings of Maurice Merleau-Ponty to describe frontline ICU nurses' lived experience of family-centered rounds. Eight ICU Registered Nurses were recruited from across two adult Intensive Care Units (ICU) in Southwestern Ontario over six weeks between April and May of 2021. Three themes have emerged from the data and provide both a pre-pandemic and intra-pandemic view from the perspective of participants: (1) Family presence during rounds versus family updates after rounds; (2) Nursing the patient versus nursing the family; and (3) Then and now – pre-pandemic versus intra-pandemic implications. Recommendations for future implications and additional research are explored, including nursing education, practice, and policy development, as well as leveraging the use of technology, such as iPads and conferencing software, to conduct virtual rounds and create a hybrid model of family-centered care.

DEDICATION

To my amazing husband Darcy, who has supported me throughout my thesis and graduate studies. You’ve kept me grounded and committed to seeing this through to the end. To our children – Parker, Hailey, Brigette, and Audrey – who inspire me every day to be the best version of myself.

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CHAPTER 1: Introduction and Background

A paradigm shift, in the Canadian healthcare system, has transitioned the patient and family from care recipients to integral and valued members of the multidisciplinary team. In Canadian healthcare organizations, patient- and family-centered care (PFCC) has been identified as a key priority; however, organizations continue to struggle with translating this philosophy of care to organizational policy (Canadian Foundation for Healthcare Improvement [CFHI], 2016). According to Ahmann et al. (2003), as cited by the Institute for Patient- and Family-Centered Care [IPFCC] (n.d.), current hospital visitation policies continue to remain restrictive and, even when they are more open, the physical environment of the unit often fails to be welcoming or accommodating. This has been further complicated by the declaration of the COVID-19 global pandemic in which several hospitals have instituted blanket policies to restrict visitation, except for in exceptional circumstances (CFHI, 2020). Furthermore, hospitals continue to define family traditionally and may exclude a patient’s key support and care partner, such as a close friend or extended family member (IPFCC, n.d.).

The Canadian healthcare system faced numerous challenges pre-pandemic including: an aging population, increasing costs, fiscal constraints, and escalating demands by both citizens and government for increased accountability and transparency of healthcare spending (Critical Care Services Ontario [CCSO], 2015). Patients and families, as residents of Ontario, both expect and deserve a high performing healthcare system with greater engagement, participation, and achievement of positive patient outcomes. A shift in culture that focuses on improving access, quality and system integration “ensures that patients are receiving the ‘right care’ at the ‘right time’ in the ‘right place’ by the ‘right providers” (CCSO, 2015, p. 15).

As of January 30, 2020, the World Health Organization’s Director-General declared the Novel Coronavirus (2019-nCoV) a public health emergency of international concern (PHEIC), WHO’s highest level of alarm (World Health Organization [WHO], 2020). The coronavirus disease (COVID-19) is caused by the newly discovered coronavirus and spreads primarily through respiratory droplets to cause an acute respiratory infection (WHO, 2020; Windsor Essex County Health Unit [WECHU], 2021). COVID-19 can cause mild to severe illness and mutate into a variant of concern (VOC) that “may spread more easily, cause more severe illness, and be resistant to the protection offered by vaccines” (WECHU, 2021, para. 2).

As the pandemic progresses, the Canadian Foundation for Healthcare Improvement (2020) continues to advocate for healthcare organizations to shift from considering families as visitors, to essential care partners. During times of crisis, such as the COVID-19 pandemic, it is critical that patient- and family-centered care principles are applied, and creative interventions are implemented to enable families and caregivers to remain partners in care (CFHI, 2020).

What is Critical Care?

Critical care services use advanced therapeutics, monitoring and diagnostic technologies ordered by a specialized team of health professionals to support organ system functioning of patients with a life-threatening health condition in the Intensive Care Unit (ICU) (CCSO, n.d.). The ICU admits patients from the emergency room, hospital wards, and following surgery in the operating room, in which vital organs are failing or at risk of failure. According to CCSO (2015), Level 2 ICUs provide critical care services to patients with single organ system failure requiring short-term non-invasive ventilation or post-operative care. Level 3 ICUs provide the highest level of critical care to patients requiring prolonged invasive ventilatory support and/or facing multi-organ system failure (CCSO, 2015). CCSO conducts an annual systems assessment to identify provincial pressures related to critical care bed capacity and make recommendations to the Ministry of Health and Long-Term Care (MOHLTC) (CCSO, 2019).

At the regional CCSO Townhall Meeting that took place October 1, 2019, the organization reported that the current critical care bed capacity within the province of Ontario included 1,370 adult Level 3 beds and 649 Level 2 beds across 198 adult critical care units, 111 hospital sites, and 81 corporations (CCSO, 2019). Although the population of Ontario has increased over the last several years, the critical care bed capacity within the province has not significantly changed since 2015 (CCSO, 2019). With the onset of the COVID-19 pandemic, the volume of patients and demand for critical care beds has been significant, thus requiring a strategic approach at the local, regional, and provincial tables to leverage capacity across all organizations within the province (CCSO, n.d.). CCSO has implemented a ventilator stockpile within Ontario for hospitals to access during times of increased capacity pressures to ensure patients can continue to access care and core services, sometimes in non-traditional spaces.

Critical Care Services Ontario (CCSO)

Critical Care Services Ontario is a group of system leaders and key stakeholders, including hospital administrators and healthcare providers, with a mission to identify critical care system needs and to collaborate “with health care partners to improve access, quality, and integration for patients (CCSO, 2015, p. 10). This management group was appointed by the Ministry of Health and Long-Term Care to oversee the implementation of programs and initiatives recommended in the Critical Care Strategy through engagement and partnership with system leaders (CCSO, 2015).

Throughout the COVID-19 pandemic, CCSO has developed daily provincial and regional critical care dashboards to provide hospitals, provincial leadership, and critical care clinical leads with the required information related to COVID-19 activity in critical care units across the province (CCSO, n.d.). This information helps provide early identification of system pressures that impact critical care capacity to inform system planning (CCSO, n.d.).

Ontario Critical Care Plan 2018-2021

After extensive consultation, the Ontario Critical Care Plan 2018-2021 was developed to serve as the blueprint to guide the work of CCSO and critical care system leaders over three years (CCSO, 2018). CCSO’s first of the five strategic goals is to “advance patient and family partnerships to improve patient centered, team-based care” (p. 7). CCSO published the following objectives to meet the first strategic goal:

- Lead the development and adoption of a system framework for patient and family partnerships.
- Disseminate leading practices to move beyond patient and family involvement to achieve partnerships.
- Implement mechanisms for measuring and evaluating patient and family satisfaction. (p. 7)

What is Patient- and Family-Centered Care?

The concept of person- and family-centered care includes multiple terms and definitions that have been described in the literature as a practice, model of care, philosophy, and paradigm (Registered Nurses' Association of Ontario [RNAO], 2015). The lack of standardization in defining person- and family-centered care and its associated components has created a gap in theory and practice that creates a significant challenge in its implementation at all levels of the Canadian healthcare system (RNAO, 2015).

The World Health Organization [WHO] (2007), as cited by RNAO (2015), views "person-centered care as a broad concept in which the provision of care and services encompasses not only the health of the individual but also their family, culture, and community" (p. 7). This perspective focuses on a global strategy to improve the social, economic, and environmental determinants of health and target disease prevention in the health of populations (RNAO, 2015).

In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the National Academy of Medicine (publishing as the Institute of Medicine [IOM], 2001) defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (p. 6). According to this definition, patients are empowered to assist with decision-making about their own health as they are in control of their own care (IOM, 2001).

In 2018, The Canadian Association of Critical Care Nurses (CACCN) published a position statement on patient- and family-centered care acknowledging patients and their families as “essential members of the health care team and respected as collaborative partners who contribute to the critical care experience” (p.1). In addition, the CACCN adopted the following definition proposed by the Institute for Patient- and Family-Centered Care (adapted from Johnson & Abraham, 2012):

> Patient- and family-centered care is an approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families. It redefines the relationships in healthcare by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all healthcare settings. In patient- and family-centered care, patients and families define their “family” and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control (p. 1).

According to the Canadian Foundation for Healthcare Improvement, in partnership with the Canadian Patient Safety Institute (CPSI) (2020), patient- and family-centred care or partnered care “is an approach to the planning, delivery and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, families and caregivers” (p. 4). Additionally, they define essential care partners as family members, friends, or any other individual as identified by the patient or a substitute decision maker who provides physical and emotional support related to decision making and coordination of care. Open family presence policies support care givers and care partners to be present at the patient’s bedside at all hours and are not limited to specific visitation times (CFHI & CPSI, 2020).

CCSO is focusing on three main strategic objectives to advance patient and family partnerships in Critical Care: 1) develop a framework for patient and family partnerships, 2) implement leading practices, and 3) continuously measure satisfaction (2018). According to CCSO (2015), some hospitals were including family representatives on several of their advisory committees. Key stakeholders have expressed the need for standardized tools for measurement of patient and family satisfaction in critical care to help in the consistency of data collection, analysis, and comparison of metrics that are important to patients and families (CCSO, 2015; CCSO, 2018).

CCSO has found that patients and families offer a unique perspective and, with their engagement, they can contribute at a system-wide level to improve patient and family experiences. To achieve this strategic goal, projects and initiatives should focus on: (a) identifying best practices in the literature related to patient and family experiences in critical care, (b) conduct focus groups and advisory panels to determine what is most important to patients and families within the context of critical care, (c) develop educational tools to engage patients and families, and (d) develop, implement, and evaluate a tool to measure patient and family satisfaction in critical care. Integrating patients and families in multidisciplinary rounds can help to achieve the first strategic goal as set out by the Ontario Critical Care Plan 2018-2021 (CCSO, 2018).

What are Multidisciplinary Rounds?

According to the Institute for Healthcare Improvement (IHI) (2015), multidisciplinary rounds are a patient-centered model of care that enables all disciplines caring for a patient to come together to offer their individual “clinical expertise, to coordinate patient care, determine priorities, establish daily goals, and plan for potential transfer or discharge” (p. 4). IHI has found that organizations that have implemented multidisciplinary rounds have improved the “quality, safety, and patient experience of care” (p. 4). Engaging patients and families in multidisciplinary rounds can provide numerous benefits, especially with improving communication with providers, feeling part of the healthcare team, and participation in decisions regarding care (IHI, 2015).

Study Purpose

The purpose of this study is to describe, from the nurse’s perspective, the experience of family-centered rounds. The central research question is: What is the experience of family-centered rounds for nurses working in ICU?

Since one of CCSO’s strategic directions in the Critical Care Strategy 2018-2021 is to improve patient and family partnerships to provide patient-centered team-based care, identification of the facilitators and barriers to adoption of patient and family-centered rounds will help to understand the challenges that healthcare leaders might face with sustaining this best practice initiative. In addition, bringing to light the barriers from the perspective of the frontline nursing staff will help to develop risk mitigation strategies to ensure overall project success.

Researcher’s Perspective

As the operations manager of an adult critical care unit, I routinely performed leadership rounds and checked in with patients and families throughout the duration of their stay in the ICU pre-pandemic. Through conversation, I would ask how their stay has been, if they have been kept up to date on their daily plan of care, and if they have any questions, comments, or feedback to provide to improve the quality of care delivered within the unit. Prior to the roll-out of patient- and family-centered rounds in the ICU, I would consistently hear from patients and families that they have not yet spoken to the physician, or the patient and family were still waiting to hear what the plan of care for the day would be. To improve satisfaction and communication with patients and families, I became a passionate advocate to lead my team in the implementation of patient- and family-centered rounds in the ICU.

As of January 2019, we started including patients and families in our daily multidisciplinary rounds and were initially met with resistance from frontline nursing staff and physicians alike. I continued my routine leadership rounds and found that patients and families were more satisfied when included in multidisciplinary rounds and given the opportunity to provide input into their own or their loved one's care planning.

As the COVID-19 pandemic was declared, several organizations across the province, including the study sites, instituted a visitation restricted policy. For several months, visitation was not permitted except in palliative, end-of-life patients who tested COVID negative, or visit by way of virtual format via Facetime, Skype, or Zoom on an iPad. Updating patients and families in person, in real-time was no longer possible with infection control protocols, social distancing, and technological challenges. My ability to check-in with patients and families was also no longer possible unless I helped bridge any gaps in communication telephonically. This was a very stressful time for both families of critically ill patients, as well as staff within the ICU. Frontline staff struggled to balance providing care along with setting boundaries and effectively communicating with frantic families to accurately paint a picture of what was going on with their loved one while they could not physically be there to support them.

My background as a critical care nurse, coupled with my experience as the manager of an intensive care unit during the COVID-19 pandemic, has provided me with a unique perspective that adds to the richness of this thesis. I have been able to provide frontline support to patients, families, and staff that has strengthened my leadership experience.

Significance

In the Spring of 2021, COVID-19 visitation restrictions began to lift and one visitor per patient per day, to a maximum of two visitors per patient's stay, was implemented at the study sites. The challenge to reintegrate patients and families into multidisciplinary rounds continues to exist. As we move forward, organizations will need to review how to effectively include patients and families back into the rounding process while continuing to consider social distancing, infection control measures, and use of new technology.

In this study, I explored the lived experience of frontline critical care nursing staff and their perception of family-centered rounds in the ICU. The method of inquiry was an applied approach to Existential Phenomenology developed by Thomas and Pollio (2002) based on the work of French philosopher Maurice Merleau-Ponty. Asking frontline critical care nurses to describe their lived experience of family-centered rounds provided insight into the perceived barriers to family-centered rounds pre-pandemic, as well as challenges that have arisen throughout the pandemic to inform future implications to practice.

CHAPTER 2: Literature Review

Critical appraisal of the literature is less often used during the initial proposal of phenomenological studies (Creswell, 2014). Creswell recommends use of “related literature in the final section, where it is used to compare and contrast with the results (or themes or categories) to emerge from the study” (p. 30). Traditionally, phenomenologists have held onto the belief that the literature should be reviewed after data collection and analysis so that knowledge of prior studies does not influence the researcher’s perception and interpretation of transcribed interviews and other pertinent data (Gray et al., 2017).

Several phenomenologist researchers today continue to defer looking at the literature until the final section of a study. Thomas and Pollio (2002) suggest an initial survey of the literature to determine “what is already known, and not yet known, about a phenomenon” (p. 46). Analysis of previous research findings is also critical to evaluate the potential contribution to ongoing research about the phenomenon being studied (Thomas & Pollio, 2002). Additionally, Thomas and Pollio suggest a preliminary review of the literature does not imply bias provided that “the researcher initially brackets, and continually re-brackets, prior knowledge while interacting with participants and analyzing data” (p. 46). For the purpose of this study, I completed a modified bracketing interview with a research assistant to acknowledge my experience with patient- and family-centered rounds in the ICU.

Historical Context

According to Cullen et al. (1999), present-day hospital visiting policies originated in practices that began with the creation of the first intensive care units in the 1960’s, where strict visitation restrictions were enforced without an understanding of the effects on either the patient or families. ICU nurses held onto a belief that "family visitation increases physiological stress in the patient and interferes with the provision of care, is mentally exhausting to patients and their families, and contributes to increased infection" (American Association of Critical Care Nurses [AACN], 2016, p.16). Despite the thoughts of healthcare providers, there has been no evidence to support these beliefs.

Over the last several decades, evidence has emerged that patients and families both desire less restrictive visitation policies, their presence benefits both patients and families, and satisfaction improves (AACN, 2016). Various organizations began to develop guidelines and practice recommendations that called for open visitation and presence during high stress events, such as family presence during resuscitation (Davidson, 2007). Isolating patients from the family members, who know them the best, during their most vulnerable time places them at increased risk of harm, error, and inconsistency in care, and incurs unnecessary costs (Cacioppo & Hawkley, 2003; Clark et al., 2003).

The Better Together Campaign

In 2014, the Canadian Foundation for Healthcare Improvement (CFHI) partnered with the Institute for Patient- and Family-Centered Care (IPFCC) to adopt the Better Together Campaign in Canada (CFHI, 2015). This best practice initiative helped to promote patient and family engagement in healthcare improvement to transform and catalyze "improvements in patient- and family-centered care and other quality domains" (CFHI, 2015, p. 6). According to the International Commonwealth Fund, as cited by CFHI (2015), Canada ranked "8th of 11 comparable countries on patient-centered care" (p. 7), validating the need to improve upon this domain. Furthermore, several hospitals have prioritized patient-centered care as a key strategic directive at the organizational level (CFHI, 2015).

The Canadian Foundation for Healthcare Improvement (2015) also supports the adoption of family presence policies, which helped operationalize the shift from families as visitors to the concept of families as partners in care. With this concept, patients are engaged to “designate family members or other caregivers to participate in their care and have unrestricted access to them while hospitalized” (CFHI, 2015, p. 4). The CFHI drafted a report compiling the visiting policies at 114 acute-care hospitals across all Canadian provinces and territories between February and April 2015. For the first time, this review established the openness of visitation policies in Canada’s acute care hospitals, how these policies were communicated, and whether there was consistency in communication of visitation hours between staff and the hospital’s website. Establishing open visitation policies is an essential step towards the delivery of patient- and family-centered care (CFHI, 2015).

Hospitalization is a major life event where patients are most vulnerable and can be compromised clinically, mentally, and emotionally (CFHI, 2015). CFHI also found that support provided by people who know them the best can enable participation in care based on the patient’s preferences to improve quality of care delivered and prevent adverse events. According to the IPFCC, Canadian hospitals have recognized the following benefits of implementing a family presence policy:

- Improved patient experience of care and satisfaction
- Improved staff satisfaction and attitudes toward family presence
- Decreased patient/family anxiety

- Sustained patient cognitive and motor functions
- Improved patient safety, quality, and patient outcomes
- Fewer medication incidents and falls
- Greater organizational efficiency and outcomes
- Timely and better-informed assessments and care planning
- Improved transition planning
- Risk avoidance
- Reduced lengths of stay, admissions, and emergency department visits
- Enhanced organizational culture (p.6).

After 2016, the CFHI focused on leveraging momentum to continue to engage key stakeholders and policy makers across Canada (2020). In 2016, the organization launched an e-collaborative for quality improvement whereby their faculty of coaches supported 12 healthcare organizations with the primary objective of implementing family presence policies from development through to adoption. By 2017, CFHI hosted a pan-Canadian Policy Roundtable to distribute new family presence best practices regionally and provincially. At this pivotal roundtable meeting that took place in Ottawa, senior government policy leaders gathered with key partners and patient and family advisors to brainstorm innovative ways for policy to support family presence. as a policy in which patients identify which loved one or family member can take a role as part of the care team and remain at their bedside continuously to provide support (CFHI, 2017).

The advocacy for family presence policies continued to gain interest and by 2019 the Better Together Campaign and e-collaborative recruited more than 50 organizations and entire provinces across Canada to pledge to review their family presence policies

(CFHI, 2020). The CFHI then conducted a follow up study that took place from January to February 2020 to mirror that of the 2015 study. The comparative analysis showed “a marked increase from 32 percent of hospitals with accommodating visiting policies in 2015, to 73 percent in early 2020” (para. 7).

Myths and Misconceptions

Despite the lack of evidence, historically restrictive visiting policies have been based on the myths and misconceptions that family presence and participation in care interferes with the care delivered by the healthcare team, spreads infection, and exhausts the patient (AACN, 2016; Adams et al., 2011). More current research findings reported by the AACN in 2016, suggest family presence, particularly in the adult intensive care unit, helps to decrease anxiety of patients and families, as well as increase satisfaction.

According to Smith and colleagues (2009), as well as Adams et al. (2011), there is no association between family presence in the adult ICU and increased infection rates. In addition, Smith et al. also found that open visitation reduced cardiovascular complications. Studies of critical care units in the United States and Belgium outline that “the presence and involvement of family members is essential for their well-being and in daily decision making about care” (CHFI, 2015, p. 14). In addition to improving patient satisfaction, family presence can also help to minimize the symptoms of anxiety and depression (CHFI, 2015).

At the 2017 CFHI pan-Canadian Policy Roundtable meeting, several myths, challenges, and barriers to family presence were discussed along with feasible solutions (CFHI, 2017). Frontline staff who have raised concern for risks and overcrowding may benefit from additional knowledge regarding communication strategies that address issues of respect and safety, as well as review policies and rationale supporting family presence. The myths identified also highlighted a need to co-design a family-presence policy collaboratively with patients, family, and frontline staff involvement. The CFHI has additionally found that this would ensure there is thought to cultural sensitivity, information transfer, and an education strategy on infection control measures. Furthermore, differing perspectives among frontline staff nurses and physicians can be addressed through leadership expectations aligning with the new policy and again, frontline engagement throughout the scope of the policy draft (CFHI, 2017).

Attitudes and Perceptions of Family-Centered Rounds

With the movement towards open visitation and family-centered care, ICUs must now focus on how to operationalize the inclusion of patients and families into workflows and how to sustain this change. Few studies have looked at the attitudes and perceptions of various healthcare personnel on the topic of family-centered rounds, and there remains a gap in understanding the effect of family presence on multidisciplinary rounds in the ICU. Furthermore, resistance to change by healthcare professionals can impede the continued sustainment of family-centered rounds beyond the initial phase of implementation.

Santiago et al. (2014) conducted a quantitative study via questionnaire comparing the attitudes and perceptions of ICU staff towards family presence at bedside rounds in a 24-bed medical surgical ICU at St. Michael’s Hospital in Toronto, Ontario. Results from the study by Santiago et al. showed that, while most physicians and members of the management team agreed with the family presence, registered nurses “strongly disagreed with providing family members the option to attend rounds” (p. 13). Additionally, it was found that greater than half of respondents agreed that the presence of family members created time constraints by prolonging rounds, impaired the ability of the team to speak openly about negative medical information, and minimized the ability to provide medical education on rounds. Interestingly, Santiago et al. found that it was the more experienced registered nurses who had a greater reservation with inclusion of family during rounds as they reported having previous negative experiences. This study was critical in examining attitudes and perceptions of staff in an adult ICU towards family presence at bedside rounds since prior research has focused on exploring family presence during rounds in the context of pediatric ICUs (Santiago et al., 2014).

Despite the perception of staff regarding the fear of prolonged rounds and increased family anxiety and stress, the topic remains understudied (Davidson, 2013). According to Davidson (2013), if families are given the choice, 85 to 100% would prefer to be present during multidisciplinary rounds to hear the information required to make decisions and would be less concerned with the stress imposed by the rounds themselves. Davidson also found that current data suggests that including families during rounds does not significantly prolong the duration of rounds and actually “saves considerable time compared with meeting at another time during the day” (p. 155). Overall, families should be given the choice to attend rounds as simply including them can make the world of difference to those experiencing what may be perceived as one of the worst times in their lives (Davidson, 2013).

Holodinsky et al. (2015) conducted a mixed methods cross-sectional survey of rounding practices of adult ICUs in Canada. In this study, the majority of the medical directors of 111 ICUs across nine provinces who participated reported that patients (83%)

and families (67%) were invited to attend rounds. Patient and family involvement were one of four themes that emerged from the open-ended survey and interview questions. According to Holodinsky and colleagues the presence of family during rounds was perceived as positive when treatment options and plan of care required input for discussion. Conversely, family presence was perceived as negative if there was a lack of clarity around goals of care. Overall, the involvement of patient and families during rounds remains variable across ICUs within Canada and, despite the evidence of positive involvement in neonatal and pediatric ICUs, there remains a gap in the role and expectations of patients and family-centered rounds and associated benefits in the context of Canadian adult ICUs (Holodinsky et al., 2015).

Au and colleagues (2017) performed a cross-sectional survey of family members of ICU patients admitted to four medical-surgical ICUs in Alberta, Canada. Although the units practiced open visitation without restriction to visiting hours for the prior 10 years, there was no formal policy regarding family participation in rounds resulting in a variance in practice between intensivists (Au et al., 2017). Interestingly, while 38% of providers "estimated that less than half of patients' family members would be interested in participating in rounds, 97% of family members expressed a high degree of interest" (p. 134). Providers perceived that inclusion of family participation in rounds would create additional stress and confusion for the family; however, family members did not report these concerns. Family presence during rounds is a relatively new practice that requires increased understanding of the family and providers' perspectives to evaluate the impact of family in ICU rounds, as well as for future continued quality improvement (Au et al., 2017).

Gaps in the Literature

The implementation of family-centered care within the context of the adult ICU remains slow to be adopted in Canada and internationally (IPFCC, n.d.). This is despite evidence to support that family-centered care improves both the quality of care and the satisfaction experienced by both the patient and family. Even when an organization supports open visitation within the ICU through a formalized policy, there remains inconsistency in practice and a gap in process integrating families into multidisciplinary rounds. According to CFHI (2015), 90 percent of healthcare professionals support family presence policies; however, only 25 percent received top ratings for the implementation of visitation policies that promote and support a culture of family presence and patient- and family-centered care.

Several studies outline the attitudes and perceptions that healthcare professionals hold regarding inclusion of patients and families in multidisciplinary rounds, but there remains a gap describing specifically their perspective of the perceived barriers to sustaining family-centered rounds in the ICU. Those limited studies that do seek to understand the healthcare provider's perspective are typically through the lens of the physician, resident, or family member, and take inadequate account of the nurses' perspective. Furthermore, most research on the topic of family-centered rounds has been conducted in pediatric ICUs due to the child's age and greater presence of the parents within the unit. There is also limited Canadian research and most evidence has been studied in the United States and Europe. The privatization of healthcare in the United States and the mixed-model of private and publicly funded hospitals in Europe might provide a different customer service model and unique population-based expectations that would not translate to Canadian ICUs.

A review of the related literature has identified a shortfall in studies that can be used to inform decisions about the inclusion of families in the process of family-centered rounds in critical care in Canadian ICUs. Additionally, the COVID-19 pandemic has created an added layer of barriers that hinder a culture of open visitation and family-centered care. Insight into the perceptions of nurses, who work in these settings, regarding the benefits and barriers to family inclusion may assist in the development of formalized policies and inform risk mitigation strategies to sustain change beyond initial implementation. Frontline nurses who experienced family-centered rounds pre-pandemic and have worked throughout the challenges of the pandemic in the context of an ICU are able to provide valuable insight into how healthcare organizations can reintegrate patient- and family-centered care into practice.

Response to COVID-19

As a result of the COVID-19 pandemic in March of 2020, healthcare organizations across Canada quickly changed their family presence policies and restricted visitation as a response to control and contain the spread of COVID-19 cases. According to CFHI (2020), most hospitals implemented zero visitation policies, with very limited exceptions. While fear of increased transmission of COVID-19 was the driving factor to blanket visitor restrictions, published evidence is limited linking visitors' presence with infection rates (CFHI, 2020; Ministry of Health, 2020). Restrictive policies have not considered the potential risk and now we see the emergence of harm to patients and families across healthcare organizations in the domains of patient safety, quality of care, quality of life, and psychological and emotional distress for staff, patients, and families alike (CFHI & CPSI, 2020).

Throughout the pandemic, there has been much variance regarding how organizations have chosen to develop and implement restrictions with several leveraging the use of technology to keep families engaged through virtual formats (CFHI, 2020). Innovative approaches implemented by various organizations were then highlighted over the next several months through a Spotlight Series webinar held collaboratively by CFHI and the Canadian Patient Safety Institute (CPSI) (CFHI, 2020).

In November 2020, the CFHI and CPSI co-developed a policy guidance "to support a safe and consistent approach for reintegrating essential care partners back into healthcare facilities, long-term care and congregate care settings during a pandemic" (p. 4). This document was drafted as part of a collaborative policy process with input from policy decision-makers, health care system leaders, and individuals impacted by policy decisions, including patients, families, frontline staff, and hospital administrators. In March 2021, one year following the COVID-19 pandemic declaration in Canada, Healthcare Excellence Canada was launched, formalizing the partnership between the Canadian Foundation for Healthcare Improvement and the Canadian Patient Safety Institute (Healthcare Excellence Canada, 2021). This new amalgamation is a non-profit charity funded by Health Canada.

As outlined above, several organizations are beginning to shift towards creating policies or refining existing processes related to family-centered care. This study will contribute to what is already known about family-centered rounds in the intensive care unit from a Canadian nurse perspective. The voices of the frontline nurses, perceptions, beliefs, and the lived experience of family-centered rounds can potentially inform future practice. Insight into how changes in visitation restriction policies impacted family-centered rounds in the ICU during the pandemic can contribute to future policy revisions that align with patient-centered care.

CHAPTER 3: Methodology

Existential phenomenology, based primarily on the philosophical work of Maurice Merleau-Ponty, was the method of inquiry used in this study to describe, from the nurse's perspective, the experience of family-centered rounds. This chapter describes, in greater detail, the basic underpinnings of existential phenomenology developed by Merleau-Ponty and the qualitative approach to inquiry by Thomas and Pollio (2002). Specific steps taken to maintain rigor as described by Thomas and Pollio include a description of the sampling strategy to recruit participants, the data collection process, ethical considerations, and the interpretive process that was used for analysis of the data.

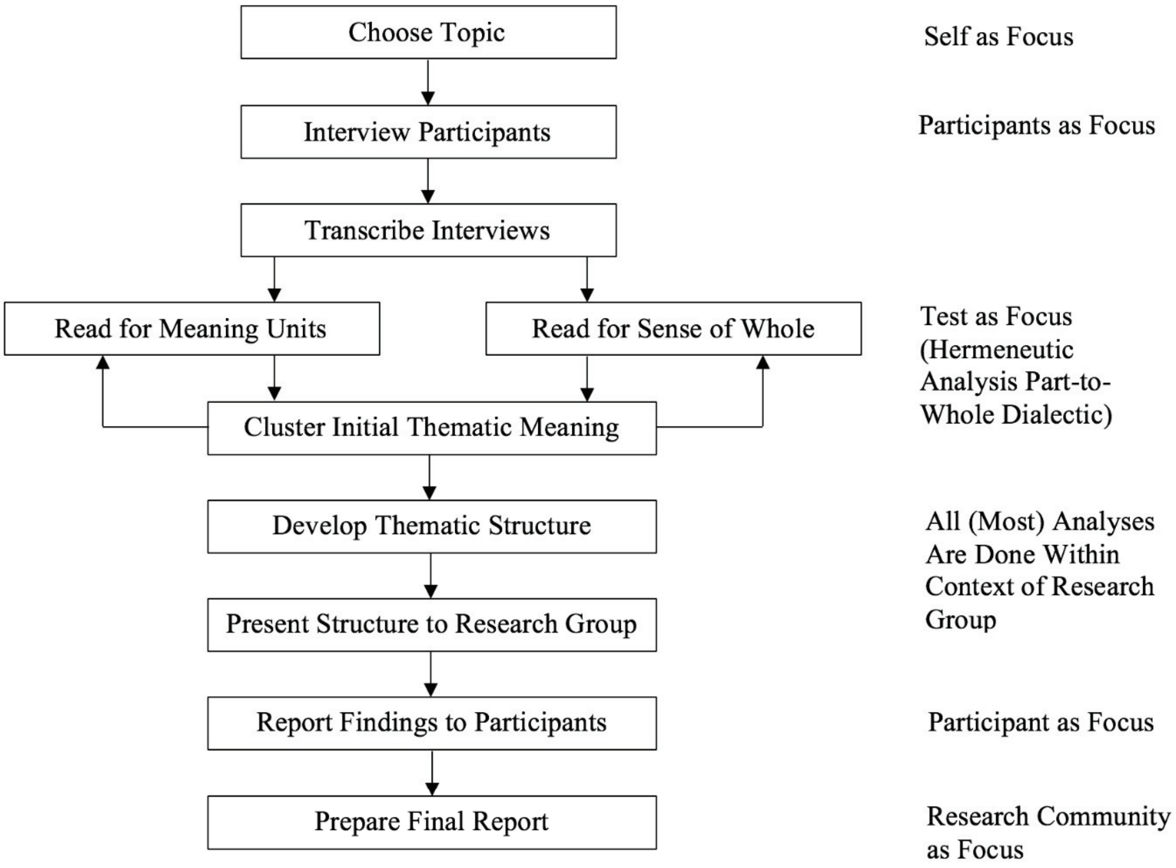
Research Design

A qualitative approach to inquiry using a phenomenological design is rooted in philosophy and psychology and provides the researcher with a mechanism to gain insight into the essences of the lived experiences of participants who have experienced the central phenomenon (Creswell, 2014; Merleau-Ponty, 1962; Yin, 2011). This approach is appropriate when a quantitative approach "cannot shed light on the *meaning* of what is happening to those who are experiencing it" (Thomas & Pollio, 2002, p. 6). For this study, a qualitative approach was appropriate to answer the research question and to gain insight into the perspectives of ICU nurses about the meaning of their involvement in family-centered rounds, particularly in the context of pre- and post-COVID visitation restrictions. The intent of this study was to add to what is already known about family-centered rounds in the intensive care unit from a Canadian nurse perspective. The interviews took place virtually during the pandemic and reflect the voices of critical care nurses sharing their lived experience of challenges to visitation during the peak of the first wave of the pandemic. See Appendix A for the interview protocol, the central research question, and examples of guiding and probing questions used throughout the interviews conducted.

Thomas and Pollio (2002) have created a sequencing method for conducting an existential-phenomenological study with dialogue interviews and thematic interpretation (see Figure 1). According to Thomas and Pollio, this flow chart is appropriate to use for organization, provided the researcher "does not take this sequence of steps as the final word" (p. 44). The researcher has used an adapted version of Thomas and Pollio's (2002) phenomenological approach to guide the data collection, transcription, analysis, and interpretation of this study. Copyright clearance for permission to reproduce Figure 1 has been obtained (see Appendix B).

Figure 1

Summary of Steps in Conducting an Existential-Phenomenological Study



From Pollio, H., Henley, T., & Thompson, C. (1997). *The Phenomenology of Everyday Life.* New York: Cambridge University Press. Reprinted by Thomas & Pollio (2002). *Listening to Patients: A phenomenological approach to nursing research and practice.* New York: Springer Publishing Company. Adapted with permission.

Philosophical Underpinnings

After much reflection, this phenomenological study used a constructivist worldview with the philosophical underpinnings of Maurice Merleau-Ponty (1962). Merleau-Ponty defined phenomenology as a study of essences of which "all problems amount to finding definitions of essences" such as the essence of perception or the essence of consciousness (p. vii). Phenomenology also "puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their 'facticity'" (Merleau-Ponty, 1962, p. vii). This transcendental philosophy places a temporary suspension on the statements that arise naturally, and considers that, before reflecting within oneself, the world is always already there. Furthermore, how we live in space and time in the world provides a description of our own experience without causal explanation.

Phenomenology can be considered as a style or way of thinking which requires a phenomenological method (Merleau-Ponty, 1962). The term 'phenomenology' was first used by Husserl in 1900, but did not surface in the nursing literature until the 1970's (Thomas & Pollio, 2002). According to Thomas and Pollio, existential phenomenology can be defined as a blend of "the philosophy of existentialism with the methods of phenomenology to produce rigorous and richly nuanced descriptions of human life" (p. 9). Thomas and Pollio further describe how Merleau-Ponty used an existential foundation, in part from Heidegger, and attempted to combine his philosophy with Husserl's descriptive approach to phenomenology. As a result, Merleau-Ponty offered a philosophy of meaning in which the aim of his phenomenology was to provide a description of human experiences on their own terms and independent from theoretical principles. By the 1960's, nurses began to find relevancy in the application of existential phenomenology to clinical practice as it provides congruence with the values and philosophical foundations of nursing theory and practice (Thomas & Pollio, 2002).

Nurses may assume they understand the feelings experienced by patients to try to empathize with them. Using a phenomenological method, we must attempt to set aside what we might think we know about a particular topic as to not influence our perception of the lived experience (Thomas & Pollio, 2002). According to Merleau-Ponty (1962), knowledge of the world, even scientific knowledge, is “gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless” (p. viii). As a result, our existence as humans is the absolute source that move towards our physical and social environment and sustains them, “for I alone bring into being for myself” (Merleau-Ponty, 1962, p. ix). The scientific point of view that our existence as a moment of the world’s takes for granted our consciousness and that the world forms around and seeks to exist for us (Merleau-Ponty, 1962).

Merleau-Ponty primarily describes the human experience through the concept of perception, which provides a continuous transaction between individual person and the surrounding world (Thomas & Pollio, 2002). The four major existential grounds of human existence include “others, time, body, and world, including personal objects” (Thomas & Pollio, 2002, p. 4). Merleau-Ponty’s primacy of perception and intentionality explains how these factors contribute to help gain an understanding of one’s individual perceptions (Merleau-Ponty, 1962). The following passage provides a view of perception through the domains of body, world, time, and others according to Merleau-Ponty (1962):

> In the same way I treat my own perceptual history as a result of my relationships with the objective world, my present, which is my point of view on time, becomes

> one moment of time among all the others, my duration a reflection or abstract aspect of universal time, as my body is a mode of objective space (p. 71).

According to Merleau-Ponty (1962) as cited by Thomas and Pollio (2002), "the human body is always experienced *from the same perspective*" (p. 51). Therefore, we are one with our bodies and cannot move away from it as it is fundamental to human existence. Thomas and Polio (2002) further explain Merleau-Ponty's perception of the body as a vehicle which carries mortality and is the originating focal point in which we view the world and our relationships. Furthermore, Merleau-Ponty continuously reinforces that the body cannot be viewed as merely an object. He describes the experience of the body with the following passage:

> We have learned to feel our body; we have found underneath the objective and detached knowledge which we have of it in virtue of its always being with us and of the fact that we are our body. In the same way we shall need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body, and in so far as we perceive the world with our body. But by thus remaking contact with the body and with the world, we shall also rediscover ourself, since, perceiving as we do with our body, the body is a natural self and, as it were, the subject of perception (p. 206).

Merleau-Ponty (1962) is also concerned with the way in which we experience time and therefore places emphasis on the present since consciousness and time only coincide while in the present. The present is explained as "the point on which the past, future, and present turn; it is that moment in which we glimpse time past and time future as these emerge in time present" (Thomas & Pollio, 2002, p. 160). Our past experiences in time collectively change our grasp of the present and impact our future relationships (Thomas & Pollio, 2002; Merleau-Ponty, 1962). Time is not objective in nature,but rather "a mobile setting that moves toward and away from us" (Thomas & Pollio, 2002, p. 160). As our perspectives evolve, our experience of time also changes (Thomas & Pollio, 2002; Merleau-Ponty, 1962).

Our experiences and perception are transactions between us and the world in which we are continually oriented and directed towards ourselves as being-in-the-world (Thomas & Pollio, 2002). The domain of world considers an objective point of view in which *intentionality* directs us both towards objects of experience and "the person for whom these objects are present" (Thomas & Pollio, 2002, p. 14). Merleau-Ponty describes the concept of *intentionality* within his phenomenology as "the directional nature of human experience – perception included – as it (and we) deal with objects, events, and phenomena *in the world.*" (Thomas & Pollio, 2002, p. 14).

Lastly, Merleau-Ponty (1962) describes that maintaining a connection with other people has several benefits, such as, overcoming isolation and experiencing himself as more than if he were alone. He additionally explains that *reciprocity* is required for a true human connection to take place:

> In the experience of dialogue, there is constituted between the other person and myself a common ground; my thought and his are interwoven into a single fabric . . . We have here a dual being, where the other is for me no longer a mere bit of behavior in my transcendental field, nor I in his; we are collaborators for each other in consummate reciprocity. Our perspectives merge into each other, and we co-exist through a common world" (p. 354).

Sample and Setting

In a phenomenological study, the two principal criteria for eligible participation are: (1) participants who have experienced the central phenomenon and (2) willingness to share their perceived experience (Gray et al. 2017; Thomas & Pollio, 2002). As a result, purposeful sampling is used to select participants who meet the above criteria and can provide a rich description of their lived experience to achieve the study aims (Gray et al., 2017). Participants selected, for this study, were a purposeful sample of actively working frontline Registered Nurses in two different Intensive Care Units located within the same city. Each participant had a minimum of one year of ICU experience at the study sites and prior experience participating in family-centered rounds pre-pandemic.

The sample size was eight participants and interviews were conducted between April and May 2021 until saturation was achieved. Compared to quantitative studies, the sample size for a qualitative study is not as large and the researcher stops data collection once there is enough rich and meaningful data to satisfy the objective of the study (Gray et al., 2017). According to Gray et al., data saturation is said to have occurred when new data begins to become redundant with the data that has already been collected and no new themes are identified. Although the sample size can be adjusted as the study proceeds, a typical sample size for phenomenological research is six to twelve participants (Thomas & Pollio, 2002). Thomas and Pollio further explain that if there is redundancy evident after review of the narratives of the first six participants, the researcher may determine that proceeding with additional interviews is unnecessary. Saturation was achieved after eight interviews and no further participants were sought.

Qualitative researchers also collect data and interview participants within their natural setting where they would typically experience the phenomenon being studied (Creswell, 2014). According to Creswell (2014), constructivist researchers “address the processes of interaction among individuals” within the context of where individuals both live and work (p. 8). The location selected should be neutral, private, and convenient for the participant, as well as maintain confidentiality (Gray et al., 2017). As a result of pandemic guidelines and the requirement for social distancing, Research Ethics Board (REB) approval was obtained to conduct one-on-one interviews virtually using the Microsoft Teams platform. Participants were able to select a private location at their convenience and connect virtually to complete the interview.

The study sites were Level 3 ICUs at two different hospital campuses in Southwestern Ontario that primarily admit patients from the Emergency Department, Operating Room, or transferred from the acute care units via activation of the Critical Care Outreach Team. Throughout the COVID-19 pandemic, both ICUs accepted critical care patients transferred from hospitals outside of their catchment area, including the Greater Toronto Area (GTA) and Winnipeg, Manitoba. The population of patients admitted to ICU prior to the pandemic had a primary diagnosis of trauma, neurological impairment, renal deficiency, or following surgical intervention at one campus, and complex medical, respirology, oncology diagnoses at the other campus. Throughout the pandemic, majority of patients admitted to the ICU at either campus had a primary diagnosis of respiratory failure related to COVID pneumonia or secondary complications related to COVID.

From January 2019 until the beginning of the COVID-19 pandemic, the ICU team conducted daily multidisciplinary rounds where they invited the patient and/or a designated family spokesperson to participate as part of the rounding process. In addition to my role as researcher, I was also the nursing lead in the rollout of family-centered rounds in the ICU, as well as the operations manager at one of the campus study sites within Southwestern Ontario. As the manager of ICU, I've acknowledged that my leadership role within the organization may influence staff to feel biased or pressured to provide responses congruent with what they might perceive to be my desired response. Furthermore, since my role as manager was also to schedule staff and approve payroll, staff reporting directly to me might feel additional pressure or suspect unfair treatment if they perceive that their answers provided were not congruent with what they might speculate I expect to hear. To avoid potential bias, a Research Assistant was hired through the University's Faculty of Nursing and clearance was gained through the REB process at both the University and the Hospital REBs. The Research Assistant completed and transcribed all the interviews, removing identifying information prior to sending them to me for analysis.

Ethical Considerations & Recruitment

This study obtained Research Ethics Board (REB) clearance from the University of Windsor (see Appendix C), as well as the REB of the Southwestern Ontario hospital study sites (see Appendix D). After the study was cleared, I connected with the Director of Critical Care at the hospitals who sent out a recruitment email (see Appendix E) and study flyer (see Appendix F) to all ICU RNs at both sites. The participant recruitment e-mail contained a Letter of Information (see Appendix D) which explained the purpose of the study, interview format, compensation, potential risks and benefits, and well as confidentiality and protection of identifying data, voluntary participation and right to withdrawal, feedback of results, and rights of the research subjects. Participants were recruited on a voluntary basis by contacting my thesis supervisor by phone or email to express interest in enrolling in the study. The research assistant and participant coordinated a date and time to schedule an interview during which the participant was not scheduled to work, such as on a day off or following a scheduled shift. A total of eight participants expressed interest in participating in the study after two e-mail requests. Overall, the recruitment process was complete within one month and participants were eager to share their experience.

Participants were informed that participating in this qualitative research study involved no foreseeable risks or discomforts, such as any negative physical, emotional, social, or economic effects. They were advised that they might experience increased satisfaction knowing their participation will help to generate knowledge to enhance patient care and the continued improvement of patient and family-centered rounds in the ICU. Participants were also informed that participation is voluntary and choosing to participate, or not participate, will have no effect on their employment with the hospital. Those who participated were provided with the assurance that their responses are confidential and de-identified throughout the research process and within any future publications and presentations.

If participants had no further questions, oral consent was provided to the research assistant to participate in the study and be video recorded throughout the interview process. Participants were then asked to choose an alternate name that they would like to use throughout the duration of the interview that was only known to the research team for the sole purpose of clarifying and validating any data collected and themes identified. Information was not linked to the participant's identity and the raw data collected remained only with the researcher and her advisor. Since participants were interviewed after a scheduled 12-hour shift or on a day off, they were compensated with a $50 Amazon gift card for participation in the study.

Participants were also advised that they may discontinue participation in the study at any time, at which point data would be immediately destroyed upon withdrawal from the study. It is also important to note that participants were not coerced in any way to participate in the study and that they also voluntarily signed written consent following full disclosure of essential information about the study (See Appendix G). Participants were provided with my supervisor's contact information to ask any questions about the study prior to or following participation. Before beginning, the research assistant reinforced that participation was voluntary and that the participant may choose to stop the interview or not answer a question at any point in time. In addition to written consent, the research assistant obtained verbal consent from the participants at the beginning of the interview. Time allocated to complete the interview was 30 minutes with the potential to speak longer at the discretion of the participant. In appreciation of the time volunteered to participate in the interview, each participant was compensated with a $50 Amazon gift card.

Consent forms were kept in a separate locked filing cabinet in my supervisor's office at the University of Windsor. Digital data, such as transcripts, were stored on a password protected computer and the files were locked with a passcode known only to me. An interpretive team including my advisor, internal reader, research assistant and I met virtually to review the transcripts and start to validate themes and categorize each theme according to Merleau-Ponty's phenomenology of perception as it relates to time, body, world, and others. Once it was determined that I was on the right track with coding transcripts into themes, I then worked to finalize the themes and sub-themes for review by my principle thesis advisor, who validated the final results.

After validation of themes was completed, the recorded interviews were deleted from the Microsoft Teams platform. Following a successful final thesis defense, all outstanding notes and transcripts will be destroyed by either a reputable secure disposal process or complete deletion of electronic files.

Data Collection and Analysis

The interviews were conducted at a mutually agreed upon time between the research assistant and participant over a six-week period. Appendix A outlines an interview protocol with introductory, guiding and probing, as well as closing questions. Recorded interviews were transcribed per verbatim by the research assistant, which has allowed me to review a visual account of the data and share findings with the thesis team for analysis and validation (Gray et al., 2017).

To ensure validity, Creswell (2014) recommends employing a strategy of triangulation of the data, whereby data is collected through multiple sources, such as interviews, observation, and a documented analysis. My advisor, internal reader, research assistant, and I participated in a discussion about thematic interpretations for one randomly selected transcript until consensus was reached to ensure that themes are supported by text (Yin, 2011; Thomas & Pollio, 2012; Creswell, 2014).

In advance of the meeting, I reviewed and printed all participant transcripts. I then worked through an analysis process to identify themes and colour code them each with a different coloured highlighter. The thesis group was then sent a sample transcript to review prior to the meeting. I then led the meeting and read a passage from the sample transcript. According to Thomas and Pollio's (2002) Summary of Steps in Conducting an Existential-Phenomenological Study, the passage was read for meaning units and also for sense of whole. The passage was then clustered into an initial theme. I then presented to the group my findings from other participant transcripts that could also be clustered within that same theme. We next discussed if the group agreed and how the identified theme best fit Merleau-Ponty's phenomenology of time, body, world, and others. This process continued throughout the same sample transcript. Following this meeting, I then reviewed again the remaining transcripts and met one-on-one with my thesis advisor to validate the remaining themes.

According to Munhall (2012), as cited by Gray et al. (2017), immersion of the data is also referred to as dwelling with the data in phenomenological research. Throughout the study, I was immersed in the data, or dwelled with the data, through reading and re-reading notes and transcripts. I completed an ongoing self-reflection of thoughts, feelings, and perceptions of family-centered rounds in the ICU. This reflection upon the data, in addition to coding, assisted in uncovering themes using a vigorous method of analysis to maintain validity (Creswell, 2014).

I completed an interview with the research assistant and transcribed my recorded video-taped interview to reveal and review personal thoughts, feelings, and attitudes towards family-centered rounds both pre-pandemic and following the restricted visitation imposed by hospital policies throughout the duration of the COVID-19 pandemic.

In summary, as the researcher I have utilized an adaption of Thomas and Pollio's (2012) approach to conduct this existential-phenomenological study.

CHAPTER 4: Findings

The purpose of this study was to describe, from the nurse's perspective, the experience of family-centered rounds in a critical care setting. The participants who volunteered to be interviewed were critical care nurses actively working in a Southwestern Ontario intensive care unit (ICU). The results of the study provide varying insights into the experience of family-centered rounds in the ICU both pre-pandemic and throughout the course of the COVID-19 pandemic from each individual nurse's perspective.

Research Participants

A total of eight critical care registered nurses responded to the invitation to participate in the study. All participants were employed by one regional hospital in Southwestern Ontario and worked in an ICU at either of the hospital's two campuses. It is unknown to the researcher how many nurses participated from either site. The following chart depicts the age range, number of years employed as a nurse with their current employer, number of years working in their current department (ICU), and number of overall years of ICU experience. In addition, the below chart includes additional departments within the hospital the participant has worked, and their highest level of education achieved.

Table 1

Summary of Research Participant Demographics

Demographic	Categories	Number of participants (n)
Within which age range do you fall? *	20 to 29 years old	1
	30 to 39 years old	5
	40 to 49 years old	0
	Over 50 years old	1
How many years have you been nursing for your current employer?	Less than 5 years	1
	5 to 10 years	4
	11 to 20 years	3
	Over 20 years	0
How many years have you worked in your current department?	Less than 5 years	5
	5 to 10 years	2
	11 to 20 years	1
	Over 20 years	0
How many years have you worked in an ICU setting?	Less than 5 years	6
	5 to 10 years	1
	11 to 20 years	1
	Over 20 years	0
What is your highest level of Education?*	Diploma	0
	Bachelor of Science in Nursing	5
	Master of Nursing or Master of Science in Nursing	2
	PhD	0

*Note: one participant declined to answer

From the total sample of participants, alternate departments that the nurses have worked in prior to ICU include: Medicine, Surgery, Oncology, Dialysis, ER, and Home Care.

Patient and Family-Centered Care Defined

Prior to the beginning of data collection, I was interviewed by the research assistant hired for this study. This interview allowed me to provide initial feedback to ensure that the questions were asked and probed as intended. Additionally, this also allowed me to self-reflect on my own perception and definition of family-centered care.

In my words, patient and family-centered care “truly means placing the patient, in addition to their family, at the center of everything that we do”. I further described during the interview that “as part of our rounding process, as part of all the care that we provide, we make sure that the patient and the family is an extension of our team”. After reviewing the transcripts from participants, I identified that my perceived definition of family-centered care is congruent with that of participants. One of the participants who identifies as Blair provides the following definition:

> Patient and family-centered care to me is that the patient and their family members are involved in the patient’s care and involved in the decision-making process. They are always the first people to get any new information and they work with us to make a plan and make major decisions.

The definition provided by Blair aligns with that provided by Susan who states:

> Patient and family-centered care refers to allowing the family and the patient to participate within the patient’s care so that they can have a full understanding of basically from head-to-toe, like, what’s going on with them health-wise. And it gives them the ability to like, ask any questions that they need clarification on and choose to participate so that everyone is on the same page and they have a better understanding of what is going on with their care.

One of the participants who is referred to as Charlotte provides a broader definition and includes an example of her approach to communication with families. First, she defines patient and family-centered care as “molding the care plan around the patients’ needs… but incorporating family in that care where possible. In the ICU… that means keeping them informed and asking them their opinions because they know more about the patient than, than you do.” Charlotte asks families of patients assigned to her care the following:

> What is it that you can tell me that would help me to take better care of your family member? What is it that I should know? And sometimes it’s you know, really big things. Sometimes it’s just something simple like they don’t like to have their feet covered. They don’t like to have their hands covered. You know, they have a problem with this or they have a problem with that. Just anything that would help me to take better care of them so that they would be more comfortable.

John includes in his definition of family-centered care that family is who the patient defines it to be. He explains:

> It’s dealing with the whole entire aspect and family is to a patient whoever they consider family, right? Whether that be a cousin, whether that be a best friend, whether that be someone they haven’t seen in ten years, but they are so close to from e-mail or text or what not, so the whole point is, who is important to the fam, to the patient, and who do they consider family and bringing those people in and having them involved in the care as much as the patient wants them to be.

Lastly, both nurses identified as Jesse and Leah respectively include in their definitions of family-centered care that family also functions as patient advocates. Jess explains that:

> Especially in the ICU, a lot of our patients are unconscious due to their illness or sedation or intubation, and so the family kind of becomes the patient or the patient advocate in that sense. So, when we’re talking about their care, we’re just

> basically talking about making sure we're answering the patient or the family's questions, and also including them in how we're making the decisions for their plans of care.

Leah adds that patient and family-centered care means:

> When families are able to participate and be able to be involved in our, in our rounds and decision making involving the more specifically, when those patients are not able to speak for themselves a lot of times. Or, you know, may not have a voice of their own, so we really like to you know in, you know involved the family in that for those decisions and conversations.

As data analysis continued, there were three predominant themes that emerged: (i) Family presence during rounds versus family updates after rounds; (ii) Nursing the patient versus nursing the family; and (iii) Then and Now – Open visitation versus restricted visitation. Each of these themes will be discussed with supporting quotes from participants.

Theme 1: Family Presence During Rounds Versus Family Updates After Rounds

The first theme recounts the experience of frontline ICU RNs and how the rounding process is conducted. Three sub-themes have also been identified: (1) benefits and challenges, (ii) physician variability, and (iii) use of technology. The first theme also provides insight into how family-centered rounds were conducted prior to the COVID-19 pandemic and is then compared to how the ICU team has adapted and changed their rounding process after the onset of the COVID-19 pandemic. Prior to the pandemic, the multidisciplinary team would gather outside of the patient's room. According to Elisha, family-centered rounds were conducted as follows:

> We used to just kind of stay about 10 feet back from the bed and the family could come up to the doctor’s little podium. And the nurse would usually stand across from the docs and we would go over our assessment and then we would review it with pharmacy, with dietary, the nurse practitioner, and physio. Then we also talked to the family and asked them if they have any questions or any concerns and go over all of our test results and everything with them.

Blair recounts a similar experience with family-centered rounds and one of the benefits for families was that they “could just come in… participate in rounds, you would know that information and you’d be able to convey it to your family members and everybody else in the family.” The power of attorney or next of kin was typically designated as the family spokesperson. They were the individual often identified to participate in daily rounds and disseminate information and the plan of care to the rest of the family. One of the challenges Blair shares that changed during pandemic visiting restrictions is that the family has to be updated over the phone by either the nurse or the physician. Depending on the family, the staff might arrange a Zoom call, but this comes with challenges as well. Blair shares that “it’s harder to convey things over the phone and over Zoom ‘cause there’s that barrier of just the screen and the phone, and it’s harder to convey sometimes how sick people are and what their needs are.”

Charlotte describes a similar experience regarding how family-centered rounds were conducted pre-pandemic. However, she recalls that this sometimes varied depending on who the Intensivist was for the week. She explains that family “would listen to the discussion between all the professionals… depending on the physician of course.” She adds that “sometimes the physician would go right into the room and speak with the family member and sometimes the family member would come to the doorway of the room and listen and they would interject or add information." Physician variability in practice around family-centered rounds is further complicated intra-pandemic as there is a lack of policy standard in communication. Charlotte describes that some physicians "make a point of updating family" after rounds are fully complete while others collaborate with the ICU Nurse Practitioner (NP). They will discuss with the NP and "between them decide who's going to take care of that." Elisha also describes that "it's usually the nurse practitioner that calls and updates the family every day."

Compared to rounds conducted pre-pandemic, John feels that "families obviously have a lot more questions because they aren't there to see the patient." Staff in the ICU have had to leverage the use of technology and applications such as Facetime to update families. However, John describes this experience as challenging because the families are "not really participating in care rounds like they were before." As the pandemic progressed and visitation eventually allowed for one visitor in one-time block per day, the time that the visitor selected for visitation often did not align with the timing of rounds. John goes on to explain that the "odd time we've had family be there while we're rounding and we've invited them to kind of listen in rounds, but sadly, I just think we did a really good job before the pandemic with having the families involved."

All of the eight participants preferred having family-present rounds versus having to update families telephonically or virtually after rounds. According to Blair, it was easier to talk to family members directly. She describes the following:

> If they had questions, they just asked them. They could get all the information that they needed right there directly and they would go and visit with family members

> after. So, if they had any more questions or if they wanted to know anything else, they could just press the call bell. And I would come in and answer them. And they could talk to the doctor anytime they wanted to.

Furthermore, each of the eight participants described their perceptions of benefits to in-person family centered rounds including, increased patient and family satisfaction, increased feelings of comfort, patient and families feeling like they were listened to or heard, and feelings of their concerns being addressed more promptly. Several participants also commented that family-centered rounds helped decrease the number of phone calls they received in a day as families were satisfied with the plan of care discussed at daily rounds. As a result, the participants felt like they had more time to spend caring for their assigned patients with less interruptions. Charlotte describes from her perspective the following:

> I think on the overall, the families were more satisfied, placated with the information that they had felt more comfortable with the care their… family member was receiving. Felt that they were listened to and heard. If they had a problem with something, they brought forward the problem… They were just more deeply involved in the care of the patient. I think it made them feel better. And I think for the patients that knew what was going on that were awake, they felt better as well.

Theme 2: Nursing the Patient Versus Nursing the Family

At the beginning of this chapter, research participants provided their definition of patient and family-centered care. A common theme identified was that patient-centered care extended to their patient’s identified family. Hospitalization of a loved one is a stressful experience for both patients and their families and in the context of the ICU where patients are often intubated and sedated, the family takes on the role of patient advocate. The second theme identified provides insight into how the bedside ICU RN provides care to the patient while also providing supportive care to their family members.

Research participants describe that their primary role as bedside nurse is to care for their assigned patient; however, they explain that there exists a need to care for the family as well. Charlotte explains that "the family is part of that patient… the family is part of that scope. So, when you're looking after your patient, you also want to look after the family." Jesse adds that "when we're talking about patients and their families, we usually include the family as part of the word patient."

According to the study participant named Charlotte, she describes her role in supporting the patient's family as follows:

> You know, some families are just more needy than others, and they need that interaction. They need the reassurance, but even in all of that need… misdirected anger, interactions, you know you can do everything that you feel is possibly possible to calm them down or calm their fear, calm their anger, placate them, whatever it is you know, not with false information, but just to try and be as supportive as possible.

Charlotte goes on to explain how the family sometimes needs someone from the team to listen, and that individual is most often the nurse. If the family is upset, they want to feel heard and reassured. This isn't likely to change any outcomes, but it helps to provide the psychological support to the family that is needed.

Participants described that their support to the family is most often through translation of medical jargon and ensuring that family understands the updates from rounds and what the plan of care is. The first participant who is referred to as RN1 describes their experience following family-centered rounds as often requiring “a lot of explaining afterwards… because a lot of the things that we’re saying during rounds is like a lot of medical speak.” They feel that their role is critical when families do not understand what the physician has explained and the RN “takes a big role in like, re-explaining things to them as well and just making sure that their questions and thoughts are heard as well.” Prior to the COVID-19 pandemic, the ICU nurse would have had the opportunity to meet and talk to the family at the patient’s bedside prior to rounds. Therefore, they’re typically aware of what questions the family might have before rounds and they can ensure that they have the opportunity to ask their questions during the rounding process. John describes the experience for families as “a little bit overwhelming for them or over their head, but at least they’re involved in that care and we can kind of simplify it for them afterwards.”

Elisha describes that in her role as the nurse, she plays an important role in translating for families. She states: “I find that I’m a good translator in between what the doc is saying and what the family can understand.” Even if her updates with family is over the phone, she feels as though she “can kind of follow up and use the language, language that we know the family is familiar with.” She provides an example in which a family member is asking about a patient’s lab value however, the doctor did not comprehend the information that the family member was seeking. Elisha helped translate for the family so that the doctor could understand their question:

> I had a patient who’s in kidney failure and the family kept asking if she was getting rid of the toxins… meaning, was her creatinine improving? But when they asked the doctor, the doctor couldn’t comprehend what they were trying to ask. So that’s where we come in. We can kind of go back and forth in between the two of them ‘cause I knew exactly what they were talking about.

Overall, the second theme of “Nursing the Patient Versus Nursing the Family” validates from participants that their role as bedside RN extends to providing support to the family. Based on participant responses, this is typically achieved by ensuring that families have a voice at rounds and translating any unfamiliar medical terminology to ensure that families truly understand their loved one’s current status and overall plan of care.

Theme 3: Then and Now – Pre-Pandemic Versus Intra-Pandemic

The theme of “Then and Now” is predominant throughout the study findings. Woven throughout each theme is also the concept of “Then and Now” as participants continuously compare and contrast how their experiences with family-centered rounds were conducted pre-pandemic versus how they’ve changed since after the COVID-19 pandemic began. This has been particularly influenced by hospital-instituted visitation restriction policies and visitation policies that have continuously evolved throughout the course of the pandemic.

Pre-pandemic, the ICUs had transitioned to open visitation and allowed visitors to enter the unit to visit with their loved one at any time of day. The only limitation imposed at the time was a limit of two visitors at one time, however they could rotate out with any number of family members. There’s been varying times throughout the COVID-19 pandemic where the hospital has restricted visitors entirely or has implemented restricted visitation policies with a limited number of visitors assigned to limited times.

According to the participant named RN1, having families able to visit their family member in the ICU “took a lot of stress off them”. John adds that “COVID has kind of changed all of that. It’s unfortunate with the visitation rules, but just prior to that, we were really wanting families to be involved in our care rounds.” Elisha shares the same sentiment and further describes that “it’s not even that they’re not at the bedside, it’s that they’re not even in the hospital.”

In addition to family updates and family meetings over Facetime and Zoom, this same technology loaded on an iPad is also used by the beside ICU RN to help facilitate virtual visits with patients and families. According to Jesse, they describe that “iPads have been used pretty frequently for visiting with their family member or maybe their family members are sedated so just turn it on so they can see them and you know, give them a loving message.” The use of technology has helped increase connectivity and visitation for multiple family members simultaneously while also helping to connect family members across the country or out of country. Elisha describes that the “biggest thing is that they can have ten people on a Zoom call and I can go over everything one time as opposed to having ten phone calls and going through it one at a time. That’s a big help.”

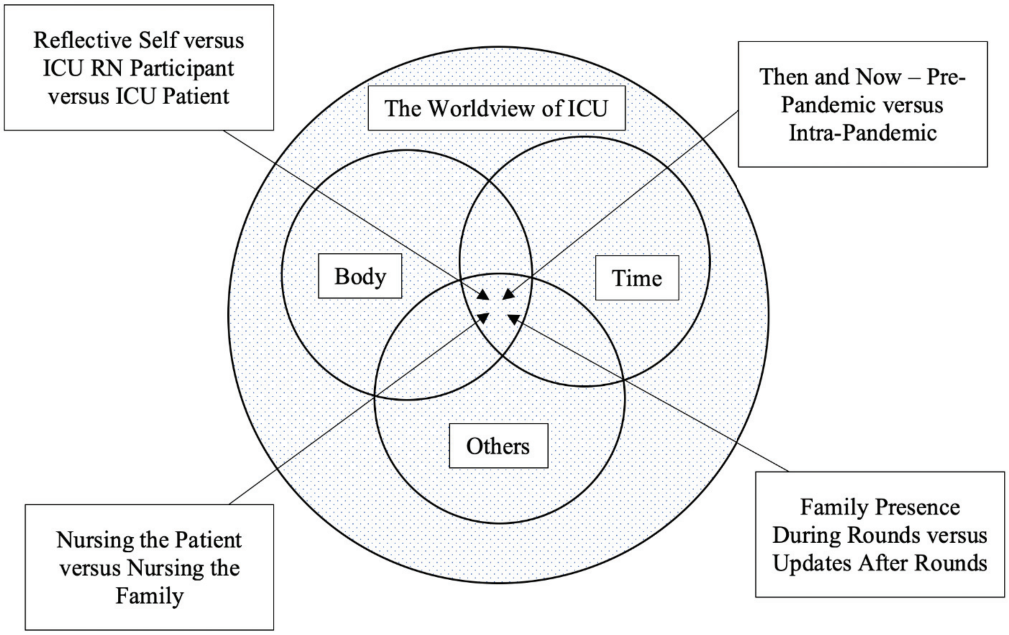
While the use of technology has several benefits and has helped to provide a bridge to facilitate visitation virtually during times of restricted visitation, participants generally describe that family presence is the preferred method of visitation. In light of the COVID-19 pandemic, it remains unknown if policies and processes will return to how they were “then”. The COVID-19 pandemic has highlighted the fact that we very well might need to find new best practices for managing visitation and patient and family-centered rounds “now”.

Thematic Structure

The themes identified above have been illustrated into a thematic structure as shown below in Figure 2. This pictorial representation identifies body, time, and others as overlapping circles that each contribute to the worldview of the ICU. The central area in which the circles overlap provides a space in which figural themes have emerged from the narrative. In addition to the three emerging themes referenced in prior sections of this chapter, the researcher has additionally identified her reflective self, the ICU nurse participants, as well as the ICU patient as three contributing bodies according to Merleau-Ponty that also contribute to the worldview of this research.

Figure 2

Thematic Structure: The Experience of Critical Care RNs with Family-Centered Rounds in a Southwestern Ontario ICU



The Worldview of the ICU

All eight participants had similar perceptions and thoughts about patient and family-centered care and family centered rounds in the ICU. They each have the skills, experience, and expertise as ICU RNs to provide their insight and ideas. As a previous ICU nurse, and as the Operations Manager of the ICU during the data collection, I also share a similar level of understanding and definition of the World of the ICU.

Each participant provides a similar perception of patient and family-centered care. From their perspective, in the world of the ICU, patient-centered care extends to include care of the family. Patient and family-centered rounds take place physically in the ICU just outside of each patient's room. Participants in multidisciplinary rounds in the ICU also extend to include the patient, if able, and family, in addition to other team members such as the ICU physician, bedside nurse, respiratory therapist, dietician, and pharmacist.

The participants of the study have worked in at least one of the two ICUs across two different campuses at the study site. The hospital had amalgamated services in 2013 and over numerous years, standardization and optimization of departments had taken place to create new and congruent standards of care. The ICU Nursing Director and ICU Medical Director both oversee both ICUs with nursing leaders and physician leaders reporting to each role respectively. While the physical layout of each ICU differs, the organizational structure ensures that care, processes, and policies are standardized between the units.

Frontline nursing staff are hired to work dedicated in one of the two ICUs and do not cross campuses unless they consent to be called-in and agree to pick up a shift that is offered at the alternate site. There are approximately 110 frontline RNs in one ICU versus approximately 70 RNs in the alternate ICU. At either campus, there are approximately three Intensivists that work exclusively in one ICU, while approximately five provide cross-coverage and rotate weeks between both sites. The patient population is the primary factor that differs between the two campuses. The ICU at one campus is a 20-bed level 3 ICU regional stroke, trauma, and renal care. The ICU at the alternate campus is a 19-bed level 3 ICU providing primarily medical, surgical, and oncology care. This ICU also occasionally cares for pediatric ICU patients requiring additional monitoring or while awaiting transfer to a higher level of care.

Although there are some differences between either ICU, it is important to note that the process of family-centered rounds was developed collaboratively with frontline nursing and physician representation from each campus. Open visitation pre-pandemic and visitation restrictions throughout the course of the pandemic was the same at either campus.

Circle of Time

The concept of time was one of the most important considerations of the identified themes. The lens of time has provided rich data that compares family-centered rounds pre-pandemic to intra-pandemic. The perception of participants who have experienced family-centered rounds in both moments of time provides insight into the benefits and challenges that timing of sharing information has to offer.

In particular, each of the eight participants have referenced time to describe when and how they update families with information about their patient. Pre-pandemic, the timing of family updates was typically in real-time as families participated in rounds at the bedside. Throughout the course of the pandemic, family updates typically took place after rounds by a phone call from the bedside nurse, the nurse practitioner, or ICU physician, depending on the level of detail required to be delivered. In a family who might already be anxious and stressed by their loved one's hospitalization, the timing and frequency of updates is critical to put families at ease.

According to Thomas and Pollio (2002), Merleau-Ponty "contended that the human experience of time depends upon moments that burst forth, uniquely revealing time to the person" (p. 161). Furthermore, Thomas and Pollio (2002) reference Heidegger's view that time is considered a precious possession, in particular, when it becomes limited by impending death. In the context of the ICU, patients are critically ill and may face limited time prior to passing. This is of particular importance as visitation restrictions further limit the time that families can spend with their loved ones prior to dying.

The Human Body

According to Merleau-Ponty (1962) as cited by Thomas and Pollio (2002) "the body is the fundamental category of human existence. In fact, the world is said to exist only in and through the body." The human experience of the human body is described from the perspective of the frontline ICU nurse through their objective and subjective findings as they assess their patient. They use their assessment findings to provide report at daily multidisciplinary rounds. If family is present, they can compare to their assessment findings about their patient to their family's account of the patient's baseline function.

Through each encounter with family, research participants must consider that their experiences are their unique perspectives from the point of view of their body.

Additionally, the researcher must also consider throughout the study and analysis of the data, that her own perspectives from her body's point of view can influence how she sees and interprets the data.

Others

Merleau-Ponty (1962) describes reciprocity as a requirement for true connections to take place between humans. Human connection through dialogue and communication is explained through the participants' interaction with the patient, family, and healthcare team.

The theme of "Nursing the Patient versus Nursing the Family" provides examples of how study participants have formed a human connection with their patient, as well as the patient's family. The nurse uses communication and dialogue to help translate medical terminology from the multidisciplinary team to the family, while ensuring that they understand the patient's plan of care. In addition, reciprocity is demonstrated by the ICU nurse when they advocate for their patients' care needs and ensuring any questions or concerns raised by family members are addressed.

Participant Recommendations

Four main recommendations have emerged from the interviewed participants: 1) Family re-integration and visitation, 2) Physician buy-in, 3) Student Involvement in the ICU, and 4) Staff Feedback.

Family Reintegration and Visitation

The first recommendation is that the family should be brought back into the rounding process. Several participants recommended that this be facilitated through virtual participation in rounds through video-conferencing software, such as Zoom or Facetime. RN1 explains:

> It’s like, if we found a new way to include them. Like if we have a set time every day. It’s kind of hard with the ICU… changing all the time, but it would be nice to have, like, a scheduled time, like, maybe say, like, Noon, where the doctor or the Nurse Practitioner walked around and just did, like, video calls with each family.

A suggestion by this same RN is that there could be an iPad on the ICU charge nurse station or have the bedside nurse call ahead to the family when he or she notices the team will be rounding next on that particular patient. A recommendation to update families by telephone is also a viable option, especially during peak times when access to technology is limited. As family visiting hours are reinstated, it could be possible for a team member to touch base physically especially if the family member is on the unit following rounds.

Study participants also recommended that virtual visitation options and hospital visitation hours be reviewed. A priority goal should be to re-integrate families into the rounding process, but to provide a narrower window of time for families to come into the ICU to participate. In the past, pre-pandemic, the timing provided was a 6-hour window, and this was not necessarily conducive to family work-life schedules.

> I think the ultimate thing would be that families used to… they want to be part of rounds and they want to know what time the doctor’s rounding and they kind of make their plans with their day based on when you tell them. You know, it’s hard to give them such a ballpark. You know, anywhere from like 9:00 AM ‘til like

> 3:00 PM in the afternoon. Like, you're telling them to be there 6 hours and like, I know I don't know what to tell you, we just don't have a set time. So, maybe if we could figure out some way to say like 'Hey, like, we're going to be rounding in these rooms at this time.' So we give the families a ballpark that could really help get them in, because they would sometimes make, like, changes to their life schedule.

The RN named Jesse also agrees and states:

> Obviously, the pandemic is here and it's not going away in the foreseeable future. The, the current way we're doing rounds is, is I mean since last year, it's been an impromptu. We just started and this is just how the way that we do it, just how it's kind of formed. I would like to have the family members back included, so if that means uh, like, if that means calling them up and seeing if they are available and just having them on the phone to listen.

The participant named Blair also recommends an appointment or time be provided to family members so that they know when rounds are happening and when they can come be included. She states: "Potentially, like, being able to change visiting hours or giving patients' family members appointments so they can come in and you know, be involved in rounds during the day."

The RN who chose to be named Jesse re-affirms the need for family presence:

> I think the great thing would be to have the family either on the video or on the telephone… our visitation and the isolation, if all of this is staying then we need to find a way to include them again.

According to Charlotte, family-centered care is also needed in all areas of the hospital and visitation policies, as well as family-inclusion should be reviewed. She states:

> Family input is also very much needed, and… I'm finding that lacking now because the family is not at the bedside, so, but I think it's something that should continue and should be a focus. Really, it's very important to get family involved… The patient and family-centered care really plays a huge role I say in ICU, but really in, in general in every aspect of patient care in the hospital. From every level from critical care, ER… down to like a step-down unit or whatever other unit; med-surg, surgical, neuro, whatever unit they're on, the family-centered care is really important.

Physician Buy-In

Study participants have also made the recommendation to improve staff buy-in through education. Participants explain that the level of engagement of the ICU physician in patient- and family-centered rounds has an impact on the RN buy-in regarding the involvement of family in the rounding process. Additional research is required to validate the connection between physician engagement and the effect on the rest of the interdisciplinary rounding team. Leah shares her perspective of physician buy-in and states "I think there's some that are all about it and want families there. And there are some that are more reluctant." She goes on to share her experience with the roll-out of family-centered rounds in the ICU:

> I know in the past there has been some physicians that were like 'Oh no, we don't want families in here while we're rounding, it's interrupting' and whatever. But I

> think the benefit far outweighs those interruptions and just kind of giving them those, you know those boundaries of like, you know, ‘We’re going to wait ‘til… we’re done and then you can ask questions’ and things like that. But I think a big part of it is the physicians and how they perceive it and how they look at it.

Moving forward, Leah provides her thoughts on future need for physician support:

> I think that… continuing to get that physician support is probably the biggest thing, and when the nursing staff feel the physicians are all about it, they tend to be all about it too. But if they’re like, the physicians are like ‘Oh no, we don’t want family’ then the staff’s a little reluctant even though it’s part of our rounding model.

Student Involvement in the ICU

Undergraduate nursing students have been hired into the ICU throughout the pandemic as Undergraduate Nursing Employees (UNE). They’ve worked as unregulated health professions and can perform tasks within their defined scope. The ICU RN named Susan feels that the student UNEs, one of their primary tasks was to assist the staff with setting up virtual visits between patients and families with the use of the ICU iPads:

> I really, like, like the iPad thing, how they… can communicate like, even when they’re not physically able to come in, right, so they can at least lay eyes on their loved ones. But if we’re gonna go that route, then we definitely need like, the volunteers or the assistants to kind of hold the iPad there ‘cause if they’re on a ventilator like, for me to gown and glove and get all my gear and go in there with the iPad like, it is very time consuming. So, we need someone to sort of slowly

> just do that part of the job if, if they're able to. When we had students, like, they were mostly doing that, so that was really helpful for us. Yeah, it's just with all the PPE now, like, you can't just run in and go do that quickly.

Charlotte recommends that new graduate nurses spend some time as students in the ICU prior to entering the workforce:

> You know, the new nurses coming out into the, into the workforce… it's a bit of a shocker, maybe, it's very different. And I, I think that young nurses need to be in the environment experiencing some of that as students a little bit more to see that first hand.

Lastly, the ICU RN named John recommends future research studies review ICU staff satisfaction with the availability of UNEs:

> If you have any interest in the future, like now that I'm just thinking about it, a UNE study would be really interesting. Yeah, I've never looked into research on it, but it's like, we did it, and I wonder what staff satisfaction is with UNEs.

Staff Feedback

One of the participants recommends a feedback loop to ICU staff on family satisfaction with family-centered rounds. Participants feel that there is not a great mechanism to measure patient and family satisfaction and share their experience back to the ICU team. Leah states:

> I would say like, getting some feedback from the family on family-centered rounds… Something specific you know, just to give the nursing staff, to give them that piece back of like, how that impacted them and how that impacted you know, what may have been a really tragic sort of event, or you know, like a

> certain type of situation they had in the unit, but how that family-centered care really brought the whole picture together. And be able to give that feedback back, back to the nurses. Because sometimes I think they don’t hear that side of it and how it’s impacted those families. And you know, I mean, I’ve had family saying to me like ‘I can’t tell you how amazing this has been.’ So, unless you’re getting that directly back, and not all families are like that, right?

Patients Dying Alone

One of the greatest challenges for ICU nurses throughout the course of the pandemic has been patients dying alone while visitation restrictions were in place. Although the focus of this study was on family-centered rounds, it is important to note the impact created by restricted visitation. One of the study participants named Charlotte shares her experience of patients at end-of-life during a time of restricted visitation during the COVID-19 pandemic:

> You know, before the pandemic and family centered rounds, family-centered care, if someone was passing, you know we could have entire families around the bedside. You know, it was an exception we made for that situation. You know, even my mother-in-law, my mother-in-law was in on our unit, and we had 10 people in the room surrounding her as she passed. Well, can't do that now. You know, and if they're COVID positive or whatever, there can be no one but the nurse. And as the nurse, we have become in a great sense that replacement for that family, family-centered care. You know, we can have the Zoom, Zoom call going and what I've experienced there, I mean as a nurse, often we're in there holding the patient's hand. And you know, listening to the family… It's not, not even close

> to being the same... It's almost like being a surrogate in some large sense, because when the family can't be there, we are. So, we're there in their last moments when no one else can be.

In summary, when describing the concepts of time, body, and others within the worldview of the ICU, the most common themes that emerged from the data were: (i) Family Presence During Rounds versus Family Updates After Rounds; (ii) Nursing the Patient Versus Nursing the Family; and (iii) Then and Now – Pre-Pandemic Versus Intra-Pandemic. The researcher has also analyzed each participant's definition of patient and family-centered care, and has provided a self-reflection of their own worldview of the ICU and patient and family-centered care.

CHAPTER 5: Discussion

The phenomenological inquiry process was an enlightening journey that allowed me as the researcher to fully immerse myself in the study and gain an understanding of different nursing perceptions on a topic that I am so passionate about. Throughout the duration of the study and the COVID-19 pandemic, I kept a reflective journal in which I noted my personal values, feelings, and belief systems. Throughout the data analysis, I would often refer back to my identified thoughts and feelings to refresh my perspective and minimize the risk of lack of neutrality. Through this method, I was able to retain a clear vision of my own understanding of the experience while describing the phenomenon through the lens of participating ICU nurses.

Theme 1: Family Presence During Rounds versus Family Updates After Rounds

Family presence during rounds was described by all eight participants as having changed significantly from pre-pandemic compared to following the onset of the pandemic. Prior to the COVID-19 pandemic, all study participants considered patients and family members part of the ICU team and their presence was included in the ICU rounding process. Additionally, all eight study participants described family as whomever the patient defined it to include. The study participants were also congruent in their definition of patient- and family-centered rounds as they each described the process as daily multidisciplinary rounds attended by the patient, if able, the family, the ICU physician, Nurse Practitioner, ICU Charge Nurse, the patient's assigned bedside RN, the Registered Respiratory Therapist, Pharmacist, and Dietician. The participants described how the family would participate in rounds with the ICU team by actively listening to the RN's report of head-to-toe assessment, report by other disciplines in attendance, review of various lab, and results of diagnostic tests. This process also allowed for the family to get a real-time update on the plan of care for the day and they would have an opportunity to ask the ICU team any questions they might have regarding their loved one. With the lack of visitation during the pandemic, staff expressed a challenge in communicating in real-time with families as they are no longer present to participate in rounds. The participant named Leah adds that the family's presence provides them with the opportunity to hear "a really detailed report compared to just that quick, you know, touch base sort of conversation that we're kind of doing now, unfortunately."

Seven of the eight ICU RN participants went on to explain that, since the onset of the COVID-19 pandemic, the ICU physician or ICU Nurse Practitioner now calls the patient's family with an update after rounds. Since visitation is restricted and family is no longer present at the bedside, the team must discuss how the family will be updated and who is best to speak to the family spokesperson. As there is no standard process regarding calls to family, the timing and designated individual that updates family is variable based on physician preference. Some physicians will have the ICU RN call the family member after rounds to provide an update and the ICU MD or NP will additionally call ad hoc if there is specific information requested regarding diagnostic reports and results. Other physicians will make a point to call each family after they round on that patient; however, the staff express this process is great to update families, but does prolong rounds overall. Some physicians will also coordinate with the ICU NP and divide up the patients in the unit with the physician updating some families via phone and the NP will update the remainder. This allows them to divide the number of calls that need to be made; however, there is no standard regarding timing of the calls. At times, the calls by physician and NP occur immediately following rounds, while other times it is towards the end of their down. Overall, the study participants explained that a call to family with an update by either the NP or the physician is of great value as families often want to hear from someone other than the RN.

Four of the eight study participants also discussed that the presence of families during rounds allows for advocacy on behalf of the patient who cannot speak for themselves. According to the participant who chose to be named John, during the rounding process “a lot of these patients aren’t able to speak for themselves, so the family really has to jump in and be that advocate for the patient.” Additionally, Jesse adds: “So especially in the ICU, a lot of our patients are unconscious due to their illness or sedation or intubation, and so the family kind of becomes… the patient advocate in that sense.” Leah further validates the need for family in the ICU by stating: “So, I think just being there and being present is very beneficial for that family. For the patients really, right, they’re the advocate for them.”

Prior to the COVID-19 pandemic, Kalocsai et al. (2018) conducted a study using purposeful sampling to interview nineteen family members of critically ill patients admitted to a medical-surgical ICU at a large academic hospital in Toronto, Ontario. The purpose of the study was “to explore family members’ perspectives on the enablers and challenges to establishing therapeutic alliance with ICU physicians and nurses” (p. 1). Studies of family members of critically ill patients conducted prior to the study by Kalocsai et al. (2018) have highlighted the importance of improving communication among family member and healthcare providers; however, most interventions aimed at achieving family-centered outcomes have failed. Multidisciplinary bedside rounds were initially introduced in ICUs with the primary goal of making decisions related to patient care and providing education to residents. The recent movement to a more patient- and family-centered approach to care provided an opportunity to open up these rounds to include families in the rounding process. This study by Kalocsai et al. was pivotal in highlighting that “family attendance on rounds does not necessarily lead to family-centered rounds” (p. 7).

A qualitative study with a grounded theory approach by Nygaard et al., (2022) took place in four ICUs in Norway. Data collection occurred during pre-pandemic years from July 2017 through to August 2019. Nygaard et al. found that family can be considered part of the ICU team through the implementation of flexible visitation, communication, and participation in rounds; however, the impression given throughout this observational study was that family were viewed as passive team members and not actively invited to join bedside rounds. Despite convincing evidence of the benefits of patient and family-centered rounds, the concept continues to lack standardization and an established process in the context of ICU (Nygaard et al., 2022). The results of this work by Nygaard and colleagues suggests that “family presence during shift reports and bedside rounds is far from common practice” (p. 8).

From the interviews conducted, ICU nurses had congruent thoughts to the data that was collected by Nygaard et al. (2022). Similar to the participants in the study by Nygaard et al. (2022), the study participants also considered family as part of the ICU team and expressed that they were not always actively invited to join rounds. This seemed to be explained by most participants as a result of the physician variability and buy-in to family-centered rounds in the ICU. Despite the evidence to support the initiative, our study also found the same results as Nygaard et al. (2022) in that family-centered rounds lacks standardization and an established process. This further validates the need for additional research to create a standard process for this best practice initiative.

In a study by Kalocsai et al. (2018), researchers found that inconsistencies in physician practice was a perceived hindrance to family members feeling part of the team. Some physicians would promise to update the families after rounds and never followed through. Additionally, family members who were only able to visit in the evenings and on weekends due to work commitments felt as though they never got to see or speak to a physician (Kalocsai et al., 2018). Hetland, et al. (2017) identified that one of the most common barriers for healthcare workers to involve families in rounds was differing opinions on the topic of family presence amongst interdisciplinary team members. In their study, Hetland et al. stated that some physicians did not approve of family presence during medical rounds and nurses alike did not support their involvement and viewed the family as an imposition. Conversely, several nurses remarked that the mindset of families being an imposition was an antiquated perception (Hetland et al., 2017). This difference of opinions has led to inconsistencies in practice where one nurse will welcome family on rounds and the next with discourage their participation, creating mixed messages and conflict within the team. This creates a negative impact on the quality of patient care (Hetland et al., 2017).

The studies by Kalocsai et al. (2018) and Hetland et al. (2017) were conducted pre-pandemic and still today, study participants share a similar experience regarding inconsistencies in physician practice. From our study conducted, participants reported that there was variability in who and when the families would be updated. Following the onset of the pandemic, if families were at the bedside during visitation hours, they may or may not be invited to actively participate. If families were not present, there was variability in regards to who would call to update them and when this call would take place. Study participants expressed that sometimes it would be the bedside nurse or the ICU Nurse Practitioner or the ICU physician. The timing of the call could also vary as sometimes this call occurred right after the round on that particular patient, while other times it was at the end of rounds altogether. Lastly, and unlike the findings by Hetland et al. (2017), the participants in our study generally all wanted to include families in rounds, despite the thoughts of the ICU physician. The ICU nurses still felt strongly that there was value in including families as they could see the benefits from participate with those physicians whom did conduct them well.

According to Kalocsai et al. (2018), family members reported that physicians encouraged their participation as a member of the care team through attendance at interdisciplinary rounds and participation in exchange of information and decision-making. Rounds were also perceived to be the best opportunity to speak with the physician and; therefore, families reorganized their day to plan their ICU visits in attendance at rounds. Kalocsai et al. (2018) also found that family members reported that they did not understand much of the information discussed and rounds were found to be intimidating. Nurses helped bridge this gap and families felt the bedside nurse was particularly good at explaining information discussed at rounds and translating any medical jargon that was not understood (Kalocsai et al., 2018). Nygaard et al. (2022) also found that nurses often functioned as the link between the family and healthcare team through advocacy of the family's point of view and wishes.

We also found through participant interviews that ICU nurses viewed themselves as translators to any medical jargon or information that was not well understood by family members during rounds. As evidenced by the transcripts, study participants also felt that they could collect the questions in advance of rounds that family members had, so that they in turn could advocate on behalf of the families and ensure their questions were answered. ICU study participants valued their role in bridging this gap in communication.

Although the study by Kalocsai et al. (2018) provided a perception through the lens of the family members of critically-ill patients, the results were very congruent with the perceptions of ICU nurses in this research study. A consistent theme identified was that ICU nurses also expressed similar challenges to the implementation of family-centered rounds through inconsistencies in physician practice. Furthermore, ICU nurses interviewed perceived their role largely to be an advocate for the family and assist in translation of medical jargon. This highlights the need for future research in clearly defining the roles of each member attending patient- and family-centered rounds.

Within the literature, a study conducted by Bansal et al. (2021) found that restricted visitation was one of the most critical changes and largest stressors for family members of patients in the ICU at the beginning of the pandemic. According to Bansal et al., these restrictions "increased patient isolation, hampered the ability of family members to advocate for their loved ones, and created barriers in care environments where clinicians rely on that patient's circle of care to fully provide for their needs" (p. 1). The tragic result has been patients dying alone, creating much distress and burden at end-of-life (Bansal et al., 2021). Intensive care units that previously had family-centered rounds experienced disruptions with the restricted visitation policies resulting from the COVID-19 pandemic and now struggle to find a way to re-integrate families virtually into the rounding process.

The perspective of participants interviewed is congruent with the study conducted by Bansal et al. (2021). According the participant named John, he compares his thoughts of rounds pre-pandemic to post-pandemic:

> I thought it went really smooth and it obviously just cut cold turkey since COVID hit. Unfortunately, it was going well. I think you can really see the difference in between the anxiety levels and probably the length of stay of patients.

John additionally adds that he feels restricted visitation has contributed to a longer length of stay and additional days a patient is on a ventilator for life support:

> When families were able to visit and be part of those rounds, 'cause they were just more informed, they could see their loved one. They knew the healthcare team and they, they probably had more trust in us just because you know, they were there and able to meet everyone versus they don't know what any of us look like or what any of us are doing for their loved one right? So that loss of connection is definitely difficult. I think it, I think it for sure it's contributed to longer lengths of stay for patients in the ICU or longer lengths of time that patients are kept on a ventilator when the family might have otherwise chosen to withdraw care.

Two years into the pandemic, as restrictions start to ease, visitation policies are relaxing; however, hospital policies continue to maintain less family visitors compared to pre-pandemic times. A study by Alhussaini (2021) found that these restrictions continue to put a strain on communication between the healthcare team and family members. During the COVID-19 pandemic, there has been a shift in the use of technology to fill the communication gap created by visitation restrictions, and also to allow for increased social distancing (Alhussaini, 2021). Alhussaini most notably observed that some ICUs have leveraged the use of technology for video calls with families and to enable communication or participation in virtual rounds with the healthcare team.

Seven of the eight study participants mentioned the use of virtual visitations via platforms such as Zoom or FaceTime to facilitate communication between the patient and their family, or family and the healthcare team. Elisha describes her experience with facilitating virtual visitation as overall positive:

> It's not even that they're not at the bedside. It's that they're not even in the hospital. So, we're doing a lot more Zoom calls, a lot more FaceTime, a lot more like Messenger calls, all of that. And you know, I honestly think that this gives the nurses a lot better connection with the family… I can show them on video and there can be… 10 people on a Zoom call and I can go over everything one time as opposed to having 10 phone calls and going through it one at a time. That's, that's a big help.

Susan also finds virtual visitations valuable but shares her experience with the use of technology with families whom may not be technologically inclined or have video conferencing technology readily available:

> Sometimes we'll FaceTime or just do like a call in over the phone. But then we… were finding like a lot of difficulty because some of our patient population.

> They’re older so then you know the spouses or some of them are not very technology based, like just not their generation. So, then they’ll get together with like their children.”

Susan additionally describes how families seem to be more anxious as a result of restricted visitation:

> Sometimes there’s too many people like at one house that are all asking questions like over the phone and then I have found like since COVID, just so many phone calls, like, just that like uneasy sort of nervous, like, you can’t go visit your family member so they call in multiple times.

John has also found that families have a lot more questions since they cannot physically visit their family member in person:

> Families obviously have a lot more questions because they aren’t there to see the patient, it’s through FaceTime… they are eventually able to come, but they’re not really participating in care rounds like they were before because there’s only those selected time for visitations.

Charlotte also agrees with the perception of increased anxiety amongst family members who cannot visit:

> One of the biggest things I've noticed. Since the pandemic, because they're, they're not allowed to come in until the patients had some negative COVID tests, is the sense of panic and anxiety level in the families is like over the top because they can't be there because even with the iPad and the visual Zoom calls, it's not the same as being able to reach out and touch your loved one or talk to them or engage with them in any way, shape or form.

Harvey and Kueper (2020) published their family's reflections of Mike Kueper's hospitalization with COVID-19 with an aim of providing recommendations to improve the patient experience during the pandemic. Mike is a 52-year-old, previously healthy male, who never so much as spent a couple hours in the Emergency Department prior to the pandemic. He had never spent a night in hospital until he was admitted with difficulty breathing as a result of COVID-19. Within 24 hours after admission, he was transferred to the ICU where he would spend the next 17 day alone, fighting for his life on a ventilator.

Wendlandt et al. (2021) conducted a study that analyzed the impact of visitation restrictions resulting from the COVID-19 pandemic on ICU nurses and physicians' experience in the workplace. A key finding reported by both physicians and nurses was that they perceived "an increase in family emotional distress and a decrease in family comprehension during telephone updates" as compared to in-person visitation (Wendlandt et al., 2021, p. 2). A benefit perceived by participating nurses was that they felt as though they gained more time to provide uninterrupted patient care with visitation restrictions while physicians felt their workflow was more significantly impacted as crucial conversation, such as those discussing goals of care or end-of-life conversations, were more distressing over the phone (Wendlandt et al., 2021).

Overall, both groups expressed their concern that restricted visitation in the ICU has a negative impact to some degree on healthcare workers, families, and patients throughout the pandemic. Although our study had exclusively ICU nurses as study participants and did not include ICU physicians, our findings are congruent with

Wendlandt et al. (2021) in that frontline staff perceived to have more time to complete patient care tasks, but overall felt that lack of family had a negative impact.

Overall, pre-pandemic research validates that the concept of patient- and family-centered rounds is novel in practice. While evidence supports that inclusion of family in bedside rounds is best practice for numerous reasons, there remains a gap regarding how best to implement and operationalize the process. At the onset of the COVID-19 pandemic, visitation restriction policies further hindered communication between the healthcare team and families and highlighted the need to implement a process to inclusively integrate family into rounds. ICU study participants further validate the need for family-centered rounds by consistently referencing their challenges with communication throughout the pandemic. There was congruency in their expression of benefits to communication and family-centered rounds pre-pandemic, and the desire continues to exist to advocate for changes to policy to include families real-time, whether in-person or in a virtual format.

Theme 2: Nursing the Patient Versus Nursing the Family

Five of the Eight study participants describe the role of the bedside ICU RN as translator of medical jargon. Elisha states that “I find that I am a good translator in between what the doc is saying and what the families can understand.” In addition, RN1 feels that the ICU RN “take on a big role in like re-explaining things to them as well and just making sure that their questions and thoughts are heard as well.” They also go on to explain that sometimes the rounding process is most efficient in the ICU when the team moves on to the next patient and the bedside RN stays back with the family to ensure they understand the discussion that took place:

> I think it just saves a lot of time like for the whole interdisciplinary team to kind of go on to the next patient and then leaves the rest of the explaining to the nurse. And then if they need a more detailed explanation then we always have the Nurse Practitioner call as well.

Cypress (2011) conducted a phenomenological study that examined the lived ICU experience of nurses, patient and family members using a Merleau-Pontian perspective. The aim of this pre-pandemic study was "to describe and understand the lived intensive care unit experience of nurses, patients and family members during critical illness" (p. 273). A significant finding of the study was the theme of 'Family as a Unit'. The patients and their families were perceived by nurses to be one unit. Conversely, participating "patients and family members viewed the nurse as part of the family" (p. 277). In congruence with Cypress' findings, all eight study participants viewed the family as an extension of the healthcare team, or as one operational unit in which required support of the bedside ICU RN.

Gavaghan and Carroll (2002) describe family as a social unit that significantly impacts patient outcomes. According to family systems theory, a change in one family member affects the entire family system and therefore, hospitalization creates a crisis for both patient and family. Nurses provide holistic care and understand that family is an extension of the patient. When a family member is critically ill, the nurse not only provides care for the patient, but are also "at the forefront of identifying interventions that support families" which also contributes to an improvement in patient outcomes (Gavaghan & Carroll, 2002, p. 69). While family members serve as great advocates for their loved one who is critically ill, their new role as spokesperson may cause great stress that threatens the family unit's stability and ability to cope (Gavaghan & Carroll, 2002).

Gavaghan and Carroll (2002) identify that nurses might struggle with the nurse-family relationship since they focus primarily on providing care to the patient. However, their support of the family member is critical to help provide families with access to resources to assist in coping with stress, such as access to social workers, spiritual care, and patient advocates. Nurses should be informed and use research findings on family-centered care to dispel myths on family presence at the bedside, develop empathy for families, and strengthen the nurse-family relationship (Gavaghan & Carroll, 2002). Through timely assessments and with a holistic lens, nurses are pivotal in providing supportive care to both patients and their family members.

The ICU RN named Charlotte provides her perceived benefit to the patient of early involvement and support of the entire family:

> Getting the family involved and having them on board with the patients care kind of also encourages, I think them. And encourages the patient as well because it's a team effort. The patients not there by themselves fighting this all by themselves and the family member is not there by themselves, fighting this all by themselves. It's a supportive, interactive, group effort and that's important 'cause it's supportive and it's interactive between the entire professional group and the family in support of the patient's health and well-being and getting them out of the ICU wherever they need to be better, over the hump of whatever illness they're fighting, and it's just, it's a much more positive environment and a much

> more positive forward-thinking process that way. And we get the valuable input from the family.

Family Support Teams (FST) are a novel concept that organizations are beginning to trial as a means to provide additional support to both patients and family members of critically-ill patients diagnosed with COVID-19 (Burke et al., 2021). The Palliative Care Team at a large, academic, medical centre in the Midwest created an FST in the spring of 2020. This team "was comprised of palliative care and ICU social workers, palliative care chaplains, and a university psychology professor/clinical psychologist" (Burke et al., 2021, p. 158). ICU nurses and physicians work collaboratively through referral to the FST who in turn helps to connect to families virtually. This has allowed families to better stay connected to their loved ones through virtual platforms, and they are also provided with emotional support through participation in virtual support groups that address grief and coping with emotions (Burke et al., 2021). Organizations' adoption of FST's may help alleviate the burden of supporting the family from the bedside nurse by providing a dedicated and qualified FST member to provide emotion support and resources to the family.

Throughout this study, research participants have consistently expressed that their role as ICU nurses is not only to provide care to the patient, but also to provide support to the family. Most participants identified their support and care of the family as an organic part of their role as an ICU nurse; however, it remains unclear how exactly they provide this support. As concluded in the research by Gavaghan and Carroll (2002), which identifies nursing referrals to the patient advocate and social work, additional studies are required to identify the best interventions to support families of critically ill patients. The hypothesis could be made that inclusion of families in the rounding process would help provide support and coping through active participation, but additional research is required to validate this concept.

Theme 3: Then and Now – Pre-Pandemic Versus Intra-Pandemic

The onset of the COVID-19 pandemic and imposed visitation restrictions brought one of the most challenging aspects of providing care to both patients and families (Burke et al., 2021). The depth of the emotional impact that visitation restriction would have on not only patients and families, but also hospital staff, was unpredictable. As a result, hospitals have had to adapt and establish new and innovative strategies to maintain communication and connection with patients and families (Burke et al., 2021).

Throughout their respective interviews, all eight participants consistently compared their experience with patient- and family-centered rounds pre-pandemic to the world in which they practice post-pandemic. We remain within an intra-pandemic phase in which the restrictions of the COVID-19 pandemic have eased; however, future waves and outbreaks remain a very likely probability. It was important to hear the perspective of participants as to what worked well pre-pandemic, to take those learnings and inform future practice while we look to re-integrate families into patient-centered care initiatives.

Within the literature, it was noted that several institutions have consulted patient and family advisory committees, the community, and healthcare team members for recommendations to improve the patient and family experience. For example, the Frontline Connect Canada (FCC) program was an initiative developed by an interdisciplinary team of community entrepreneurs, physicians, and students to help provide tablets and smartphones to patients and hospital staff (Bansal et al., 2021). The work of Bansal et al., describes the purpose of the FCC program “to enhance overall patient and family experience by using these devices to enable communication between patients, their loved ones, and their care team” (p. 2). In light of the imposed visitation restrictions due to the COVID-19 pandemic, there is increasing evidence that use of real-time video conferencing can help maintain a high standard of quality patient-centred care (Bansal et al., 2021).

From the interviews with participants, there is consistent messaging that ICU nurses perceive the use of video-conferencing technology platforms, such as Zoom and FaceTime, could be leveraged to help decrease the anxiety of family members seeking updates on their loved ones. Additional research is required to establish best practice guidelines and standardized operating processes to ensure congruence amongst healthcare workers.

The study by Bansal et al. (2021) found that the FCC program was used most often by participants during the COVID-19 pandemic to help facilitate virtual communication amongst patients, families, and the healthcare team while visitation was restricted. Bansal et al. describes how the devices were used for a variety of purposes; however, they were most often utilized to connect families to the healthcare team to communicate a patient’s health status, history, or goals of care. Although our study site does not currently have an FCC program, the ICU nurses and staff did also utilize technology to communicate information about patients’ health status.

Kaslow et al. (2021) also found similar opportunities for future improvement related to patient and family-centered care (PFCC) that has been hampered by the COVID-19 pandemic. Many issues related to lack of knowledge regarding transmission of the virus, as well as availability of personal protective equipment have now been resolved, yet return to previous pre-pandemic visitation policies continue to lag behind other pandemic re-opening plans, such as re-opening of small businesses, restaurants, and schools. The study by Kaslow et al. provides an overview of the experiences of health care workers, family members, and patients while also providing a roadmap for PFCC implementation at the systems level. The recommendations made within the PFCC roadmap help provide a humanistic approach and balance of public health measures with initiatives that maintain the psychosocial wellbeing of patients and families (Kaslow et al., 2021).

Eight of eight ICU participants within this research study have provided the perspective consistent with Kaslow et al. (2021) and Bansal et al. (2021) with regards to both use of technology for virtual visitation and the need to re-address visitation restrictions imposed by the COVID-19 pandemic. The intention of imposed strict visitation policies had the priority goal of protecting frontline healthcare workers, families, and patients for additional viral transmission; however, evidence from the COVID-19 pandemic and prior pandemics throughout history have demonstrated “that such policies negative impact the well-being of patients, families, and HCPs; patient safety; and decision making and choices related to health care” (Kaslow et al., 2021, p. 9). We now must move forward in planning how to reinstitute family-centered rounds and family-centered care principles into ICUs post-pandemic. The use of technology can help provide new innovations for better connecting patients and families which may not have been as progressive pre-pandemic.

CHAPTER 6: Limitations and Implications for Future Practice

The findings of this study provide rich participant perspectives that can inform future practice and policies at an individual, organizational, institutional, and government levels. The study limitations will be discussed within this chapter, along with recommendations for system-wide change as we move forward in the COVID-19 pandemic. Lastly, a discussion on the recommendations for future research will help inform what gaps continue to exist regarding patient- and family-centered rounds in the ICU and how we can continue to strive to establish a best practice guideline.

Study Limitations

This study explored the lived experience and perspective of eight ICU RNs of patient- and family-centered rounds in two ICUs at an Ontario hospital with two campuses. Sampling was purposeful as participants were required to have at least one year of ICU experience and experience with patient- and family-centered rounds. Eight participants were recruited and interviews were conducted virtually by a research assistant. While saturation was achieved, the sample size is small and represents the experiences of a small cohort of nurses working in an ICU in one geographic location in Ontario.

In addition to limited interviews, the majority of the participants were from the same age range and had limited experience as an ICU RN. Five of the eight participants were between the ages of 30 and 39 years old. Furthermore, six of the eight participants had less than 5 years of experience working in an ICU. The researcher questions whether the age and level of ICU experience impacts their perception and experience of patient- and family-centered rounds in the ICU. Would their perception and experience differ with additional life and professional experience? For example, nurses with more experience in the ICU or with more nursing experience in general may feel more comfortable speaking to patients and families. Furthermore, nurses whom have had a family member or loved one hospitalized in the ICU or had previous experience dying may be more sensitive towards restricted visitation. Additional interviews and research are required to determine whether this would be a possibility.

Another possible limitation is the unknown cultural background and ethnicity of each participant. Does each participant's cultural background and religious affiliation influence their support or preferences for family-centered rounds? Do personal values and beliefs and religious affiliation change their perception of patient- and family-centered rounds? Additional research is needed to determine if there is a correlation between cultural values and religious beliefs and the experience of patient- and family-centered rounds.

As mentioned previously, this study recruited participants from two hospital sites, geographically located in a medium sized city. Future research should include multiple sites across Ontario including ICUs in larger metropolitan areas and smaller rural hospitals. While the participants in this study provided rich textual data, a mixed methods methodology may elicit additional results that could link thematic structure with satisfaction or data from other scoring tools.

Moreover, participants were all ICU Registered Nurses, but as discussed in this study, patient- and family-centered rounds are a team-based process that includes the patient and family as an extension of the team. Future research would benefit from including the perspective of all participants in the patient- and family-centered rounding process, including the Intensivist, Nurse Practitioner, Respiratory Therapist, Pharmacist, Patient, Family, and any additional personnel that might be present and participate in rounds.

Implications for Future Practice

The COVID-19 pandemic has highlighted system-wide problems and completely changed the experience of patients, families, and clinicians (Hamilton, 2021, p. 25). Patient volumes quickly overwhelmed organizational capacity and surge planning became an immediate priority requiring conversion of previous non-clinical spaces to retrofit negative pressure critical care rooms (Hamilton, 2021). The sickest of patients became isolated alone and lost the humanistic connections and support from their loved ones (Hamilton, 2021). When families are denied access to visitation, the benefits and safety validated through PFCC no longer exist (Kaslow et al., 2021). Following the pandemic, PFCC initiatives that incorporate an option for virtual care could enhance the patient and family experience and provide numerous benefits to families that otherwise would not be able to visit regularly (Cheney, 2020; Webb et al., 2020). The following section provides recommendations and implications for future practice that outlines examples of PFCC initiatives from the individual to systems level.

Standardized Process and Best Practice Guideline

Intensive Care Units should look to develop standardized protocols, policies, and scripting for inclusion of patients and families in the rounding process. Additional engagement of frontline clinicians is required, as well as additional research to develop best practice guidelines as we move forward from the COVID-19 pandemic. Development of rounding policies should allow for both in-person and virtual formats based on patient and families' preferences. This would allow for the flexibility to continue to engage and include families in future health emergencies and pandemics.

Future implications should also consider that widespread adaptation of virtual care poses significant barriers to families that cannot access the technology or have limited technological literacy in being able to use video-conferencing devices (Rose et al., 2021). Having the ability to offer families an in-person or virtual option for participation would allow them to choose a model that best fits with their life circumstances. A hybrid model would allow for inclusion of families that are not local or individuals that need to continue working to support their family. The study previously mentioned by Bansal and colleagues (2021) also suggests that opportunities exist for future improvement such as addressing concerns with infection control, device security and privacy, increased training of end-users on the setup of virtual programs, and potential cost of damage to the devices.

According to Harvey & Kueper (2020), from Mike and his family's experience, one major recommendation to improve the patient experience for those with COVID-19 is to have "a more systemic approach to communication" (p. 762). For example, Mike and his family recommend implementation of a daily call between the family and the healthcare team while on multidisciplinary rounds to strengthen the relationship between families and healthcare personnel. This recommendation would be a feasible option for implementation as a way to reassure families their loved one was receiving excellent care and open communication.

Health Human Resources and Nursing Shortage

As a result of burn out, mental health, and nursing shortage, Canada is currently experiencing a health care crisis that will create even more of a challenge for staff to include families in rounds and provide patient- and family-centered care while staff struggle to provide basic care needs to their current assignment. Leveraging the use of family in providing basic care at the bedside may provide an opportunity for inclusion and also decrease workload for staff.

The pandemic has strained the nursing workforce with burnout and mental health burden that has resulted in a severe shortage of Canada's health workforce. The RN understaffing in Ontario has been a decade-long issue in which the Registered Nurses' Association of Ontario [RNAO] (2021) has long advocated to improve, however the COVID-19 pandemic has further carved out a deeper crisis. Nurses have historically been resilient while facing stress but there is a limit to the magnitude and length of time in which an individual can endure. Many nurses in Ontario have reached that limit and have left their current roles, while others have left the professional altogether (RNAO, 2021).

According to the Canadian Federation of Nurses Unions [CNFU] (2022), 60% of nurses intend to leave their job within the next year. Of those considering leaving, the top reasons for wanting to make a career change includes: burn out, capacity issues and unable to provide adequate levels of care, insufficient staffing, lack of support by administration or management, and unpredictable staffing and re-deployment (CFNU, 2022). Furthermore, the number of healthcare workers reporting severe burnout in 2021 has doubled reports from pre-pandemic levels (Maunder et al., 2021). Most alarming is the fact that 20% of healthcare workers on the frontline have experienced thoughts of suicide and 6% have planned how they would carry out an attempt to end their life (Mental Health Research Canada, 2021). The COVID-19 pandemic has now magnified the longstanding understaffing of Registered Nurses in Ontario as a human resources crisis (RNAO, 2021).

The healthcare workforce is currently experiencing the biggest crisis seen to date and affects not only nursing, but also frontline staff from all healthcare disciplines. If we do not create a plan soon, Canada's healthcare system could suffer devastating repercussions. The Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) have hosted two emergency summits to hear from near to 40 health organizations representing various healthcare disciplines. They listened and heard how frontline staff are exhausted, depleted, distressed, and leaving the workforce in their respective disciplines in their entirety (CMA & CNA, 2022). They've additionally partnered with the College of Family Physicians of Canada (CFPC) to create a briefing to the House of Commons (2022, April 14) on the topic of Health Human Resource Policy Recommendations. They've drafted eight recommendations that have been divided into a timeline as: short-term (1-6 months), medium-term (7-12 months), and long-term (13-18 months). Recommendations are aimed at workforce retention through initiatives such as monetary incentives; access to care for Canadians through primary health teams or virtual primary care initiatives; training and education for internationally trained doctors and nurses, as well as investment in post-secondary institutions for training current Canadians; and implementation of a mental health strategy for healthcare workers (CMA & CNA, 2022).

Participants within our study were grateful for the support and extra hands of the student nurses. As health human resources were stretched thin during the COVID-19 pandemic, the student nurses helped provide support with connecting families and lending a hand to ICU nurses to help with turns and mobilization of their patients. As staff become more burnt out as a result of the staffing crisis, it is pivotal to ensure that our current workforce has support and strategies implemented to retain our nursing workforce.

According to Statistics Canada (2021), there are 118,200 job vacancies nationally in healthcare across the country. Of all occupations measured, Registered Nurses and Registered Psychiatric Nurses have seen an 86% increase in the past two years (Statistics Canada, 2021). Furthermore, RN vacancies in Ontario have quadrupled since the beginning of 2016 and doubled since the onset of the pandemic with a 50% increase in vacancies remaining unfilled for more than 90 days (Statistics Canada, 2021).

Nursing Education and Hospital Orientation

Undergraduate and graduate nursing programs should review their curriculum for inclusion of patient- and family-centered care principles. This is a best practice concept and therefore should be interwoven throughout undergraduate baccalaureate and graduate level courses in both nursing, medicine, and other health discipline programmes.

As new staff are hired within an organization, general corporate orientation should provide an overview to all new hires on the core values of patient- and family-centered care. PFCC goes beyond the duties at the bedside and all individuals hired within a healthcare system should have a general awareness and practice being patient-centered.

Registered Nurses hired within Critical Care should additionally be provided with education on patient- and family-centered rounds and best practice guidelines right from the onset of their transition to the ICU. Since patient- and family-centered rounds is considered best practice, a culture of inclusivity should be fostered and education provided on this process right from the onset of critical care orientation.

Recommendations for Health System Leaders

Hospital administrators and clinicians should also look at the human resources and time investment required to facilitate a virtual rounding protocol. Health human resources are already strained and creative ways to press forward with patient- and family-centered rounds will require strong leadership. System leaders, including ICU managers, can play a pivotal role in addressing barriers to implementation and supporting frontline staff. The management and leadership team can ensure that there are resources in place for frontline staff to be able to continue to provide family-centered rounds and engage other disciplines as required, such as social work and patient advocates. This concept is not novel as Nygaard et al. (2002) states that "unit managers must facilitate a culture supporting and prioritizing family care, where family members are included as an active part of the ICU team and interprofessional dialogue is emphasized" (p. 9). The leadership team is key to address facilitators and barriers to adoption of any new process and the reintegration of families into the rounding process is no different.

As new policies are developed and reach the implementation stage, it is important to engage frontline staff and identify those who are informal leaders that can be appointed as champions to help with advocating for the new process to their peers. This includes seeking out volunteers from all disciplines, including assigning a physician champion as well.

In addition to virtual care, organizations must also look in the future to the architectural design of future hospitals and health systems. The COVID-19 pandemic has shown us that we require facilities that are designed and built with “a caring environment that is safe and clinically effective” (Lim et al., 2021, p. 27). This is an opportunity for administrators, frontline clinicians, and architectural design consultants to all come together to provide insight into a patient- and family-centered facility (Lim et al., 2021).

Future Research

Prior to the onset of the pandemic, Kalocsai et al. (2018) echoed the Society of Critical Care Medicine’s (SCCM) call that the integration of families into rounds requires “further research on the best ways to incorporate families into rounds beyond their mere presence” (p. 8). The concept of patient- and family-centered rounds remained novel at the onset of the pandemic and still required additional research at that time to define and standardize a best practice approach to implementation. Now that we are over two years into the COVID-19 pandemic, additional research is required to redefine how rounds can best be conducted in the ICU with the inclusion of family while respecting new infection control standards.

While this study sought to analyze the perspectives of ICU nurses, future research should also consider the thoughts and perceptions of other ICU team members that participate in the rounding process, such as physicians, respiratory therapists, pharmacists, and family members. Gaining insight from additional team members would additionally help to provide considerations into the rounding process and may provide additional buy-in by hearing directly from the family members of ICU patients. A family member representative could also be considered as part of the ICU working group on the development of any family-centered processes.

While qualitative research provides rich data and thematic structure, a mixed methods methodology for future research could include additional scoring tools, such as those that look at satisfaction scores and anxiety levels, to create inferences between qualitative and quantitative data sets.

The COVID-19 pandemic has also created the need for organizations to restrict visitation out of concern for frontline staff. With pandemic restrictions starting to ease, additional research reviewing visitation hours in the context of infectious disease outbreaks could provide insight into ideal visitation policies that can be implemented moving forward. As we discussed the recommendation for implementation of virtual visit options, additional research that analyzes the best platforms, ease of use, access to technology, and satisfaction with virtual visitation and virtual family meetings would also be beneficial to create virtual visiting policies in the future.

Conclusion

In conclusion, this study used a qualitative approach through the lens of Merleau-Ponty to examine ICU nurses' experience of family-centered rounds in the ICU. In light of the COVID-19 pandemic, this study provided a rich set of data with a pre-pandemic and post-pandemic view that provides a valuable contribution to the body of evidence and future research on the topic of patient- and family-centered care (PFCC). I could not agree more with Hamilton (2021) who states that "we must be better positioned to deal with outbreaks and epidemics while preserving the emphasis on a positive, humanistic patient, family, and staff experience” (p. 27). I hope that this study provides inspiration to other researchers passionate about improving patient- and family-centered care in the ICU post-pandemic.

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APPENDICES

APPENDIX A: Interview Protocol

Introductory Questions

1. By which name should I refer to you?
2. How long have you worked at Windsor Regional Hospital? How long in the ICU?
3. Have you worked in critical care at any other organizations?

Central Research Question

What is nurses' experience of patient and family-centered rounds in the ICU?

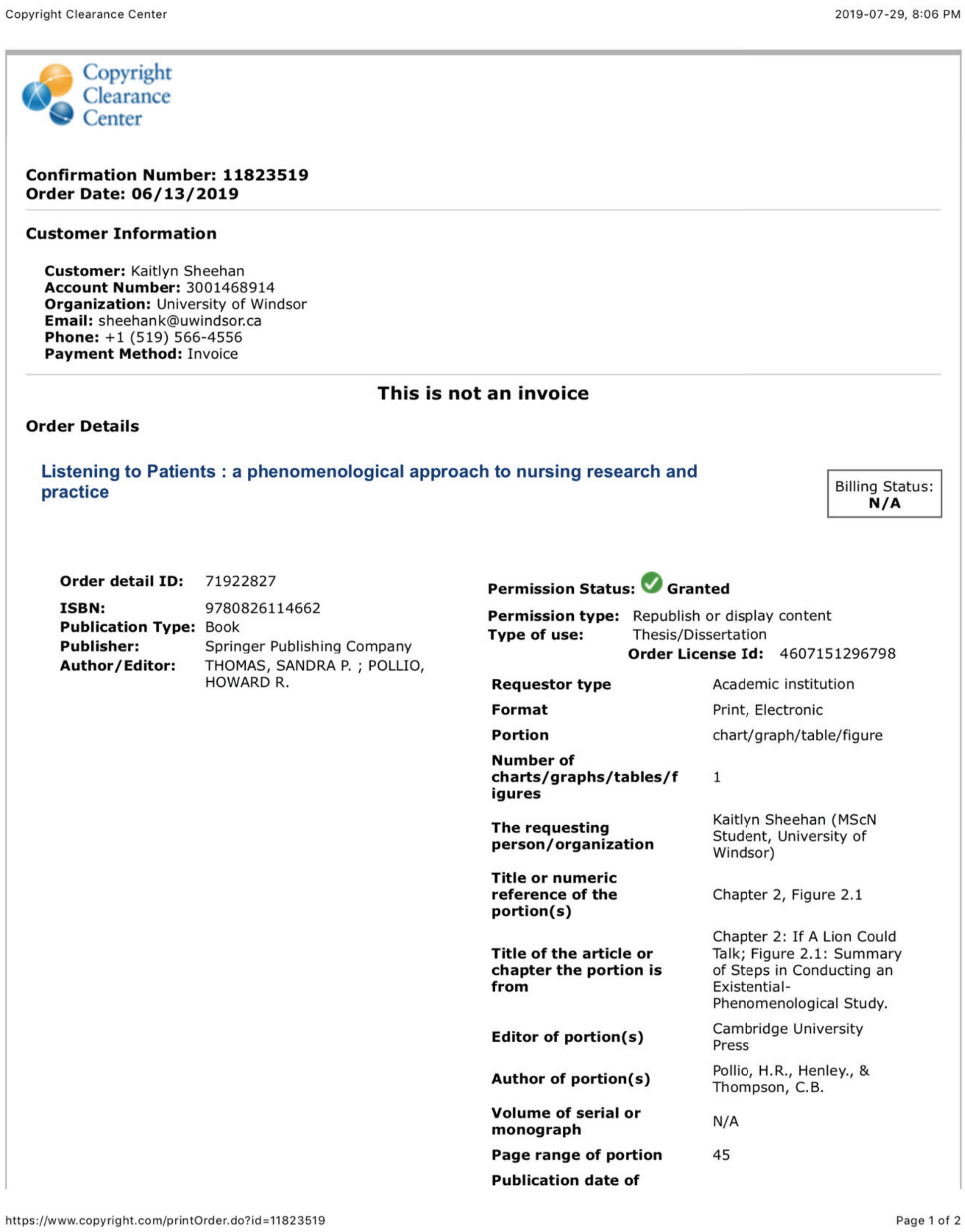
Examples of Possible Guiding and Probing Questions

1. What is the meaning of patient and family-centered care to you?
    a. What is patient and family-centered rounds?
    b. How is patient and family-centered care related to rounds?
2. How are patient and family-centered rounds conducted in the ICU?
    a. What is the role of the nurse from your perspective?
    b. What is your experience with patient and family-centered rounds?
    c. How do other interdisciplinary team members support patient and family-centered rounds? I.e. physician, pharmacy, etc.
3. Can you describe for me any challenges experienced that make it difficult for patient and family-centered rounds to take place?
    a. How does the environment in the ICU impact family-centered rounds?
    b. How are legal concerns and confidentiality managed?
    c. How does the culture of the unit impact rounds?
    d. What do you think might be a recommendation for improvement?
4. What works well? Why?

Closing Questions

1. Do you have any additional closing comments or remarks?
2. Can I contact you to validate your interview after transcription?
3. To thank you for your time and participation, I would like to provide you with a $50 Visa Gift Card.

APPENDIX B: Copyright Clearance



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The requesting person/organization	Kaitlyn Sheehan (MScN Student, University of Windsor)
Title or numeric reference of the portion(s)	Chapter 2, Figure 2.1
Title of the article or chapter the portion is from	Chapter 2: If A Lion Could Talk; Figure 2.1: Summary of Steps in Conducting an Existential-Phenomenological Study.
Editor of portion(s)	Cambridge University Press
Author of portion(s)	Pollio, H.R., Henley., & Thompson, C.B.
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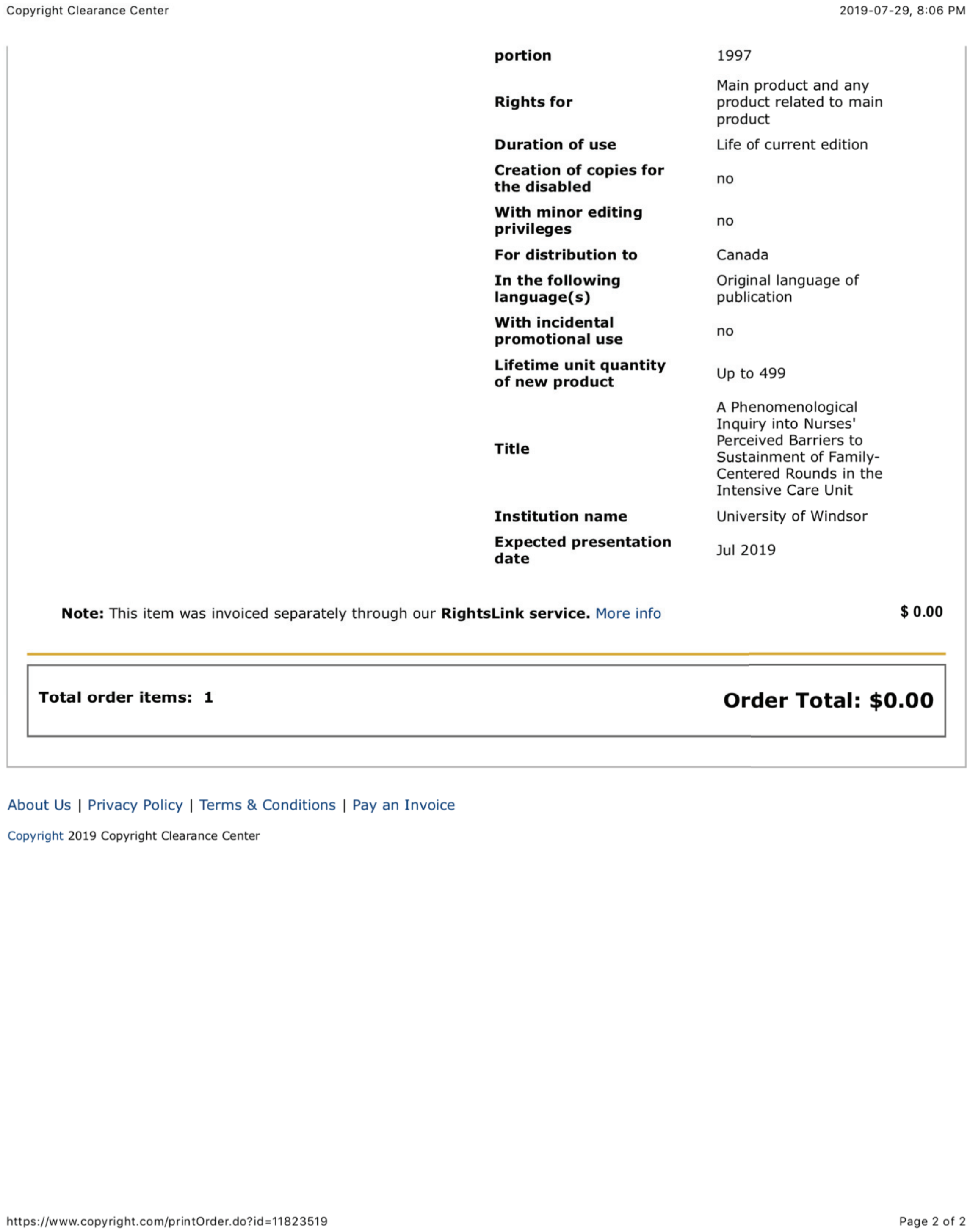

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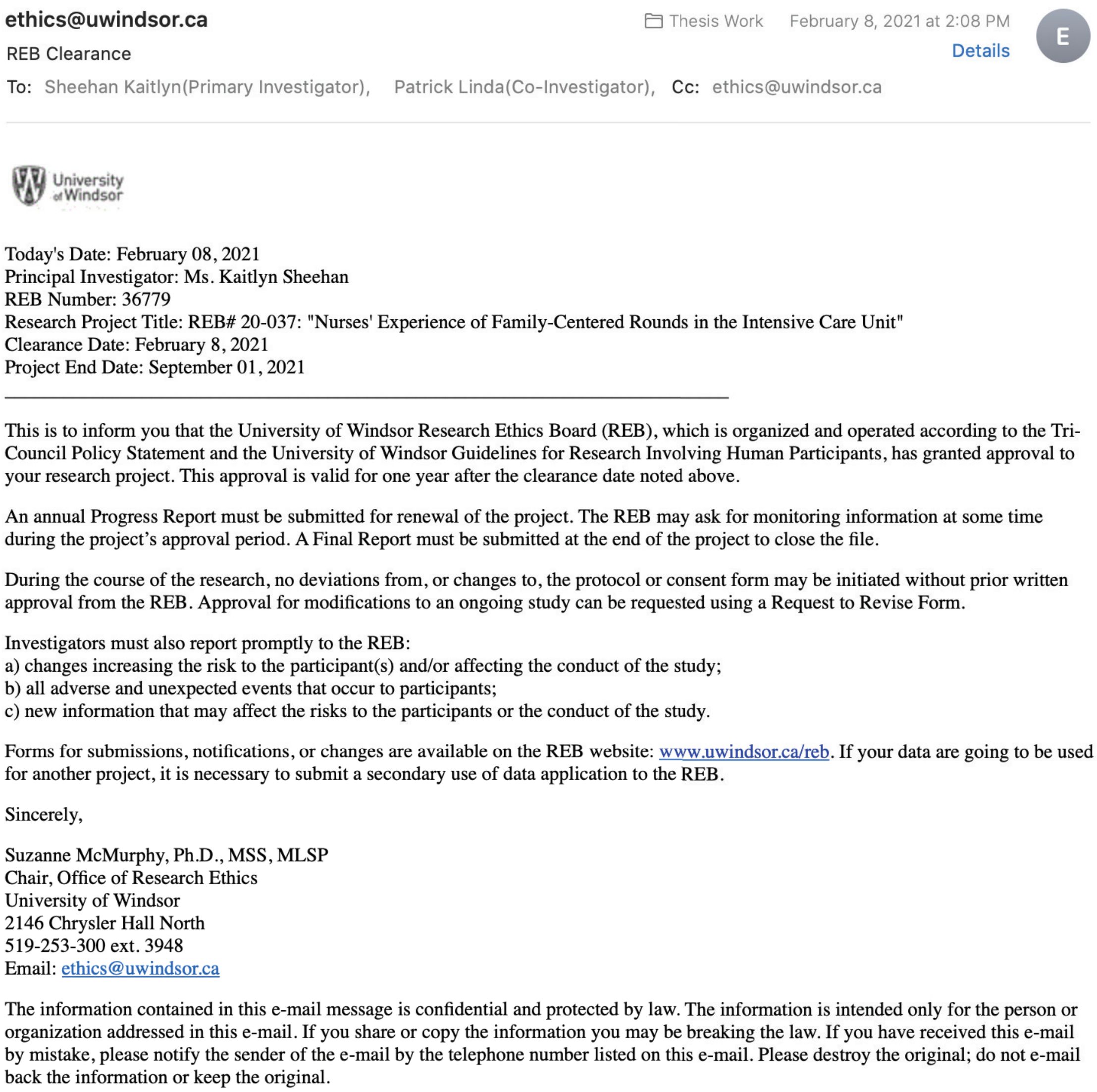
APPENDIX C: REB Clearance from the University of Windsor



ethics@uwindsor.ca
REB Clearance
To: Sheehan Kaitlyn(Primary Investigator), Patrick Linda(Co-Investigator), Cc: ethics@uwindsor.ca

Today's Date: February 08, 2021
Principal Investigator: Ms. Kaitlyn Sheehan
REB Number: 36779
Research Project Title: REB# 20-037: "Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit"
Clearance Date: February 8, 2021
Project End Date: September 01, 2021

This is to inform you that the University of Windsor Research Ethics Board (REB), which is organized and operated according to the Tri-Council Policy Statement and the University of Windsor Guidelines for Research Involving Human Participants, has granted approval to your research project. This approval is valid for one year after the clearance date noted above.

An annual Progress Report must be submitted for renewal of the project. The REB may ask for monitoring information at some time during the project's approval period. A Final Report must be submitted at the end of the project to close the file.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the REB. Approval for modifications to an ongoing study can be requested using a Request to Revise Form.

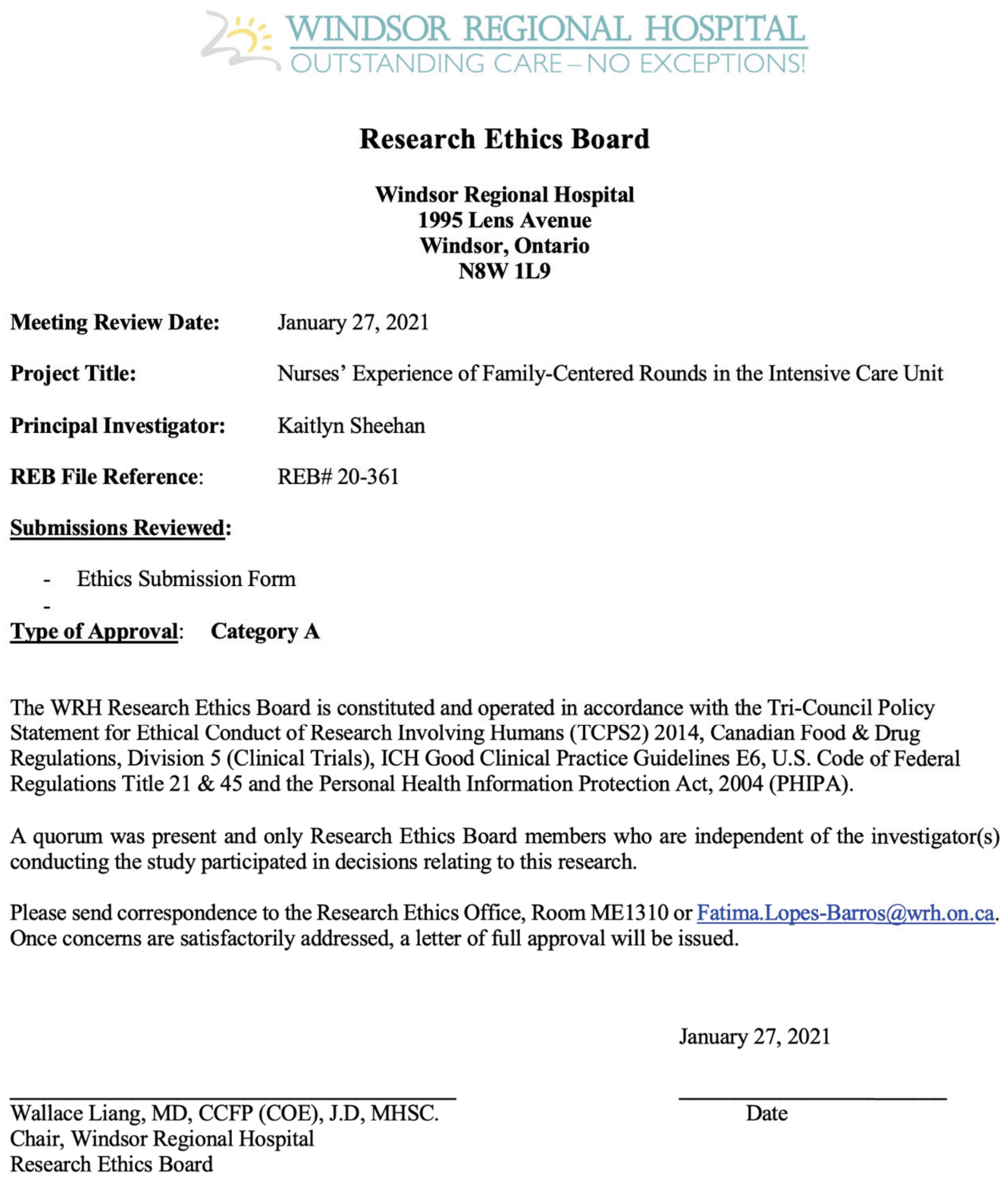
Investigators must also report promptly to the REB:
a) changes increasing the risk to the participant(s) and/or affecting the conduct of the study;
b) all adverse and unexpected events that occur to participants;
c) new information that may affect the risks to the participants or the conduct of the study.

Forms for submissions, notifications, or changes are available on the REB website: www.uwindsor.ca/reb. If your data are going to be used for another project, it is necessary to submit a secondary use of data application to the REB.

Sincerely,

Suzanne McMurphy, Ph.D., MSS, MLSP
Chair, Office of Research Ethics
University of Windsor
2146 Chrysler Hall North
519-253-300 ext. 3948
Email: ethics@uwindsor.ca

APPENDIX D: REB Clearance from Windsor Regional Hospital



WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Research Ethics Board

Windsor Regional Hospital
1995 Lens Avenue
Windsor, Ontario
N8W 1L9

Meeting Review Date: January 27, 2021

Project Title: Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

Principal Investigator: Kaitlyn Sheehan

REB File Reference: REB# 20-361

Submissions Reviewed:

- Ethics Submission Form
-

Type of Approval: **Category A**

The WRH Research Ethics Board is constituted and operated in accordance with the Tri-Council Policy Statement for Ethical Conduct of Research Involving Humans (TCPS2) 2014, Canadian Food & Drug Regulations, Division 5 (Clinical Trials), ICH Good Clinical Practice Guidelines E6, U.S. Code of Federal Regulations Title 21 & 45 and the Personal Health Information Protection Act, 2004 (PHIPA).

A quorum was present and only Research Ethics Board members who are independent of the investigator(s) conducting the study participated in decisions relating to this research.

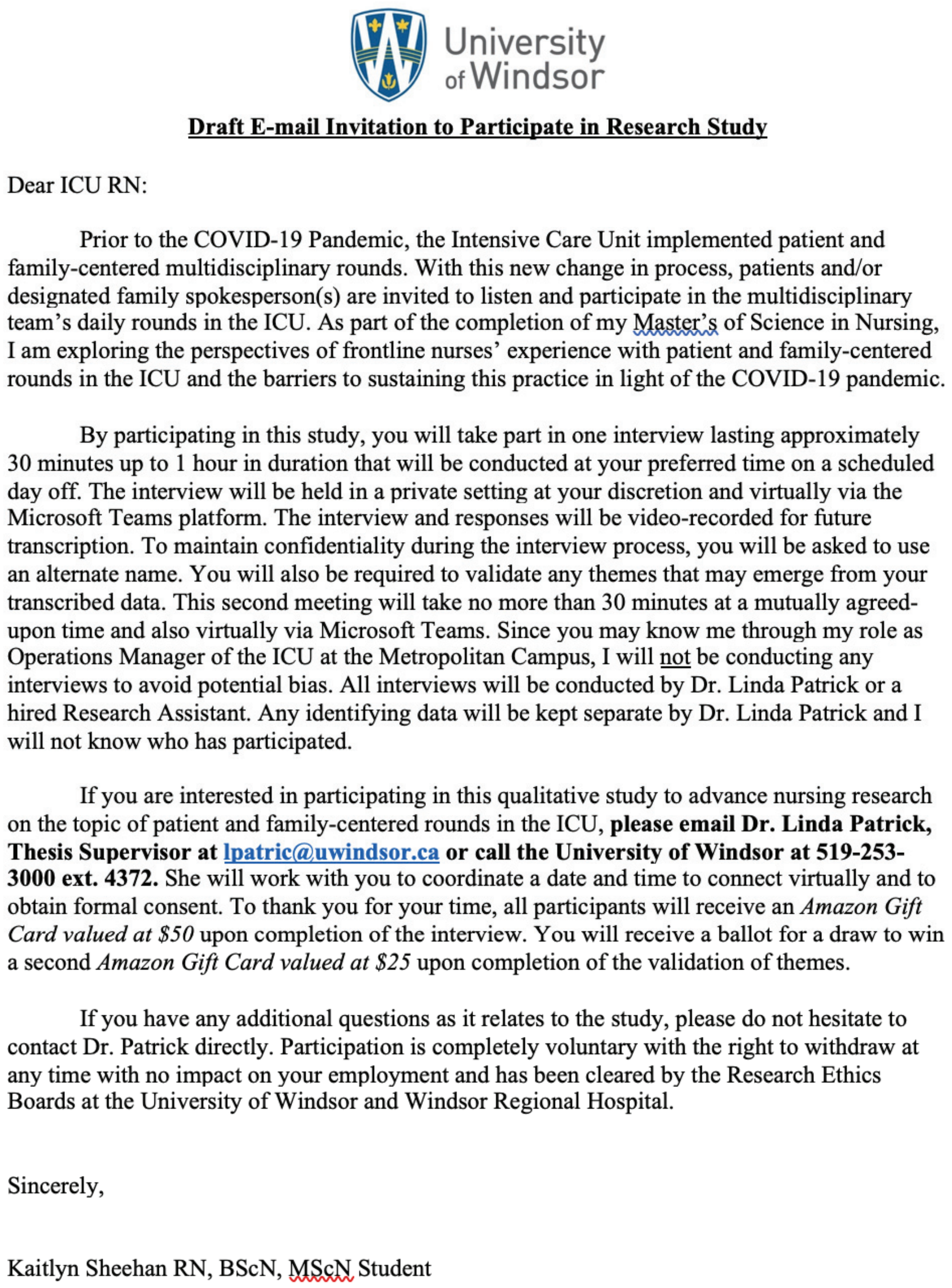
Please send correspondence to the Research Ethics Office, Room ME1310 or Fatima.Lopes-Barros@wrh.on.ca. Once concerns are satisfactorily addressed, a letter of full approval will be issued.

January 27, 2021

____
Wallace Liang, MD, CCFP (COE), J.D, MHSC.
Chair, Windsor Regional Hospital
Research Ethics Board

____
Date

APPENDIX E: Participant Recruitment E-Mail



University of Windsor

Draft E-mail Invitation to Participate in Research Study

Dear ICU RN:

Prior to the COVID-19 Pandemic, the Intensive Care Unit implemented patient and family-centered multidisciplinary rounds. With this new change in process, patients and/or designated family spokesperson(s) are invited to listen and participate in the multidisciplinary team's daily rounds in the ICU. As part of the completion of my Master's of Science in Nursing, I am exploring the perspectives of frontline nurses' experience with patient and family-centered rounds in the ICU and the barriers to sustaining this practice in light of the COVID-19 pandemic.

By participating in this study, you will take part in one interview lasting approximately 30 minutes up to 1 hour in duration that will be conducted at your preferred time on a scheduled day off. The interview will be held in a private setting at your discretion and virtually via the Microsoft Teams platform. The interview and responses will be video-recorded for future transcription. To maintain confidentiality during the interview process, you will be asked to use an alternate name. You will also be required to validate any themes that may emerge from your transcribed data. This second meeting will take no more than 30 minutes at a mutually agreed-upon time and also virtually via Microsoft Teams. Since you may know me through my role as Operations Manager of the ICU at the Metropolitan Campus, I will not be conducting any interviews to avoid potential bias. All interviews will be conducted by Dr. Linda Patrick or a hired Research Assistant. Any identifying data will be kept separate by Dr. Linda Patrick and I will not know who has participated.

If you are interested in participating in this qualitative study to advance nursing research on the topic of patient and family-centered rounds in the ICU, **please email Dr. Linda Patrick, Thesis Supervisor at lpatric@uwindsor.ca or call the University of Windsor at 519-253-3000 ext. 4372.** She will work with you to coordinate a date and time to connect virtually and to obtain formal consent. To thank you for your time, all participants will receive an *Amazon Gift Card valued at $50* upon completion of the interview. You will receive a ballot for a draw to win a second *Amazon Gift Card valued at $25* upon completion of the validation of themes.

If you have any additional questions as it relates to the study, please do not hesitate to contact Dr. Patrick directly. Participation is completely voluntary with the right to withdraw at any time with no impact on your employment and has been cleared by the Research Ethics Boards at the University of Windsor and Windsor Regional Hospital.

Sincerely,

Kaitlyn Sheehan RN, BScN, MScN Student

APPENDIX F: Participant Recruitment Flyer

Attention: Intensive Care Unit Nurses

You are invited to participate in a study describing
Nurses' Experience of Family-Centered Rounds in the ICU

Eligibility:

- At least 1 year of nursing experience as an ICU RN
  Experience participating in family-centered rounds in an Intensive Care Unit

Commitment:
In this study, you will be asked to participate in one virtual interview via Microsoft Teams lasting approximately 30 minutes up to 1 hour in duration sharing your experience with family-centered rounds in the ICU. You will also be invited to participate in one additional session to review and confirm the findings that emerge from your transcript.

Compensation: To thank you for your time, you will be provided with a $50 Amazon Gift Card. Once you have completed the second meeting to review the findings from your first interview, you will be provided with an entry to win a second Amazon gift card valued at $25.

The investigator of this study is Kaitlyn Sheehan RN, BScN, MScN Student. This study has been approved and received clearance by the Research Ethics Boards of the University of Windsor and Windsor Regional Hospital.

If you are interested in participating in this study, please call or e-mail Dr. L. Patrick at the University of Windsor at 519-253-3000 Extension 4372 or lpatric@uwindsor.ca

APPENDIX G: Letter of Information for Consent to Participate in Research

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

You are asked to participate in a research study conducted by **Kaitlyn Sheehan** of the University of Windsor for her Major Thesis project in partial fulfilment of the Master's of Science in Nursing Program.

If you have any questions or concerns about the research, please feel to contact **Dr. Linda Patrick**, Thesis Supervisor at **(519) 253-3000 ext.4372 or via email at lpatric@uwindsor.ca**

PURPOSE OF THE STUDY

The purpose of this study is to explore the ICU nurses' experience of family-centered rounds in the Intensive Care Unit. The researcher hopes to gather the perspectives of frontline critical care nurses' experience in their involvement with family-centered multidisciplinary rounds, both prior to and during the COVID-19 pandemic.

PROCEDURES

If you volunteer to participate in this study, you will be asked to complete one interview with the researcher's Thesis Supervisor, Dr. Linda Patrick or a hired Research Assistant, lasting approximately 30 minutes up to 1 hour in duration. The interview time may run shorter or longer depending on the amount of information you have to share on your personal experience with patient and family-centered rounds. Interviews will be video-recorded via the Microsoft Teams platform for future transcription. You will be contacted at a later date for validation of the identified themes that emerge. This second meeting with last up to 30 minutes in duration.

POTENTIAL RISKS AND DISCOMFORTS

Participation in this study carries no foreseeable risks or discomforts, including negative physical, social, or economic effects. There is a medium emotional risk that sharing your experience within the context of the ICU and the COVID-19 pandemic might trigger an emotional response to your lived experience.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIET

Participants may experience increased satisfaction knowing the contribution of their experience will help to generate knowledge to enhance patient care and the continued improvement of patient and family-centered rounds in the ICU. The findings may benefits others seeking to implement patient and family-centered rounds within their organization as identification of barriers to sustainment can assist in developing strategies to manage change and mitigate risk of project failure. Additionally, the findings may help inform how to adapt the standard work of family-centered rounds in light of the current COVID-19 pandemic.

COMPENSATION FOR PARTICIPATION

To thank you for your time, study participants will be provided with a $50 Amazon gift card upon completion of the interview. Additionally, each participant will receive a ballot to enter a draw to win a second Amazon gift card valued at $25 on completion of the second meeting to validate themes.

CONFIDENTIALITY

The researcher provides the assurance that responses of participants are confidential and identities will not be identifiable throughout the research process and within any future publications and presentations. Participants will be asked to choose an alternate name that they would like to use throughout the duration of the interview process that will be known only to the researcher, research assistant, principle advisor, and internal reader for the sole purpose of clarifying and validating any data collected. Information will not be linked to the participant's identity and the raw data collected will remain only with the researcher's Thesis Advisor, Dr. Linda Patrick.

All data collected in accordance with this study will be stored in a locked cabinet and on a password protected laptop with 2-factor authentication. All data will be destroyed one year after completion of the study. Video-recordings via Microsoft Teams will be deleted immediately after validation of the transcribed data. Data will only be accessed for the purpose of analyzing data by the research team.

Should the participant disclose at any point in the study that they are thinking of harming themselves or others, the researcher has a duty to report and will be required to breach confidentiality in the interest of safety of the participant and/or others identified as at risk of harm.

PARTICIPATION AND WITHDRAWAL

The investigator may withdraw you from this research if circumstances arise which warrant doing so. Participation in this research study is completely voluntary. Should you consent to participate, you may withdraw from the study at any point without consequences. Participants may choose to not answer any questions that make them feel uncomfortable and will continue to be considered as part of the study. Data cannot be withdrawn after 7 days following your interview date as the transcription process and thematic interpretations will likely have started. Choosing to participate and/or withdraw at any point will have no consequences and no effect on your employment.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

Participants may agree to be contacted when results of the study are available to obtain a copy. Following the completion of the study, results will also be available for access at https://scholar.uwindsor.ca/research-result-summaries/.

SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

____________________________________ ____________________
Signature of Investigator Date

APPENDIX H: Consent to Participate in Research

University of Windsor

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

You are asked to participate in a research study conducted by **Kaitlyn Sheehan** of the University of Windsor for her Major Thesis project in partial fulfilment of the Master's of Science in Nursing Program.

If you have any questions or concerns about the research, please feel to contact **Dr. Linda Patrick**, Thesis Supervisor at **(519) 253-3000 ext.4372 or via email at lpatric@uwindsor.ca**

PURPOSE OF THE STUDY

The purpose of this study is to explore the ICU nurses' experience of family-centered rounds in the Intensive Care Unit. The researcher hopes to gather the perspectives of frontline critical care nurses' experience in their involvement with family-centered multidisciplinary rounds, both prior to and during the COVID-19 pandemic.

PROCEDURES

If you volunteer to participate in this study, you will be asked to complete one interview with the researcher's Thesis Supervisor, Dr. Linda Patrick or a hired Research Assistant, lasting approximately 30 minutes up to 1 hour in duration. The interview time may run shorter or longer depending on the amount of information you have to share on your personal experience with patient and family-centered rounds. Interviews will be video-recorded via the Microsoft Teams platform for future transcription. You will be contacted at a later date for validation of the identified themes that emerge. This second meeting with last up to 30 minutes in duration.

POTENTIAL RISKS AND DISCOMFORTS

Participation in this study carries no foreseeable risks or discomforts, including negative physical, social, or economic effects. There is a medium emotional risk that sharing your experience within the context of the ICU and the COVID-19 pandemic might trigger an emotional response to your lived experience.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIET

Participants may experience increased satisfaction knowing the contribution of their experience will help to generate knowledge to enhance patient care and the continued improvement of patient and family-centered rounds in the ICU. The findings may benefits others seeking to implement patient and family-centered rounds within their organization as identification of barriers to sustainment can assist in developing strategies to manage change and mitigate risk of project failure. Additionally, the findings may help inform how to adapt the standard work of family-centered rounds in light of the current COVID-19 pandemic.

COMPENSATION FOR PARTICIPATION

To thank you for your time, study participants will be provided with a $50 Amazon gift card upon completion of the interview. Additionally, each participant will receive a ballot to enter a draw to win a second Amazon gift card valued at $25 on completion of the second meeting to validate themes.

CONFIDENTIALITY

The researcher provides the assurance that responses of participants are confidential and identities will not be identifiable throughout the research process and within any future publications and presentations.

Participants will be asked to choose an alternate name that they would like to use throughout the duration of the interview process that will be known only to the researcher, research assistant, principle advisor, and internal reader for the sole purpose of clarifying and validating any data collected. Information will not be linked to the participant's identity and the raw data collected will remain only with the researcher's Thesis Advisor, Dr. Linda Patrick.

All data collected in accordance with this study will be stored in a locked cabinet and on a password protected laptop with 2-factor authentication. All data will be destroyed one year after completion of the study. Video-recordings via Microsoft Teams will be deleted immediately after validation of the transcribed data. Data will only be accessed for the purpose of analyzing data by the research team.

Should the participant disclose at any point in the study that they are thinking of harming themselves or others, the researcher has a duty to report and will be required to breach confidentiality in the interest of safety of the participant and/or others identified as at risk of harm.

PARTICIPATION AND WITHDRAWAL

The investigator may withdraw you from this research if circumstances arise which warrant doing so. Participation in this research study is completely voluntary. Should you consent to participate, you may withdraw from the study at any point without consequences. Participants may choose to not answer any questions that make them feel uncomfortable and will continue to be considered as part of the study. Data cannot be withdrawn after 7 days following your interview date as the transcription process and thematic interpretations will likely have started. Choosing to participate and/or withdraw at any point will have no consequences and no effect on your employment.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

Participants may agree to be contacted when results of the study are available to obtain a copy. Following the completion of the study, results will also be available for access at https://scholar.uwindsor.ca/research-result-summaries/.

SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study **Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit** as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

______________________	______________________	________________
Name of Participant	Signature of Participant	Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

______________________________	________________
Signature of Investigator	Date

APPENDIX I: Consent for Video Recording

University of Windsor

CONSENT FOR VIDEO-RECORDING

Research Participant Name:

Title of the Project: Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

I consent to the video-recording of my interview on the above-mentioned topic via Teams platform.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the recording be stopped. I also understand that my name will on be known to the principle researcher and her thesis supervisor and that recordings will be kept confidential. Participant names with alternate name identity are stored in a separate file from the transcripts.

The destruction of the video recordings will be completed immediately after transcription and verification.

I understand that confidentiality will be respected and that the video recording will be for professional use only.

This research has been cleared by the Research Ethics Boards at the University of Windsor and Windsor Regional Hospital.

______________________________	______________________
(Signature of Research Participant)	(Date)
______________________________	______________________
(Printed Name of Research Participant)	(Date)

APPENDIX J: Patient Demographic Sheet

Demographic Data Collection

Title: Nurses' Experience of Family-Centered Rounds in the Intensive Care Unit

Principle Researcher: Kaitlyn Sheehan RN, BScN, MScN Student

To be completed by the Research Participant prior to Interview:

Name: ______________________________

Phone Number: _______________________ E-mail: ___________________________________

Age (Please circle one) *20-29 years* *30-39 years* *40-49 years* *50+ years*

Employment

How many years have you been nursing for your current employer (Please circle one)

Less than 5 *5-10* *11-20* *21-30* *30+*

How many years have you worked in your current department (Please circle one):

Less than 5 *5-10* *11-20* *21-30* *30+*

How many years have you worked in an ICU setting (Please circle one):

Less than 5 *5-10* *11-20* *21-30* *30+*

What other departments have you worked in?

____

____

Education

What is your highest level of education completed (Please circle all that apply):

Diploma *BScN* *MN/MScN* *PhD* *Other:*___________________

Alternate Name to use during Interview: ____

Preferred Date/Time of Interview: ____

VITA AUCTORIS

NAME:	Kaitlyn Sheehan
PLACE OF BIRTH:	Windsor, ON
YEAR OF BIRTH:	1990
EDUCATION:	St. Anne’s High School, Tecumseh, ON, 2008
	University of Windsor, B.Sc.N., Windsor, ON, 2012
	University of Windsor, M.Sc.N., Windsor, ON, 2023